The external assessment of health services

Since the 1990s new accreditation programmes have developed in many countries and, elsewhere, individual health care organisations can buy services from other countries. The independent assessments, and the standards which they use increasingly reflect an emphasis on patients, safety and clinical performance – and thus they appeal not just to health care managers but also to the public, purchasers and regulators.

Who wants external assessment?
Before choosing a model or a provider of external assessment, managers and regulators need to be clear about their objectives, their customers and the potential stakeholders. But frequently they choose first and then find out later whether it meets conflicting and un-stated expectations.

For managers the motive is often organisational development (to build teams by systematically examining policies, procedures and communications across the institution) which demands much internal effort, self-assessment and time. Others may be seeking a seal of approval, a badge which can be used for competitive marketing and contracting, or just to comply with legal requirements; here, the less effort required internally the better. But the strongest driver is the prospect of access to additional funding (with or without pressure from government or other bodies which regulate professional training, safety or public health).

Regulators and purchasers may use third-party assessment as an economical and independent referee of legal or contractual compliance, if the standards and criteria are compatible. Many recent health reform projects include the establishment of a national accreditation programme to monitor the impact of changes (and the international investment) on health systems.

What are the broad options?
A research project funded by the European Union identified systematic approaches which link national (or international) standards to local practice, and which have been applied to the private or public sectors. These approaches have been systematically compared in a number of studies of standards and methods used by industry-based (ISO certification, the ‘Excellence’ model) and health care based (peer review, accreditation) programmes. Each programme, to varying degree, is voluntary and independent and uses explicit standards to combine internal self-assessment with external review by visits, surveys, assessments or audits. Alongside these (usually) voluntary programmes, are many specialised and generic systems of
statutory inspection and licensing.

**Inspection**

Most countries have statutory inspectorates to monitor compliance of hospitals with published regulations required for licensing. More specialised versions typically relate to fire, hygiene, radiation, medical devices and medicines but some countries include infection control and blood transfusions. Standards are in the public domain as legal regulations and are thus difficult to update. They address the minimal legal requirements for a health care organization to operate and care for patients, in terms of structure and capacity to protect basic public health and safety; they do not usually address clinical process or hospital performance. In many countries, institutional licences are issued before a new institution opens and there is no systematic or regular follow up; in some, operating licences are reissued in return for payment of a fee with minimal or no inspection. Such assessments by local government agents may be inconsistent nationally and do not provide a credibly independent check on the public sector.

**International Organization for Standardization**

The International Organization for Standardization (ISO) developed a series of standards (ISO 9000) which were originally designed for the manufacturing industry (e.g. medicines, medical devices) but which has been used to assess quality systems in specific aspects of health services and in whole hospitals and clinics. Hospitals (or, more commonly, parts of them) are assessed by independent auditors who are themselves regulated by a national ‘accreditation’ agency. Performance is measured in terms of compliance with the ISO standard. Certification is widely available from independent certificated auditors and is recognised in many other service and manufacturing industries, and across national borders. But the current ISO 9000 standards relate more to administrative procedures than to hospital performance, and the terminology is difficult to relate to health care, leading to varying interpretations between national agencies. The audit process tests compliance with standards and is not intended in itself for organisational development.

However, the ISO 9000 series of standards for quality systems were adopted in 2000 to become more easily applied to health care and to include the assessment of outcomes and customer satisfaction. There are initiatives in USA (led by the major motor manufacturers who purchase health care for their employees) and in Europe (led by CEN) to interpret quality standards for health care. The more specific ISO 15189 is becoming the international standard for medical laboratories and includes issues of clinical judgement, process and outcome.

**Excellence model**

This assessment model is based on the Malcolm Baldrige criteria for management systems which evolved from the USA into national and international assessment programmes such as in Australia (Australian Business Excellence Model) and in Europe (European Foundation for Quality Management). It is primarily a tool for self-assessment but some countries offer national awards to the highest achievers following external assessment. Many health care institutions and even accreditation programmes have adopted the framework of standards and structure of scoring.

