

## *Chapter Five*

### **ACCREDITATION OF HOSPITALS**

Advances in medical technology and continuous integration of expensive techniques, are putting health systems under constant pressure. Ensuring equitable accessibility to modern and quality medical services remains the most tedious challenge for middle and low income countries in light of the scarcity of resources. The situation of some developing countries like Lebanon, with important private care delivery is particularly delicate because on one hand, the private sector has not reached yet the stage of having an inherent culture of quality improvement like in developed countries; while on the other hand, governments have limited regulation capabilities, especially when it comes to controlling private for-profit providers.

Lebanese entrepreneurs have always enjoyed the freedom to conduct business with minimal government control. Provision of hospital services is considered a private enterprise activity, where profit is pursued without enough concern for the quality of the services provided, or for client satisfaction. The functioning of private hospitals has been determined largely by a supply-driven market, with practically no control over the proliferation of medical technology nor on its proper use.

The situation is further complicated by an oversupply of physicians, graduates from many different countries, with significantly different backgrounds. In the absence of national clinical protocols, this has led to differences in medical diagnosis and treatment, compounded by the lack of transparent policies and procedures at the administrative and financial levels.

Contracting with the MOPH and other financing agencies is vital for hospitals, and they use all means to that end, including social and political pressure. While the MOPH may use its financing role as a leverage for regulating private provision and inducing change. In this respect, hospital accreditation may be considered as one of the mechanisms that could reorient private providers' behavior in a climate of market failure, aggravated by political interference in health financing.

The quality assessment of hospital care in Lebanon has seen a paradigm shift since May 2000, from a traditional focus on physical structure and equipment to a broader multidimensional approach, emphasizing managerial processes, performance and output indicators. In the absence of an effective consumer voice, the impetus for change has come from the Ministry of Public Health, which has induced and supported the development of an accreditation programme for hospitals<sup>1</sup>.

## **1- THE CLASSIFICATION SYSTEM**

Originally, an alpha-star classification system for hospitals existed, based on a 1983 decree. The alpha rating reflected the level of medical services: the greater the quantity and complexity of clinical services offered by a hospital, the better its alpha rating. The number of stars reflected the level of hotel services provided by the hospital. In the alpha system, any hospital failing to fit in classes A, B, C or D fell into class E. Consequently, no hospital was declared unclassified or failed. It is worth mentioning that the tariffs of medical services were set by the MOPH according to the hospital class. This system provided a strong financial incentive for

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<sup>1</sup> Ammar, W., Wakim, R. and Hajj, I. 2007. Accreditation of Hospitals in Lebanon: A Challenging Experience. *Eastern Mediterranean Health Journal*, Vol.13 (1): 138-149.

hospitals to invest in sophisticated equipment and to venture into high-tech services without rational planning.

## **2- THE ACCREDITATION SYSTEM**

The accreditation of hospitals aimed at creating incentives for continuous quality improvement by developing a new external evaluation system. Particular emphasis was put on patient and staff safety, reporting data on morbidity, mortality, utilization and workload, as well as infection control mechanisms and patient advocacy. The final evaluation would lead to the formulation of explicit recommendations and quality action plans<sup>2</sup>.

The introduction of an accreditation system in Lebanon has been possible on the basis of a 1962 legislation<sup>3</sup> amended in 1983<sup>4</sup>. Article 7 states, “the MOPH has to evaluate, classify and accredit hospitals according to their status, field of specialty and range of services provided”. The amended law sets a “Committee for Evaluation, Classification and Accreditation of Hospitals” chaired by the Director-General of Health, which includes high-level representatives of the MOPH, the Syndicate of Private Hospitals, the Order of Physicians, the Army Medical Brigade, the National Social Security Fund, and University Medical Centers. The 1983 law stipulates that the Committee may seek the assistance of external expertise and that accreditation results should be tied to contractual agreements with hospitals.

### **2.1 Developing the first version of Standards**

In May 2000, and following an international bidding process, an Australian Consultant Team was contracted to set up accreditation standards and to develop guideline manuals for hospitals in Lebanon.

