

POLITIQUE DE SANTÉ/HEALTH POLICY HOSPITAL ACCREDITATION POLICY IN LEBANON Its Potential for Quality Improvement

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ABSTRACT : Limited evidence exists on whether government owned-and-funded hospital accreditation system brings long-lasting impact in terms of continuous quality improvement to patient care. Literature shows that hospitals might adopt opportunistic behaviors solely with the aim of gaining accreditation particularly when governments link the quality improvement objective of accreditation with payment mechanisms. Literature also suggests that there is true value in creating an independent, not-for-profit national commission dedicated to improve quality of care.

In 2002, the Lebanese Ministry of Public Health with the assistance of an Australian consultant team developed and implemented a new hospital accreditation policy. Since its implementation, little information is known on whether this policy has the potential to bring long-lasting quality improvement to patient care.

By synthesizing literature, and reviewing other countries' accreditation experiences, this paper will identify barriers and derive observations and lessons for health policy makers and hospital leaders in Lebanon to consider for their ongoing efforts to further improve the hospital accreditation policy and its implementation. Also, it will provide valuable lessons for other countries in the East Mediterranean region which have implemented accreditation process or are in the process of doing so.

INTRODUCTION

Hospital accreditation implies confidence in a hospital by the population [1]. Accreditation is a process organizations use to evaluate and to improve the quality of services. Its benefits are well documented in terms of maximizing quality of care and patient safety and ensuring the most effective and efficient use of resources. Accreditation is both a regulatory tool for the State to guarantee quality care to the population and a process that organizations use to evaluate and improve the quali-

ty of their health services [2]. As a regulatory policy instrument, many governments see accreditation as a potential response to address the many problems which arise in the quality of health services delivery [3].

In 2002, and for the first time, the Lebanese Ministry of Public Health (MOPH) with the assistance of an Australian consultant team named Overseas Project Corporation of Victoria (OPCV) developed and implemented a process of evaluating the quality of patient care in public and private hospitals through a policy known as Hospital Accreditation. This new policy, which replaced the old classification system (in use since 1983), has been implemented in four phases [4]. The MOPH is now using this policy as an incentive-based regulation by implementing a payment system which links accreditation to reimbursement [5].

Since its implementation, little information is known on the actual potential of this government-owned policy and its achieved outcomes, particularly whether it brings long-lasting quality improvement practices to patient care. How can we know that hospital accreditation in Lebanon will lead to quality improvement ? What are the kinds and mix of incentives (i.e. financial, non-financial) that the accreditation policy provides for hospitals to improve quality of care ? Is it an effective incentive-based regulation of quality ? These are legitimate research questions that need to be examined for further improvement to the policy implementation.

While it is too early to examine all the above questions, particularly, the impact of hospital accreditation in Lebanon on patient outcomes, the objective of this review paper is to derive observations and lessons for health policy makers and hospital leaders in Lebanon. By synthesizing literature, and reviewing relevant MOPH reports and other countries' accreditation experiences, this paper will identify the barriers that need to be addressed to make the accreditation policy tools more effective in bringing long-lasting quality improvement practices. In addition, this paper will identify key research questions that need to be investigated to examine whether the changes in hospitals as a result of accreditation are classified as a 'focused activity' to comply with standards only during the survey period or long-lasting in terms of quality improvement.

REVIEW OF RELATED LITERATURE

Quality care is, after all, the ultimate goal for the patient, the provider, the organizational leader and the policy maker. Due to alarming incidents of adverse

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events resulting from quality problems, quality of care is now prominent on health policy agendas of many governments in many countries [6].

Health care organizations use accreditation to examine everyday activities and services against standards of excellence [7]. In terms of its value and effectiveness, literature demonstrates that accreditation is a powerful tool that enables health organizations to • conduct open and rigorous analyses of services provided • identify processes that are being well done and those that need to be improved • recognize services for their compliance with international standards of excellence and • apply the knowledge gained from the accreditation review recommendation. In addition to improving patient safety and resources allocation mechanisms, accreditation assists organizations to • create a safe environment for patients and staff • develop information systems assisting management in the planning and provision of services • be accountable and transparent • make evidence-based decisions • address the needs of the population served by a health care organization, and continuously learn and improve. It exhibits a commitment to quality ; improves communication and collaboration within the organization ; promotes team building ; enhances an educational process for all staff ; increases credibility ; and provides recognition for what is being done well and identifies quality improvement opportunities [7].