**Peer review**

Reciprocal visiting is driven by professional and often uni-disciplinary organisations and has a long tradition as a form of peer review – especially for the recognition of training posts. It has also been applied to service development, such as in the hospital specialties programme in the Netherlands (visitatie). Peer review is generally supported and endorsed by clinical professions as a means of self-regulation and clinical improvement, and integrates well with requirements for undergraduate, specialty and continuing professional development. But it is specialty-based, not covering whole hospitals, and results are confidential and not publicly available.

**Accreditation**

Independent, voluntary programmes developed from a focus on training into multi-disciplinary assessments of health care functions, organisations and networks. Their standards for assessment have been developed specifically for health care. Measurement of hospitals include internal self-assessment, external survey by multi-disciplinary team of health professionals, and benchmarking of a limited range of statistical indicators. Programmes are available in many countries by independent agencies which may be themselves accredited under international standards (ALPHA principles and standards). The measurement process includes testing of internal systems to improve patient orientation, clinical process, outcome and organisational performance. Names of accredited hospitals are generally published on individual programme websites but details of survey results are not publicly available, except for governmental programmes. Because criteria and assessment processes vary between programmes, accreditation status cannot be assumed to be directly comparable with other countries.

**Developments in accreditation**

**Uptake and growth**

A global study for WHO in 2000 identified 36 nationwide accreditation programmes and their rapid growth since 1995, especially in Europe. A survey of the WHO European Region in 2002 identified 17 such programmes focusing on whole hospitals. Mandatory programmes have recently been adopted in Croatia, France, Italy and Scotland.

**Regulatory role**

Half of the programmes, especially during the past ten years,
have been funded or managed directly by national governments which use them more as a means of regulation and public accountability, rather than voluntary self-development.

**Graduation of standards**

Typically, new national accreditation programmes used to begin by assessment against minimal standards of capacity in terms of structure; more recent and developed programmes are now characterised by using optimum standards of performance in terms of process and outcome. This transition from structure standards to optimum standards of performance in terms of process and outcome occurs as systems develop. Once the health system has generally achieved high levels of performance against structure standards then efforts can be directed to processes, and then to outcomes. In South Africa, Cohsasa offers a programme of graded recognition and facilitated accreditation which is designed to narrow the wide gap between rich and poor facilities.

**Shifting focus**

As with quality improvement generally, accreditation traditionally developed in hospitals and then moved inwards towards clinical specialties and outwards towards community services and then to networks of preventive and curative services. The shifting of emphasis towards primary care may reflect a move to population-based medicine reinforced, particularly in developing countries, by the policies of donors of overseas aid.

Some programmes in North America accredit entire health networks, and are beginning to shift from individual health care towards population health; some recent governmental programmes in Europe address public health priorities (such as cardiac health, cancer services) by assessing local performance of preventive to tertiary services against national service frameworks.

**Standardisation**

Many national programmes, especially within Europe, have agreed in principle to voluntary convergence of standards and assessment processes according to the ALPHA Principles of the International Society for Quality in Health Care. The ALPHA programme aims to make standards-based assessment systems more reliable, valid and compatible within and between countries.

**Evaluation**

Most established programmes have been subjected to internal or external evaluation of their impact but few of these evaluations have used comparable methods to permit synthesis. There is ample evidence that hospitals rapidly increase compliance with the published standards in the months prior to external assessment, and improve
Before you start...

→ What do you expect to gain?
→ What are the risks, costs?
→ What are the incentives, or sanctions?
→ Do you have a choice of provider?
→ Do you have commitment from:
  * Governing board?
  * Senior management?
  * General staff?
  * Medical staff?

References

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Conclusion

There is growing worldwide demand and concern for quality in health care, and for effective mechanisms – such as accreditation, ISO certification, and technology assessment – to promote it. There is increasing support from governments, and from intergovernmental and funding agencies for accreditation as adjuvant therapy in health reform, at a pace which varies around the world.