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<sup>2</sup> McGregor, P. February 2001. *Evaluation and Accreditation of Hospitals in Lebanon. Final Report*. Beirut: Ministry of Public Health.

<sup>3</sup> Republic of Lebanon, *Law enforced by the executive decree # 9826*, June 22, 1962.

<sup>4</sup> Republic of Lebanon, *Legislative decree # 139*, September 16, 1983.

In setting standards, the MOPH sought consensus among different stakeholders. A two-tiered system of standards was developed: basic standards to compensate for the lack of basic requirements for licensing in legislation, and accreditation standards, based on the principles of total quality management. The basic standards were viewed as the minimum required to provide a safe environment of health care delivery for patients and staff, with special emphasis on infrastructure, waste disposal, electrical and biomedical equipment and fire safety, among others. The accreditation standards were designed to test the ability of hospitals to provide quality care to patients and to set up information systems assisting management in the planning and provision of services<sup>5</sup>. The standards were pilot-tested in 6 hospitals, chosen with consideration to their geographical distribution and size, the profit and non-profit mix, and the public/private status.

## **2.2 The Survey and Accreditation Award**

Conducting the accreditation survey required the use of a standardized tool by a multidisciplinary team. The survey was carried out in a professional educative and non-threatening manner, respecting confidentiality. A simple unitary scoring system by department was adopted: for basic standards it was either compliance (one point) or non compliance (zero point), whereas for accreditation standards, 0.5 may be given if compliance needed improvement. The passing mark was defined as a combined score (all departments) of 80% for the basic and 60% for the accreditation standards.

The consulting team started the first national hospital survey on 18 September 2001 and finished it on 1 July 2002. The survey included 128 hospitals throughout Lebanon. As the survey progressed, some hospitals hired private consultants to assist them in complying with the standards, such as writing policies and procedures. At the end of the first survey, only 47 hospitals out of 128 surveyed (37%) were awarded accreditation.

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<sup>5</sup> McGregor, P. February 2001. *Evaluation and Accreditation of Hospitals in Lebanon. Final Report*. Beirut: Ministry of Public Health.

These were rather shocking results, considering the historical good reputation of private hospitals in Lebanon. As expected, small hospitals with 100 beds and fewer, which accounted for the majority of hospitals in Lebanon, were generally operating below standards. Hospitals with a 101- to 200-bed capacity achieved a somewhat better average score than larger hospitals with more than 200 beds<sup>6</sup>. This was possible because the scoring system does not penalize for a lack of technology or the absence of a service. At this stage, only available techniques and services were scored i.e included in the denominator. The purpose was to avoid pushing hospitals for adventuring in providing services and performing techniques they are unable to handle properly, only to improve their scores. It is worth mentioning that only 2 autonomous public hospitals were fully operational at that time, and were hence included in the survey, and both achieved a relatively good score.

A follow-up audit started in October 2002 and ended in June 2003. It included the upper half of hospitals that did not meet the requirement in the first survey, as well as new hospitals not included in the first survey. Of 39 surveyed hospitals, 45 (87%) passed the accreditation.

Uptill this stage, although accreditation was a requirement for contracting, tarification had still not been linked to accreditation scores. Results were given to each hospital separately and were not made available to the public. Some hospitals, however, published their results in the newspapers for marketing purposes. This prompted the MOPH to change the new accreditation system into a system of awards, with no scores attached, to avoid any future misinterpretation or perverse use of results in the media.

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<sup>6</sup> Ammar, W., 2003. Health System and Reform in Lebanon. Beirut: WHO

### **2.3 Revision of standards and comprehensive re-auditing survey**

The high success rate achieved in the follow-up audit gave a strong signal to the MOPH that hospitals were becoming committed to the Accreditation Program and that the Ministry can go ahead and start upgrading the system.

