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IMPROVE ACCREDITATION, REGULATION, AND QUALITY STANDARDS... FOR QUALITY CARE AMIDST ABSOLUTE INFRASTRUCTURE AND RESOURCE CONSTRAINTS



THE CHALLENGE

Accreditation and re-accreditation requirements differ in existence, scope, and use across and within countries. These differences affect facilities and cadres of workers at all levels. Estimates approximate that less than 60 percent of developing countries require medical school graduates to pass national certification exams, a figure that drops below 40 percent for Africa and Southeast Asia.ⁱ Even where minimum standards exist, they can have low uptake due to a perceived or real absence of incentives (regulatory or financial) to pursue accreditation. Different capacities to pay for and devote resources to accreditation may result in gaps along the urban-rural divide in terms of the number of accredited facilities and services offered.

MINIMUM QUALITY STANDARDS EXIST ONLY AT SUB-NATIONAL LEVELS OR NOT AT ALL

In certain countries, accreditation and re-accreditation requirements simply do not exist at the national level. For example, China had no national policy for accrediting medical schools in 2008, although it was in the process of developing a set of minimum standards based on guidance from the World Federation for Medical Education.ⁱⁱ In other cases, accreditation policies vary sub-nationally. Four states in Brazil launched their own accreditation efforts during the 1990s.ⁱⁱⁱ Even pre-service education requirements differ substantially. A systematic review identified three categories of pre-service training for community health workers across and within many countries: “individuals with little or no formal education with a few days or weeks of training;” “individuals with some form of secondary education and similar training;” and “individuals with some form of secondary education and training over several months to a year.”^{iv}



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Accreditation
standards vary
greatly and
sometimes do not
exist at all.
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Existing standards
may be ignored
because they are
out of date, ill-
defined, or
unenforced. For
example, the
national family
planning
standards in
Indonesia are not
used by any
districts in the
country.
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Even When National Quality Standards Exist, They May Not Be Widely Used or Enforced

Even when national quality standards exist, their use may be limited because they are outdated or ill-defined. Few districts in Indonesia use the national Minimum Service Standards (MSS) for those reasons and none use the family planning MSS at all.^v In addition, re-accreditation evaluations may occur over long time lags, reducing pressure to standardize. Accreditation in Ethiopia is granted only when an institution is first established since the country lacks an official re-accrediting body for medical schools.^{vi} Even when medical institutions fail inspections, they can frequently contest penalties for poor quality care. Appeals can delay closures of very low-quality facilities and fighting penalties can be costly for local monitoring and enforcement agencies. In the latter case, the potential costs may disincentivize strict accreditation and reaccreditation standards. Often, health facility inspectors can also have little power to enforce consequences for subpar quality performance.^{vii}

Incentives Can Cut Against Pursuit of Accreditation

Accreditation can be expensive and difficult to achieve, leading many institutions and providers to opt out if there is no counteracting incentive in its favor. Only a few studies have reported on the costs of pursuing accreditation; based on available papers, a global review suggests that the incremental costs of accreditation comprise between 0.2 and 1.7 percent of facilities' annual budgets.^{viii} In Zambia, costs for a national hospital accreditation program totaled about \$10,000 per hospital for the first year, with a possible reduction in costs during subsequent cycles after removing start-up expenses; this expense, in a country that spent just \$7 per capita on public health expenditure at the time, was considered unsustainable without donor assistance and discontinued after its first year.^{ix} Achieving international accreditation for hospitals can cost as much as \$700,000—a sum out of reach for many facilities in low- and middle-income countries (LMICs).^x

THE PATH FORWARD: GLOBAL EXPERIENCE AND INNOVATIONS

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Evidence is mixed
about the best
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Noted factors
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accreditation will
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quality and in
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Creating Incentives for Incremental Quality Improvement and Accreditation

Several countries have accreditation and re-accreditation policies in place, but they are typically voluntary. Evidence is mixed on what leads to more effective regimes. One survey of global accreditation bodies points to quality improvement as the most common reason for pursuing accreditation, but also indicates that commercial considerations are highly influential.^{xi} Evidence from high-income countries suggests that increased participation in accreditation processes may only occur when there is strong regulatory pressure or hard financial incentives.^{xii} Engagement with underlying quality data may help motivate health providers to pursue accreditation based on their ethical obligations to provide high-quality patient care; one review argues that “in order for health care leaders and professionals to embrace the philosophy of accreditation, they must view it as making a discernible difference in quality and safety as well as a sound business decision.”^{xiii}

Where accreditation is optional, using accreditation to select providers for empanelment-based national health plans can have a powerful effect.