Accreditation, originally perceived as a vehicle to enable organizational development, is increasingly an agent of government regulation to guarantee quality of care [8-13]. From its inception, accreditation focused on helping health care organizations to improve the quality of care and with time, governments became prime users of accreditation [10]. While accreditation in some developed countries (U.S., Canada) is voluntary and independent of the government or any regulatory procedure, some other countries (such as Italy, Spain, France, Lebanon) are increasingly using it as a regulatory tool to guarantee quality care to their populations.

There is ample evidence in the literature about accreditation on how hospitals rapidly increase compliance with published standards in the months prior to external assessment, and improve organizational processes as a “one-off focused activity.” But there is less evidence that this brings long-lasting impact in terms of continuous quality improvement [14]. Some studies suggest that hospitals might adopt opportunistic behaviors solely with the aim of gaining accreditation particularly when governments link accreditation to other objectives such as payment mechanisms, resource allocation, and so on [15]. In Taiwan for example, where accreditation forms the basis for quality assurance and resources allocation, evidence shows that the majority of surveyed hospitals did invest significant resources in preparing for the hospital accreditation ; but these activities were not sustained after the survey and did not result in improvements in the quality of day-to-day work [16]. Scrivens (1995) argues that surveys permit snapshots in time ;

they do not monitor the continuous delivery of health care. In the long period between surveys, compliance with the standards may deteriorate.

Pomey et al. (2005) investigated the impact of accreditation in the French health care organizations [15]. The authors argued that all accreditation systems must account for paradoxes in accreditation and consequently decide on the level of government involvement, and the relationship between accreditation and financial incentives. The authors concluded that accreditation in France resembles more an inspection than a continuous quality improvement (CQI) process. Once the “*quality improvement objective of accreditation is combined with another objective – that of financial incentives – it carries the risk of derailing the process because the establishment is liable to adopt strategic behaviors solely with the aim of gaining accreditation instead of ‘playing the game’ according to the rules*” [15, p. 53]. Thus, one can argue that linking accreditation to funding mechanisms is not recommended. Literature shows that it is possible to use quality process and accreditation as indicators for modulating budgets, as is presently the case in Luxembourg [15].

In developing their quality framework, Shortell et al. (1995) argue that the degree of quality management implementation is viewed as a function of implementation approaches (i.e. prospector, analyzer, defender, opportunistic/reactor). A defender approach involves fine-tuning the organization’s existing quality assurance/improvement approach. In the defender approach, the organization focuses primarily on external accreditation requirements [13]. An analyzer approach to implementation of quality improvement efforts follows a relatively ordered sequence of steps from top management training to lower level employee training in which only a few highly focused quality improvement (QI) projects would be undertaken at one time and carefully evaluated before further activities were initiated. The prospector approach emphasizes seizing opportunities as they arise but within an overall planned framework of implementation. In the reactor or opportunistic approach, quality improvement techniques and approaches may be used to address problems, but they are not part of an overall plan [13].

By testing their framework in a sample of sixty-one US hospitals, Shortell et al. (1995) found that the approaches that are more like analyzer or prospector are associated with a greater degree of implementation than those of the defender or opportunistic/reactor approach.

In short, the true value associated with accreditation will only be realized when it can conclusively show that tangible improvements in quality of care are achieved. While the role of accreditation in the quality debate is still being investigated, there is limited information on how governments can successfully use the tools of accreditation to bring long-lasting impact in terms of continuous quality improvement.

In terms of the nature of bodies in charge of accreditation (i.e. government or independent national commis-

sion), literature argues that the influence of politics and political interference can be reduced through an independent organizations [17]. Given that health care quality reform is usually designed and controlled by political action, literature argues that it would be a good strategy to limit political interference in decision making by creating an organization external to the government and the ministry. There is a true value in creating organizations that are independent of government when difficult system change (such as accreditation system) is sought. With limited political interference, an independent accreditation body will be solely dedicated to improve quality of care and patient safety through assessment and accreditation.