The original standards and concomitant scoring system emphasized the existence of documentation such as medical files, policies and procedures, committees' meetings minutes, etc... but did not require, except for the medical file, thorough assessment of their content. Proper implementation was not evaluated for all written policies and procedures nor was the measurement of expected outcomes. It became imperative, therefore, for the revised standards to be written in such a way that hospitals are required to provide evidence that policies and procedures are appropriately executed to improve quality. On the other hand, the intention to tie accreditation with payment implied that results should reflect not only the quality, but also the complexity of services provided by the hospital. Specific standards have been produced for 5 additional specialty areas: chemotherapy, renal dialysis, psychiatry, cardiac catheterization and intensive care units.

For the third national survey (2004–05), the revised standards were scored differently, some remaining with unitary scoring and others with variable weights. Weights allocation took into account areas of concern identified in the previous surveys, such as documentation, infection control, clinical nursing, blood bank, biomedical services, staffing, laundry, pediatric services and central sterilizing department. These areas were highly weighed in order to encourage urgently needed reforms. In addition, the “not applicable” rating for unavailable services was removed to avoid financially penalizing advanced hospitals, and to prevent hospitals from concealing low-quality departments on the day of the survey to help their total score, as had happened on several occasions during the first 2 surveys.

For the third survey, accreditation was awarded differentially in 4 bands depending on the hospital score, and tarification was linked to these bands. The score thus became of no importance in differentiating hospitals within the same band. Most importantly, accreditation was awarded in a specific band for a variable period that is determined according to each hospital specific situation. The hospital should be re-audited within the set period of time, otherwise it loses its accreditation status.

The third round of hospital surveys launched in October 2004 included 144 hospitals, 85 (58.6%) of which were awarded accreditation<sup>7</sup> (table V- 1).

Although no recourse process was formally established, hospitals' queries submitted to the MOPH were subject, together with the auditing team feedback, to careful analysis by a committee of national experts. The committee received petitioners one by one for lengthy discussions to clarify controversial issues, related most of the time to a misunderstanding of the process and misinterpretation of the results.

Accreditation significantly improved the perceived quality of care, and at this stage, a better perception was generally observed in small and medium-sized hospitals<sup>8</sup>. This may be considered as a result of the emphasis put by the MOPH to improve service delivery in poorly performing hospitals that led to accreditation standards being tailored to induce a greater change in small and medium-sized hospitals. On the other hand, these hospitals depend more on public financing and considered accreditation as a serious threat for losing their contracts<sup>9</sup>.

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<sup>7</sup> Buckley, P., Baret, N., Abi Chahine, K., Nayler, D., Dyer, E. November 2005. *Evaluation and Accreditation of Hospitals in Lebanon. Final Deliverable*. Beirut: Ministry of Public Health.

<sup>8</sup> El Jardali, F., Jamal, D., Dimassi, H., Ammar, W., Tchaghchghian V. 2008. The Impact of Hospital Accreditation on Quality of Care: Perception of Lebanese Nurses. *International Journal for Quality in Health Care* 2008; pp.1-9.

<sup>9</sup> Buckley, P., Baret, N., Abi Chahine, K., Nayler, D., Dyer, E. November 2005. *Evaluation and Accreditation of Hospitals in Lebanon. Final Deliverable*. Beirut: Ministry of Public Health.

**Table V-1: Comparison of the third accreditation survey results (Nov. 2005) with the old classification system**

Hospital class/band	Old classification system		Third accreditation survey	
	n	%	n	%
<b>A</b>	32	25.4	15	10.4
<b>B</b>	34	27.0	8	5.6
<b>C</b>	24	19.0	36	25.0
<b>D</b>	19	15.1	26	18.1
<b>E</b>	17	13.5	-	-
<b>Failed</b>	0	0	59	41.0
<b>Total</b>	126	100.0	144	100.0

As the contract with the Australian Team came to an end, the MOPH decided to revisit the accreditation procedure to rely more on national capacities in terms of auditing. Some hospitals that felt able to improve their status within a short period of time, and did not want to wait for the new system to be set, expressed their interest to be re-audited within a year by the same team. The MOPH agreed for an additional voluntary survey provided that candidates bear the cost, and on the condition that financing is channeled by the Syndicate of Private Hospitals. Accordingly 33 hospitals were re-audited and most of these were capable to improve their situation.