To drive increased uptake through incentives, countries can opt for “carrots,” “sticks,” or some combination of the two. “Carrots” could include access to prestigious or in-demand programs and responsibilities for graduates of accredited medical schools; financial bonuses for accredited providers; or the opportunity to participate in pay-for-performance or voucher schemes. In the Philippines, for example, special administrative and financial autonomy is restricted to accredited institutions,^{xiv} while some Indian insurers offer higher reimbursement rates for accredited hospitals.^{xv} “Sticks” could include restrictions on the graduates from non-accredited medical schools, or on the eligibility of non-accredited institutions to receive reimbursement through nationally-funded universal health coverage or social health insurance programs. In Malaysia, for example, graduates of non-accredited schools are not given licenses until they pass exams at accredited schools,^{xvi} and in several LMICs—including Kenya, the Philippines, Nigeria, and Thailand—insurers require accreditation as a pre-requisite for reimbursement.^{xvii} In some countries where accreditation is not mandatory, use of accreditation to select providers for empanelment-based national health plans can create exceptionally strong financial incentives for accreditation, essentially crowding out non-accredited providers.^{xviii}

Tiered accreditation systems can also help incentivize incremental quality improvements in settings where achieving the highest quality standards may seem too costly or unrealistic in the immediate future.^{xix} In the U.S., the National Committee for Quality Assurance offered new health management organizations (HMOs) the option to pursue a separate accreditation on a pass/fail basis,^{xx} while tiered accreditation in Lebanon offers accreditation for different time horizons and levels (3 years, 18 months, partially accredited, and failed) based on performance. However, few studies empirically evaluate the effects of switching accreditation systems.^{xxi} In Brazil, a health insurance company paired incentives for achieving different tiers of accreditation with support to facilities in navigating the accreditation process (see Spotlight).

In India, professional councils have supported quality control by educating the public, investigating complaints about unqualified practitioners, and reporting such providers to authorities.

Professional Medical Bodies as Partners in Quality Control

Where human and financial resources to enforce quality standards are low, authorities can enlist professional medical groups as partners in the quality control process. In India, for example, professional councils have carried out awareness campaigns against the practice of medicine by unqualified practitioners; investigated complaints about unqualified practitioners; and reported such providers to government departments.^{xxii} To ensure complaint mechanisms are used in the future and accountability is maintained, governments need to be prepared to follow up on any tips.

SPOTLIGHT



UNIMED-Belo Horizonte Service Network Qualification Project^{xxiii}

UNIMED-Belo Horizonte (UBH) is a large private insurance company and medical cooperative in Brazil’s Minas Gerais state. In 2005, UBH introduced a novel pay-for-performance program for participating hospitals. The program—formally called the Service Network Qualification Project—sought to improve quality and patient care in its network of contracted hospitals by encouraging and facilitating their pursuit of accreditation.



In Phase 1 of the program—launched in 2002—UBH laid the groundwork by reforming its contracting models and introducing accreditation-style audits at contracted facilities to assess and improve infrastructure. However, hospitals responded to the audits with hostility, reporting pressure but insufficient reimbursement rates to make the identified structural improvements. In a second phase, beginning in 2005, UBH responded to provider feedback with stronger financial incentives to pursue accreditation—a “carrot” versus “stick” approach. Hospitals received a 7% boost in per diem rates simply for beginning the accreditation process; incentives rose to 9% for achieving Level 2 accreditation and 15% for achieving Level 3 accreditation. UBH also offered to defray the costs of accreditation-related inspections: UBH would pay 50%, while the hospital would cover the other half.

By 2009, 19 out of 45 in-network hospitals had received accreditation, covering 69% of network hospital admissions.

ENDNOTES

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- ⁱⁱ Marta van Zanten et al., “Overview of Accreditation of Undergraduate Medical Education Programmes Worldwide,” *Medical Education* 42, no. 9 (September 2008): 930–37, <https://doi.org/10.1111/j.1365-2923.2008.03092.x>.
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- ^{iv} Abimbola Olaniran et al., “Who Is a Community Health Worker? - A Systematic Review of Definitions,” *Global Health Action* 10, no. 1 (2017): 1272223, <https://doi.org/10.1080/16549716.2017.1272223>.
- ^v Global Health Workforce Alliance, “Mid-Level Health Workers for Delivery of Essential Health Services: A Global Systematic Review and Country Experiences” (World Health Organization, 2012), http://www.who.int/workforcealliance/knowledge/resources/ghwa_mid_level_report_2013.pdf.
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- ^x Akhil Tandulwadikar and Rajeshwer Chigullapalli, “World-Class via Accreditations,” *Asian Hospital and Healthcare Management* (blog), accessed September 27, 2018, <https://www.asianhnm.com/>.
- ^{xi} Charles D. Shaw et al., “Profiling Health-Care Accreditation Organizations: An International Survey,” *International Journal for Quality in Health Care* 25, no. 3 (July 1, 2013): 222–31, <https://doi.org/10.1093/intqhc/mzt011>.

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- xiii Kedar S. Mate et al., "Accreditation as a Path to Achieving Universal Quality Health Coverage," *Globalization and Health* 10 (October 17, 2014), <https://doi.org/10.1186/s12992-014-0068-6>.
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- xvii Smits, Supachutikul, and Mate, "Hospital Accreditation."
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- xix Mate et al.
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