Novaes (2001) argues that different sources of financing of a national commission (i.e. public sector, providers, professional associations, and buyers) will assure political independence of the commission and its sustainability. The author suggests that in order to promote the sustainability of a permanent accreditation process at the national level, there is a need for an establishment of a national commission on hospital accreditation [1].

THE CASE OF HOSPITAL ACCREDITATION IN LEBANON

The development and implementation of a new accreditation policy in Lebanon was made possible because of the legislation that was passed on June 22nd, 1962 [18], and amended by legislative decree # 139 of September 16, 1983 [19]. This legislation constitutes the legal framework that MOPH uses to regulate the Lebanese hospital sector [4]. Article 7 of the decree # 139 [19] specifically states “*the MOPH has the right to evaluate, classify and accredit hospitals according to their status, field or specialty and range of services provided.*” The provision of this law makes it also possible to link accreditation to contractual agreements with hospitals [4].

Between 1983 and 2000, Lebanon used a classification system named ‘Alpha-Star system’ to evaluate private hospitals. The Alpha rating was based on the presence of medical services. The greater the number and the more complex the clinical services offered, the higher the Alpha score. The Star classification is based on the level of the hotel services provided by the hospital. For example, a five-star classification would be granted to a hospital that offers the highest level of accommodation to its patients [4]. This classification system was based more on the structure or inputs of the hospital and not on its processes and/or outcomes.

Our review of relevant MOPH reports reveals that the Alpha-Star classification system in Lebanon failed to act as an incentive for hospitals to improve the quality of medical care. It was linked to payment mechanisms where for example, an A^{*****} gets higher reimbursement for similar procedures done by B^{*****}, etc. Since the classification system was tied to contracts for hospital

services and reimbursements, hospitals adopted opportunistic behaviors solely with the aim of gaining higher classification ratings. Certainly, the classification system helped hospitals improve their organizational structure (i.e. medical and human resources such as technology, nurse staffing, etc.). But since it had a strong financial component, the old classification system created perverse incentives where hospitals went through “medical arms’ race” – acquiring highly advanced and complex medical technologies even if it was not cost effective. Hence, limited efforts and investments were spent on the quality of medical services. All classes of hospitals (even if, in some cases, they provide risks to patient safety) were eligible to contract out with MOPH to treat the Lebanese population. As a result, MOPH and consumers of health care have not been able to know whether or not the end product of service is a quality one. Due to the limitations and weaknesses of the old classification system, the MOPH replaced it with an accreditation program as a way of ensuring that processes are in place in Lebanon’s health care system to help organizations deliver safe, efficient, and reliable quality care.

In May 2000, an Australian consultant team (OPCV) was contracted to prepare an accreditation manual for acute care hospitals in Lebanon [4]. The OPCV had set the accreditation standards, produced their guidelines in the accreditation manual and surveyed the hospitals. The accreditation program was developed based on several goals and policy outcomes expectations such as

- improving quality of care
- better contractual agreements between public funds and private and autonomous hospitals
- better incentives for continuous improvement for hospitals
- reducing health care expenditures by focusing on increased efficiency and effectiveness of services
- strengthening the public’s confidence in the quality of hospital services and
- collecting data and internal reporting on morbidity, mortality, demographics, utilization and workload [4].

In addition, one of the goals of accreditation is to stop MOPH contracting and reimbursement to hospitals that do not meet minimum quality and safety levels. The ministry implemented this policy through four phases [4] :

Phase I : Developing and Pilot-Testing Standards and Procedures (2000-2001)

The first set of standards was based on basic standards and a set of hospital accreditation standards derived from 7 hospital accreditation systems applied in developed countries (United States of America, Canada, Australia, Ireland, New Zealand, France and the United Kingdom) [4]. The basic standards include the minimum standards that a hospital must meet to provide safe, cost efficient and effective hospital care. For instance, basic standards emphasize safety, particularly in the areas of Fire, Electrical/Biomedical equipment, Environmental and Infrastructure areas. Accreditation standards include higher order standards that are based on quality assurance and quality improvement. The scoring system was

numerical, based on assigning points (yes = 1 point ; needs improvement = 0.5 point, etc.)

It is important to note that the standards developed for Phase I were more structure- and process-based and did not reflect quality health care outcomes (i.e. patient outcomes indicators such as mortality and morbidity rates). Six hospitals were pilot-tested in phase I.