**Table V-2: Accreditation status pre and post voluntary auditing (n=33) and final results as of Dec. 2006 (n=144)**

	A	B	C	D	Failed	Total
<b>Previous status of voluntary candidates</b>	0	1	7	4	21	33
<b>Results of the voluntary survey</b>	8	4	15	3	3	33
<b>Final results as of Dec. 2006</b>	23	11	44	25	41	144

## 2.4 Accreditations of public hospitals

It was unfair to include all public hospitals in the auditing survey, as most had just started to operate and was still in a period of staff recruitment. The MOPH insisted however on subjecting these hospitals to auditing against the same upgraded standards applied to private hospitals in order to convey a strong message to the Administration Boards that, in terms of quality assurance, no special treatment whatsoever would be granted. It goes without

saying that the MOPH did not penalize public hospitals that failed the accreditation at this stage.

However, the MOPH considered of its duty to support developing government hospitals capacities as most of these were new and lacked experience. For that purpose, a cooperation agreement was signed with the Higher Health Authority<sup>10</sup> on July 2006 to conduct a training program on total quality management. Physicians were introduced to evidence-based medicine and clinical protocols. Administrators and managers were trained on designing and analyzing policies and procedures and assessing customer satisfaction, and all staff learned about performance measurement, cost-effectiveness concepts and teamwork.

The educational program combined theoretical modules and field visits. Before the end of 2008, and upon completion of a self-assessment process, public hospitals will be audited by HAS experts against the current standards on the same footing as private hospitals.

### **3- THE NEW ACCREDITATION SYSTEM**

According to the MOPH - HAS agreement, HAS provided also technical assistance to the MOPH to upgrade the accreditation policies and procedures and to develop a new system for accreditation awards.

The new system is in line with international standards while using the available expertise in the private sector in the field of hospital audits. It consists of prequalification and selection of non-governmental auditing bodies by an independent expert committee<sup>11</sup>, based on published terms of reference. Selected bodies would subsequently be authorized by the MOPH to officially perform hospital auditing against the national standards. The candidate hospital would have to contract and reimburse one of these authorized auditing bodies<sup>12</sup>. The auditing report would be

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<sup>10</sup> La Haute Autorité de Santé (HAS).

<sup>11</sup> The names of international experts are proposed by HAS and the committee is formed by a Ministerial Decision.

<sup>12</sup> Organismes Agréés d'Audit.

submitted to the MOPH together with a self assessment report done internally by the concerned hospital. The two documents would be examined by the independent expert committee for analysis and advice, before being deliberated in the National Accreditation Committee. Accreditation will still be awarded by a ministerial decree based on the committee's opinion as stated by law.

Regarding the standards, two areas of concern were identified as needing additional development. The first relates to the evaluation of professional practices, the second deals with risk management and patient safety. However, the bulk of national standards would remain the same as issued by decree<sup>13</sup> in 2005.

Three documents have already been developed: The terms of reference for selecting the auditing bodies, the new accreditation policies and procedures, as well as the addenda to the accreditation standards. These documents are posted on the MOPH website for public consultation and debate. All stakeholders were invited to provide their comments, that were integrated within the original documents. All three documents have been subject to consensus in a national conference before final and official adoption.

#### **4- LEBANESE PARTICULARITIES AND CHALLENGES**

##### **4.1 From a Quality Management Perspective**

*The old Classification System* focused on the physical structure and equipment with no consideration to staff competencies<sup>14</sup>. Tariffs set according to the hospital class provided financial incentives for purchasing sophisticated equipment often without conducting feasibility studies or developing business plans. This induced an increase in utilization of new technology, and led to the raising of the overall hospitalization cost.

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<sup>13</sup> Republic of Lebanon, Decree # 14263, March 4, 2005.

<sup>14</sup> Jencks, S. F. 1999. *Managing Quality of Care for the Lebanese Health Care System*. World Bank unpublished consultation. Beirut: Ministry of Public Health.

