Regulating the quality of health care: Lessons from hospital accreditation in Australia and Indonesia

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Regulation of the quality of health care is a key challenge for governments, compounded by the complexities of defining and measuring quality, as well as the need to engage health providers in regulating their own behaviour. With the growing adoption of national health insurance schemes and other strategies to promote universal health coverage, there is increasing recognition of the need to address quality of care as part of these reforms.

Hospital accreditation has been established in many high-income countries and a growing number of LMICs as an approach that combines quality assurance and quality improvement.

In its classical form, a hospital accreditation program is a form of self-regulation that uses a professional independent organisation to establish a set of standards and to manage the measuring of and reporting on those standards using peer assessors. Achieving the standards requires the accredited organisation to demonstrate a firm commitment to continuous quality improvement. The award of accreditation also gives providers a competitive advantage in the health market.

With evidence of high rates of medical errors and adverse events in hospital care, and their subsequent costs, governments in a number of countries have introduced reforms in accreditation to increase accountability and government control. Reforms in Australia and Indonesia over the last decade provide an opportunity to examine how these reforms impact upon the regulatory functions of accreditation.

Responsive regulatory approach

In analysing accreditation programs from a regulatory perspective, we used the responsive regulatory framework developed by Ayres and Braithwaite in 1995. This views regulation as a series of actions or tools of varying degrees of intervention and cost, arranged in the shape of a pyramid. At the base of the pyramid are the least interventional and costly activities, such as self-regulation and persuasion, while progressively more intensive and costly interventions occupy ascending levels. At the apex are the sanctions and ‘ruinous powers’ available to government.

KEY MESSAGES

- Regulating the quality of health care is extremely challenging, because quality can be subjective and difficult to measure and is closely tied to the behaviour and practices of providers. Wherever possible, regulation should engage the providers themselves in managing their own practices.

- Hospital accreditation programs have been successfully introduced in many countries as a way to set and monitor standards of care (quality assurance), and to engage providers in measuring and progressively improving the care they provide (quality improvement).

- Aligning hospital accreditation with government priorities can strengthen regulatory aspects, but can also potentially undermine health care professionals’ ownership and engagement. This is particularly a risk in low- and middle-income countries (LMICs), where professional engagement in quality improvement is still in its early stages.
This approach proposes that regulation focus on low-cost and low-intervention activities at the base of the pyramid, and progressively escalate only if these activities fail to have the desired effect.

**Australia and Indonesia**

Hospital accreditation programs in Australia have a long history, with a range provided by independent organisations, such as the Australian Council for Healthcare Standards, since the mid-1970s. Despite high levels of voluntary participation, however, studies in the 1990s identified high rates of medical errors and adverse events, resulting in significant costs.

Reforms introduced by the Council of Australian Governments from 2000 included the establishment of a new independent agency, the Australian Commission for Safety and Quality in Health Care. This agency took responsibility for determining service standards, thus separating this function from the measurement and assessment of performance, which was still undertaken by independent accrediting organisations. In addition, the reforms increased the level of reporting on accreditation assessments to government and the public and introduced mandatory accreditation regulated by state governments.

In Indonesia, hospital accreditation was introduced more recently, through the establishment of a government agency, the Commission for Accreditation of Hospitals (KARS), in 1995. However, accreditation tended to focus on management processes rather than clinical care, and achieved only low levels of voluntary participation and little clinician engagement. In 2009, a new Hospital Law introduced mandatory accreditation, strengthened the role of KARS in setting standards and assessing hospitals and established new provincial and national hospital performance oversight bodies.
Reforms from a regulatory perspective

Applying a regulatory perspective demonstrates how governments in both countries have strengthened the regulatory and accountability aspects of accreditation, confirming similar policy shifts in other countries.

In Australia, the reforms created a meta-regulatory level and, by making accreditation mandatory, strengthened its accountability to both government and the public. The reforms strengthened the engagement and regulatory role of state authorities, as well as their responsibility to provide the resources for public hospitals to achieve accreditation. At the same time, they maintained the self-regulatory role of the independent professional accrediting organisations and encouraged ongoing professional engagement in quality improvement.

In Indonesia, reforms have also strengthened the role of government in hospital accreditation, particularly through the introduction of mandatory requirements. However, in the absence of professional or non-government organisations capable of delivering accreditation programs, the government has had to take more of an implementing and capacity-building role than in Australia. Reforms to date have not been explicit on the roles and responsibilities of provincial and district authorities, which has created challenges for KARS to deliver accreditation across the geographically dispersed archipelago, as well as limiting commitment from local government and health professionals to provide the resources needed to achieve accreditation standards.

Accreditation as a strategy to regulate quality of care

As an approach to regulate the quality of health care, accreditation offers a number of potential benefits to LMIC policy makers. These include:

- engaging the medical profession and industry in self-regulation, thus reducing costs to government;
- combining incentives and rewards, with sanctions for non-compliance, thus reducing the need for regulatory action by government; and
- supporting increased accountability by the non-state sector to government.

However, accreditation programs are invariably complex and involve a range of institutions and processes that need to be closely aligned. This presents a number of challenges in LMICs, including:

- difficulties in engaging clinicians and building capacity for self-motivated quality improvement;
- building capacity for the management and delivery of accreditation activities in professional or industry bodies;
- governance to address potential conflicts of interest for professional and industry bodies undertaking self-regulatory roles;
- aligning financial payment mechanisms to provide positive and reinforcing incentives for participating hospitals; and
- clarifying roles and building the capacity of decentralised government to oversee and ensure compliance with the regulatory pyramid.

Accreditation provides a good example of how governments can engage a range of state and non-state authorities in a cohesive regulatory strategy. However, the relatively poor capacity and engagement of professional organisations in most LMICs tend to require greater initial government involvement. There is a risk, particularly in LMICs, that strengthening government control and engagement in accreditation could undermine the key elements of clinicians’ and hospital managers’ engagement in quality improvement, thus reducing their effectiveness in improving the quality of care.

Further reading