Phase II : First National Survey (2001-2002)

The First National Hospital Survey was implemented between September 2001 and July 2002. Among the 128 surveyed hospitals, only 47 met the requirements of 80% for the basic standards score and 60% for the accreditation standard score [5]. Most importantly, 32 hospitals were found not meeting safety requirements. Small hospitals with 100 beds and less, accounting for the majority of hospital beds in Lebanon were, on average, operating below standards. Hospitals with 101-200 bed-capacity got a somewhat better average score than larger hospitals with more than 200 beds [4-5]. The results were not made available to the public ; however, some hospitals strategically used their rankings in marketing campaigns. With regard to the numerical scoring system, literature suggests that there is a risk of assigning points, or giving a precise value or numerical score to survey findings. This approach resulted in problems because in some cases, the sum total of points can fall within a category of 'excellent' or 'good' while masking an area 'with lesser points' having serious problems (false positives) [1]. To protect the general public, the MOPH started to explore the possibility of changing the current accreditation scoring system into a system of awards.

Phase III : Standards Revision (2002-2003)

The structure and process-based standards and guidelines implemented in phase I were further revised in 2003 to include outcome-based standards, which can provide a better assessment of quality care improvement practices [4]. In this Phase, the basic standards were eliminated through their integration within the accreditation standards.

In Phase II, the MOPH changed the score awarding system of accreditation into a system of category awards. That is, hospitals were provided with categories of accreditation and not individual scores [4].

Phase IV : Second National Survey (2004 -2005)

The second national survey was launched on 2004. The results were realized on November 2005 according to four categories of accreditation rather than scores. Among the 142 surveyed hospitals in Lebanon in Phase IV, only 85 met the requirements and were distributed as follows : 15 hospitals were categorized "A", 8 hospitals categorized "B", 36 categorized "C", and 26 categorized "D". The remaining 57 hospitals failed to meet the accreditation requirement.

After releasing the second survey results, the MOPH is now using accreditation as an incentive-based regula-

tion by implementing a payment system which links accreditation to reimbursement [5]. According to the MOPH, this new quality-related payment system will make the contractual relationship with private providers easier to manage [5]. For instance, accreditation will be used as an indicator for modulating reimbursement.

DISCUSSION AND OBSERVATIONS

Quality is becoming an arena of responsibility and accountability perceived to be important by policymakers, managers, clinicians, payers, and patients [20]. Purchasers and consumers of health care have a right to know whether or not the end product of service is one of good quality. Evidence shows that organizations that adopt CQI are proactive in preventing quality problems ; never satisfied, always seeking improvement ; motivated to meet accreditation requirements, and integrate quality improvement practices into their day-to-day work as if the accreditation surveyors visit them every day [21].

To meet customers' needs and expectations, accreditation is one way of ensuring that processes to help organizations deliver safe, efficient, and reliable quality care. Its main benefit is its commitment to the quality of care.

To this end, ineffective accreditation policy runs the risk of not producing the quality improvements goals. While it is too early to examine the impact of hospital accreditation in Lebanon on patient outcomes, our review of literature, including other countries' experiences, helped us identify several barriers that need to be addressed for further improvement to the hospital accreditation policy and its implementation. Addressing those barriers will make the policy more effective in guaranteeing quality care and improving patient outcomes in the Lebanese health care system.

Barriers for effective implementation of hospital accreditation policy

1. Change in organizational culture

Organizational culture refers to the shared values, norms and expectations organizational members hold about their institution and the work they do. They are the unwritten rules that members follow in their day-to-day work [1].

A lesson to be drawn from literature is that quality improvement is more of a continuous than a discrete process [15]. CQI practices require cultural shifts in the way things get done in health care organizations. However, literature argues that changing the culture of health care organizations can be difficult. For instance, resistance to change can exist when the health care quality change is seen to be inconsistent with the current cultural norms [22]. That is why some researchers suggest that health care managers must be aware of the current cultural norms within organizations and the reactions among staff and professional providers to the quality change process [1]. Literature suggests that cultures can be used by health care managers to mold quality

improvement behavior and practices [1].