The old Classification System promoted the belief that unless a hospital provided “the full options” – that is a complete range of the latest sophisticated medical technology – then it was not considered a good hospital. Scant attention was paid to whether market opportunities warrant a wide range of equipment, or indeed, whether the hospital can afford the qualified staff to operate such equipment safely and efficiently. In addition to perverse incentives this system presented a typical example of inducing opportunistic behaviors by hospitals that deployed an exceptional, on the spot effort for the survey visit to get a higher classification<sup>15</sup>. The audit tools and procedures were unable to reveal inconsistent adherence to a continuous quality improvement plan after the visit was over.

Providing good quality medical services has been an assumption based on impressive equipment and reputable physicians, because health care managers lacked the knowledge and tools for objective quality measurement and evaluation. However, some hospitals have been working towards the achievement of ISO certification, which was a good exercise for building blocks of a quality management system, but did not provide enough emphasis on health care quality.

In *the original accreditation standards* (2000) emphasis was put on the organizational aspects and staff qualification and skills. Written policies and procedures that were deemed necessary for all areas of work, and more specific information, were required for medical files. Data collection on utilization and workload was introduced to assist with planning.

While the original standards focused on tools and procedures to generate evidence for managerial as well as clinical decision-making, the 2004 revised standards (2<sup>nd</sup> version) stressed on making sure that decisions are made based on policies, procedures and provided evidence, and leading to improved output. Collected data are analyzed to monitor management functions as

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<sup>15</sup> Pomey, M-P., Francois, P., 2005. Contandriopoulos, A-P., Tosh, A., Bertrand, D. “Paradoxes of French Accreditation”. *Quality and Safety in Health Care*, 14 :51-55.

well as clinical care, and information is used to improve quality. New concepts were also introduced such as performance appraisals and competency testing, making quality improvement a daily concern for all staff. The *addenda* developed lately, aimed at raising concern for patient safety and strengthening risk management, while stressing the importance of outcome-based evaluation of professional practice. The purpose was to foster the creation of a new culture in hospital management and quality assurance without bringing dramatic change in standards that would expose hospitals to excessive stress in a period of financial constraints.

The evolution from *the rating system* of the first two surveys into a *system of awards* was meant to avoid misconceptions and to discourage opportunistic approach<sup>16</sup>. Most of the revised standards require long term implementation, and compliance necessitates continuous quality improvement efforts. On the other hand, the audit methodology allows, to a large extent, for the detection of emerging performance. However, the accreditation program would still need further development to gear the system towards deep rooting quality practice.

The transition from the old classification to the last version of standards, then the addition of two chapters later on, was smooth and progressive. No legislation had to be amended and requirements were planned to be incremental and feasible to most hospitals. The evolutionary path helped sustaining quality improvement activities, inducing cultural shifts and ensuring a long-lasting impact.

## 4.2 From a Health System Perspective

Lebanon has benefited from the experience of other countries where governments became a prime user of accreditation or even had a proactive role in quality assurance with direct regulatory implications. The MOPH has developed the accreditation programme as part of its efforts to strengthen its

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<sup>16</sup> Shortell, S.M., O'Brien, J.L., Carman, R.W., et al. 1995. Assessing the Impact of Continuous Quality Improvement / Total Quality Management: Concepts versus Implementation. *Health Services Research*, 30:2.

regulation capabilities and to attain better value for money in terms of hospital care financing. However, accreditation was intentionally presented as an activity independent of the government and other stakeholders. The neutral international expertise was sought to foster elements of objectivity and probity among hospitals that embraced this process and collaborated with the various audit teams, all through the different phases, up to the announcement of the third survey results.

The reconstitution of the accreditation committee, at the beginning of the process, has been a very useful platform for dialogue between key stakeholders. This helped convincing private hospitals that accreditation is needed for future development, to allow Lebanon to regain its historical position as a center of excellence for medical care in the Middle East. Actually, the hospital sector is taking advantage of this system to market itself by creating a new image, thus attracting clients from abroad and regaining its historical role.