If the objective is to integrate CQI practices into the culture of health care organizations and their day-to-day work, then policy makers and organizational leaders will need to bear in mind that this often takes a very long time. With leadership commitments and support at all levels, the cultural barrier can be rather transformed into an enabler that would allow organizations to integrate CQI practices in their everyday activities. True hospital leaders, “*who know how to take advantage of this impetus, can institute mechanisms at the hospital level for self-assessment and continuous quality improvement of medical care*” [1].

2. Government owned-and-funded versus an independent body

The current accreditation system in Lebanon is both government-owned and -funded. However, there is a true value in creating an independent, not-for-profit accreditation body dedicated to improve quality of care and patient safety. Literature argues that the influence of politics and political interference can be reduced through an arms-length organization [17]. An independent national accreditation body can be solely dedicated to improve quality of care and patient safety through assessment and accreditation.

Evidence also shows that different sources of financing a national commission (i.e. public sector, providers, professional associations, and buyers) will assure political independence of the commission and its sustainability [1]. In order to promote the sustainability of a permanent accreditation process at the national level, literature recommends the establishment of a national commission on hospital accreditation [1]. However, the experiences of some countries show that it is not easy to achieve a consensus among the different actors in the public and private health sectors to work together with a common goal towards creating this national commission.

To promote the sustainability of a permanent accreditation process at the national level in Lebanon, stakeholders might need to access the current status of accreditation system in Lebanon and to explore the feasibility of creating an independent professional body that could be entrusted with improving quality of care and patient safety.

3. Improving quality or better reimbursement

According to literature, the open objective of accreditation is to improve quality of care to patients. Pomey et al. (2005) argue that once the quality improvement objective of accreditation is combined with another objective – that of financial incentives – organizations might adopt strategic behaviors solely with the aim of gaining accreditation instead of integrating CQI principles as part of their day-to-day work. Limited information exists on the process that different countries use to tie national accreditation to reimbursing hospital services.

In Lebanon, the vast majority of hospitals survive as a result of patients covered by the MOPH and other public funds such as the National Social Security Fund,

Civil Servant Cooperative, Army, and Internal Security Forces. These hospitals have strong incentives for accepting the accreditation process, since it allows them to have contracts with the MOPH and probably other public guarantors.

In order for the government to pursue the quality improvement objective of accreditation, careful consideration should be given to finely balanced mix of monetary and non-monetary incentives to change behaviors. This is particularly important as the reimbursement mechanism in Lebanon is still ‘work in progress’ where MOPH is still being not able to fairly estimate the minimum costs of operating procedures in hospitals, making it difficult to determine whether providers are offering good quality care at reasonable costs. The MOPH does not have a benchmark of efficient cost for Lebanese hospitals and this makes it more difficult especially in attempting to link costs to quality outcomes and determining a value for money. Robinson (2000) argues that it is difficult for the government to distinguish generally between actual cost and efficient cost [23].

4. Regulation, enforcement, incentives and sanctions

In the context of accreditation, regulation can be defined as government’s action to improve the quality of health care services. In this regards, strong government regulation is essential, otherwise, health care organizations may engage in what Williamson (1994) calls opportunistic behavior and use accreditation as a tool to manipulate reimbursements at the expense of quality [24]. Evidence in the literature suggests that there should be an increased regulatory role for the government (herein MOPH) to make sure that government regulation is exercised over potentially opportunistic behavior by private providers. International experiences show that accreditation can create a complicated set of incentives that, in turn, requires an effective government regulatory oversight and supervision [3]. This new role requires the State to shift from a focus on inputs to an evaluation of outputs and outcomes, resulting in a major change in how the State conducts its regulatory activities [25].

Albert Einstein said “*nothing is more destructive of respect for the government and the law of the land than passing laws which cannot be enforced*” [26]. Legal considerations such as laws or regulations are important and useful but not the paramount factor. Implementation and enforcement approaches which are major issues in regulation are weak in Lebanon. Weak enforcement is unlikely to have a major impact on private health care providers [25]. For instance, it would be vital for the MOPH to enforce its regulation by ceasing its contracts, at least with hospitals that fail to pass accreditation. Failure to implement sanctions might limit the effectiveness of the accreditation policy, and affect the credibility of the MOPH, not to mention, stakeholders’ trust and cooperation.