The Lebanese experience presents many strengths: the representation of major stakeholders in the supervising committee and their active involvement in the whole process; the large consultation sought for standards development; and the stepwise approach and transition from the old classification system to a new one. The neutral and independent international expertise was also critical for success in this diversified country. As argued in the literature<sup>17</sup>, the National Committee as well as the independent survey team, granted both a relative protection from political interference, and reduced the influence of politics. In the recently developed accreditation procedure, giving a role to domestic institutions as authorized auditing bodies was considered with extreme caution. In order to ensure an irrefutable neutral process, it was decided that prequalification and selection would be done by independent international experts, according to explicit TOR published a few months prior to document submission and agreed upon among stakeholders.

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<sup>17</sup> Pink, GH, Leatt, P. 2003. The use of “arms-length” organizations for health system change in Ontario, Canada: some observations by insiders. *Health Policy*, 63: 1-15.

However, major problems were also encountered. Some were anticipated, such as the financial impact of the third survey threatening the survival of hospitals not awarded accreditation, but others were unexpected, such as the severe reaction to the unintended publication of the results in the media. Voluntary participation in accreditation is considered a critical element for success in developed countries as it reflects the willingness and commitment to quality improvement. This is a debatable issue in Lebanon for two reasons. The first is cultural, and is related to the strong belief that the hospital image depends mostly on its physical structure, the sophistication of its equipment, and the qualifications of its physicians. The second is the weak role of the consumer, who is often uninformed or even misled, which deprives the system of an important driving force towards better quality. On the other hand, linking hospital classification with both the contracting and the payment system, which is based on the 1983 legislation, has influenced the development of the hospital sector. The issue of abolishing this link has to be tackled with the greatest caution as it necessitates a lengthy legislative amendment, and could deprive the system of a powerful leverage for reform. It is particularly risky to remove financial incentives in the absence of an inherent culture of quality improvement, and while the consumer is still powerless.

### **4.3 From Social and Political Perspectives**

The Lebanese experience in hospitals accreditation would undoubtedly continue to have positive repercussions in many EMR countries. Its conception and design, and the implementation method would have also an internal impact on other sectors in Lebanon. It ought to provide a philosophical and political inspiration in the never-ending, undeclared confrontation, between professionalism and confessionism. Before the year 2000, the MOPH had the obligation of contracting with all existing private hospitals belonging to, and protected by confessionism and political powers. This obligation was not derived from a written text of law, but from an implicit pact between confessionist parties that is much harder to break. Some of the contracted hospitals were dangerously malpracticing, and even when an irrefutable proof against one of

these existed, and before attempting to breach a contract, the MOPH had to face confessional allegations of being partial for not taking the same measures against other potentially dangerous hospitals. While it was obvious that the MOPH was unable to assess all hospitals at the same time for reasons related to the confessional system itself. Regardless of whether the job was properly done or not, accusations of partiality always prevail because everyone belongs inevitably to a confession that he can be accused to favor. And, consequently all efforts crumble down, while demotivation and fatigue prevent any new attempt.

Decision makers at MOPH decided to take the challenge all the way: Every hospital has to be assessed against the same standards by un-confessional outside experts. The same rules would be applied on all hospitals without any kind of favoritism or discrimination, and every action would be documented. The system was carefully designed to avoid confessional allegations as much as could be. Nevertheless, interests at stake are tremendous and are not only of financial nature. The ferocious attacks aroused by the third accreditation survey were not only in reaction to the accreditation results per se, but were mostly triggered by the publication of results in a newspaper. The argument was stressed repeatedly in every judicial recourse that results publication was undignifying for “the establishment” (and the confessional community behind). The formation by the Minister of Health<sup>18</sup> of a “committee of claims” to examine hospital queries, and the scientific lengthy discussions with petitioners, brought the contention from the political – confessional emotional field, back to professional grounds.

For the first time in the history of its relationship with private hospitals, the MOPH was able to select hospitals for contracting, and to reject the contracts with those non complying with explicitly set criteria. The selection process has been in place since 2004, and is still effective, despite intimidation and slanderous media campaigns undertaken against those standing behind the system. It started by political and religious pressures, and continued by the media, without ending by claims against the

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<sup>18</sup> Mohamad Jawad Khalifeh. Decision # 33/1 of January 9, 2006.

State. As a matter of fact, applications for judicial review of administrative action, and court actions of damages, were filed but all rejected by the State Council, except for one action that is still pending.