Although opportunistic behavior could be controlled through the contracting process based on accreditation results and its associated enforcement procedures, these

procedures and sanctions might themselves be expensive and often politically impractical. To this end, literature suggests that governments use the right incentives to accomplish regulatory goals, such as quality of care. Literature argues that governments should pursue the quality improvement objective through a mix of requirements and incentives. It is the mix and balance of incentives that determines the effectiveness of accreditation policy.

5. Structure and process or outcome-oriented accreditation

Avedis Donabedian (1966), the father of quality movement, considers that we can get the most complete, credible and useful information to improve quality by assessing structure, process and outcomes. He urged health care organizations to look at all the three measures when monitoring and assessing the quality of care. Quality of care improvement should focus on the structure (e.g. physical and human resources, standards, policies, staffing, workload, etc.), process (i.e., what caregivers do), and outcomes (i.e. morbidity and mortality rates, patient satisfaction, etc.) of care and their interrelationships [27-28]. By not focusing on structure, process and outcomes in conjunction, organizations will not be able to correct the deficiencies that might act as barriers to providing quality and safe patient care. In the light of evidence, the accreditation program should consider a system approach where it evaluates not only structure and process, but also outcomes (including health related outcomes), which are the ultimate objective of quality improvement practices. What is missing from the current accreditation system is information to allow the MOPH, stakeholders and consumers to assess health care outcomes.

A final observation on this topic is that there is a need to develop criteria to determine or define what may be called as 'unsafe or dangerous hospital'. It would be important for future standards, to determine the criteria of unsafe hospitals based on the assessment of their structure, process and health related patient outcomes indicators.

CONCLUDING REMARKS

Hospital accreditation in Lebanon is an important first step toward making the health care system more responsive and accountable.

Based on our review, it seems that the current accreditation process in Lebanon has the potential to be an important step in the reform of the health care system of Lebanon which could lead to an improvement of the quality of medical care. However, there is still no guarantee that quality improvement practices will result from being accredited. Since quality of care is a continuous process of improvement [15], careful consideration to all the barriers that we discussed in this paper is needed in order to further develop and improve the accreditation system in Lebanon.

It should be crucial for the Lebanese health care system to address the following policy issues :

- *Whether the accreditation process should remain spearheaded by the MOPH.* Stakeholders should explore the idea of an independent, not-for-profit national accreditation body made up of representatives of private and public sectors, professional associations, private buyers, such as insurance companies, academic organizations, etc., such is the case in most developed countries.
- *Whether accreditation should remain linked to reimbursement mechanism.* If the accreditation process is separated from financial incentives, health care organizations can focus only on continuous quality improvements rather than being involved because of funding implications or contracting with the MOPH. Discussion among stakeholders should start to address the right mix of incentives that need to be put in place for hospitals to accomplish the accreditation's goal, that is, quality of care.
- *Whether the accreditation process should remain mandatory for organizations that treat MOPH's patients.* According to literature, compulsory accreditation can change the philosophy and intentions of healthcare organizations towards conformity with requirements instead of towards quality improvement [15].
- *Whether accreditation should remain focused on acute care hospitals only.* Experiences of different developed countries suggest that tangible improvement to quality care can be achieved when the accreditation process is adapted to all health care organizations providing health services across the continuum of care (primary, secondary, tertiary levels, long-term care, home care, etc.)
- *The applicability of the current accreditation system to all third party payers in Lebanon* (Private, and public funds including National Social Security Fund, Civil Servant Cooperative, Army, and Internal Security Forces).

To better inform policy makers and hospital leaders in Lebanon, research studies examining whether the current accreditation system is bringing tangible and long-lasting quality improvements to patient care are needed.

Moving from the ideology of efficiency and cost containment, health care systems in several countries in the East Mediterranean Region (EMR) are entering a new era in quality care improvement and patient safety [29]. The key discussion points raised in this paper can provide valuable lessons for Lebanon and for all the countries in the EMR that have implemented accreditation process or are in the process of doing so (i.e. Morocco, Egypt, Oman, Iran, Syria, Sudan, etc.). The region can learn from the Lebanese experience and be more aware of the issues and implications of the accreditation process and its limitations when implemented in particular ways.

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