## 5- CONCLUSION

Accreditation has been considered as being both a process that organizations use to evaluate and improve the quality of their health services, and a regulatory tool for the state to guarantee quality care to the population<sup>19</sup>. The Lebanese experience reveals another regulatory dimension for accreditation; that of selecting providers to control supply and to get a better value for money in terms of hospital reimbursement.

The evolutionary path of the Lebanese accreditation experience has followed roughly the quality management movement described by Donabedian<sup>20</sup>, by focusing initially on structures and processes and involving outcomes later on. The development of the accreditation process came as a result of a visionary strategy by MOPH officials that facilitated its introduction by promoting consensus among key stakeholders.

Whether accreditation should be mandatory and whether it should be linked to reimbursement mechanism, were extensively debated<sup>21</sup>. We remain positive, that at the time of its conception, in the absence of quality concerns among providers, and in a context of quasi inexistent consumer pressure, it would have been naive to expect any compliance on a voluntary basis and without financial incentives. We believe however that the situation has changed. At least a new culture has been introduced and genuine quality improvement practices initiated, which may allow henceforth a less coercive, even possibly voluntary adherence. The accreditation

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<sup>19</sup> Pomey, MP, Contandriopoulos, AP, François, P, Bertrand, D. 2004. Accreditation: a tool for organizational change in hospitals? *Int J Health Care Qual Assure*; 17 : 113-24.

<sup>20</sup> Donabedian, A. 1980. *The Definition of Quality and Approaches to Its Management*. Ann Arbor, Mich, Health Administration Press.

<sup>21</sup> El-Jardali, F. 2007. Hospital Accreditation in Lebanon: It's potential for quality improvement. *J Med Liban*; 55 (1): 39-45.

procedure that was introduced recently, is somehow more democratic, in a sense that it allows the hospital to choose the auditing body, and the time of the auditing visit that suits the organization. It enhances good governance by giving importance to the self assessment report considered as a document almost as equally important as the auditor's report, and by introducing a formal appeal process.

In most countries, the linkage between accreditation and contracts has taken a number of years to develop. Even though the MOPH was reserved about the impact of accreditation on contracting and reimbursement, enthusiasm for accreditation was boosted by the hospitals' interest in contracting with the MOPH and other public funds and getting a better payment.

Despite the skepticism about the willingness and ability of the MOPH to cease contracts with hospitals that fail to pass accreditation<sup>22</sup>, the Ministry was not only capable of enforcing its regulation, but also to drag other public funds on the same path. Accreditation award is currently a well-established basic requirement for contracting with all public funds as well as private insurance.

Achieving accreditation does not guarantee that care is optimal. At such an early phase of the accreditation process in Lebanon, the focus has been on establishing a framework and foundation for a consistent quality practice. However, the gradual introduction of new outcome indicators over the coming years, will reflect more and more directly the quality of hospital care delivery.

Nevertheless, according to experts' opinions<sup>23</sup>, thanks to accreditation, hospitals in Lebanon made a great leap in quality improvement. Although it is early and indeed complicated to assess quality outcomes, improvement was clearly perceived by health professionals. A study aiming at assessing nurses'

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<sup>22</sup> *idem.*

<sup>23</sup> Buckley, P., Barrett, N., Abi Chahine, K., Nayler, D., Dyer, E. November 2005. *Evaluation and Accreditation of Hospitals in Lebanon. Final Deliverable.* Beirut: Ministry of Public Health.

perception of quality, showed that hospital accreditation was considered by Lebanese nurses as a good tool for improving quality of care<sup>24</sup>.

The sustainability of the programme depends to a great degree on the commitment of hospitals and their sense of ownership of the process. A general re-education of health professionals and the community towards creating an inherent culture of quality improvement is still needed.

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<sup>24</sup> El Jardali, F., Jamal, D., Dimassi, H., Ammar, W., Tchaghchghian V. 2008. The Impact of Hospital Accreditation on Quality of Care: Perception of Lebanese Nurses. *International Journal for Quality in Health Care* 2008; pp.1-9.