

SUSTAINABILITY OF HOSPITAL ACCREDITATION PROGRAMS IN LOW AND MIDDLE-INCOME COUNTRIES: LESSONS LEARNED FROM SRI LANKA

Dilantha Dharmagunawardene^{*1,2}, *Mark Avery*¹, *Paula Bowman*³, *David Greenfield*⁴, *Reece Hinchcliff*^{1,3}

1. School of Applied Psychology, Griffith Health, Griffith University, Australia
2. Ministry of Health, Sri Lanka
3. School of Public Health and Social Work, Queensland University of Technology, Australia
4. School of Population Health, University of New South Wales, Australia

Correspondence: dilantha.dharmagunawardene@griffithuni.edu.au

ABSTRACT

OBJECTIVE:

Many hospital accreditation programs developed for or implemented in Low and Middle-Income Countries (LMICs), including Sri Lanka, have been discontinued due to multiple factors. This study was conducted to elicit and analyse factors influencing the Sri Lankan hospital accreditation program that was initiated in 2015.

DESIGN & SETTING

This case study employed document reviews and 18 key informant interviews with stakeholders involved in Sri Lanka's accreditation program. Collected data were thematically analysed.

MAIN OUTCOME MEASURES:

Data extraction was guided by the constructs of the ACES-GLEAM Framework, which was developed based on the results of a scoping review.

RESULTS:

Barriers identified were frequent changes in the leadership and strategic plans, lack of awareness and competencies on accreditation among local stakeholders, and non-alignment of accreditation standards with the local health system context hampered by resource and infrastructure constraints. Enablers for program development commonly raised were the commitment of stakeholders, the availability of institutional structures for quality assurance, donor funding from the World Bank, and technical expertise and surveyor training by the Australian Council on Healthcare Standards International.

CONCLUSIONS:

The study identified that multiple factors contributed to the poor sustainability of the Sri Lankan accreditation program. These findings can be useful reflections and guidelines for the accreditation stakeholders to establish sustainable and effective programs in LMICs

KEYWORDS

Hospital accreditation, Quality, Patient Safety, Low and Middle-Income Countries, Sri Lanka, Case Study

INTRODUCTION

Hospital accreditation programs are designed to strengthen the quality and safety (Q&S) of hospitals and health systems. Q&S issues can exert an immense burden on healthcare systems. In LMICs, there are an estimated 134 million adverse event incidents per year, resulting in 2.6 million deaths [1]. It is estimated that 25% of hospitalized people experience harm from healthcare, and 1 in 24 people die due to unsafe care in LMICs [2]. Accreditation, as a strategy to improve Q&S, is a key global focus for health systems strengthening, especially in LMICs, due to the human and economic impact of unsafe, low-quality healthcare [1, 2, 3].

Accreditation is defined as a “self-assessment and external peer review process used by healthcare organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system.” [4, p.05]. During the accreditation process, the performance of healthcare organizations is assessed based on pre-defined standards, which are usually developed based on structure, process, and outcomes (i.e. the Donabedian Framework) [5]. Accredited healthcare organizations strive to apply, meet, and maintain their performance by conforming to these pre-specified standards (quality assurance) [6]. Since accreditation agencies regularly update their accreditation standards to enhance quality, accredited healthcare organizations must also strive to adopt new evidence-based practices (quality improvement) [7]. In these ways, accreditation programs generally have focus on quality assurance and quality improvement objectives.

While positive contributions to improve Q&S are being increasingly implemented, there are numerous challenges to implementing accreditation programs in LMICs [8]. The sustainability of programs in several LMICs has been compromised due to a range of cultural, resourcing, and governance issues [9]. One of the key challenges is cost; of the initial development, ongoing operation, and

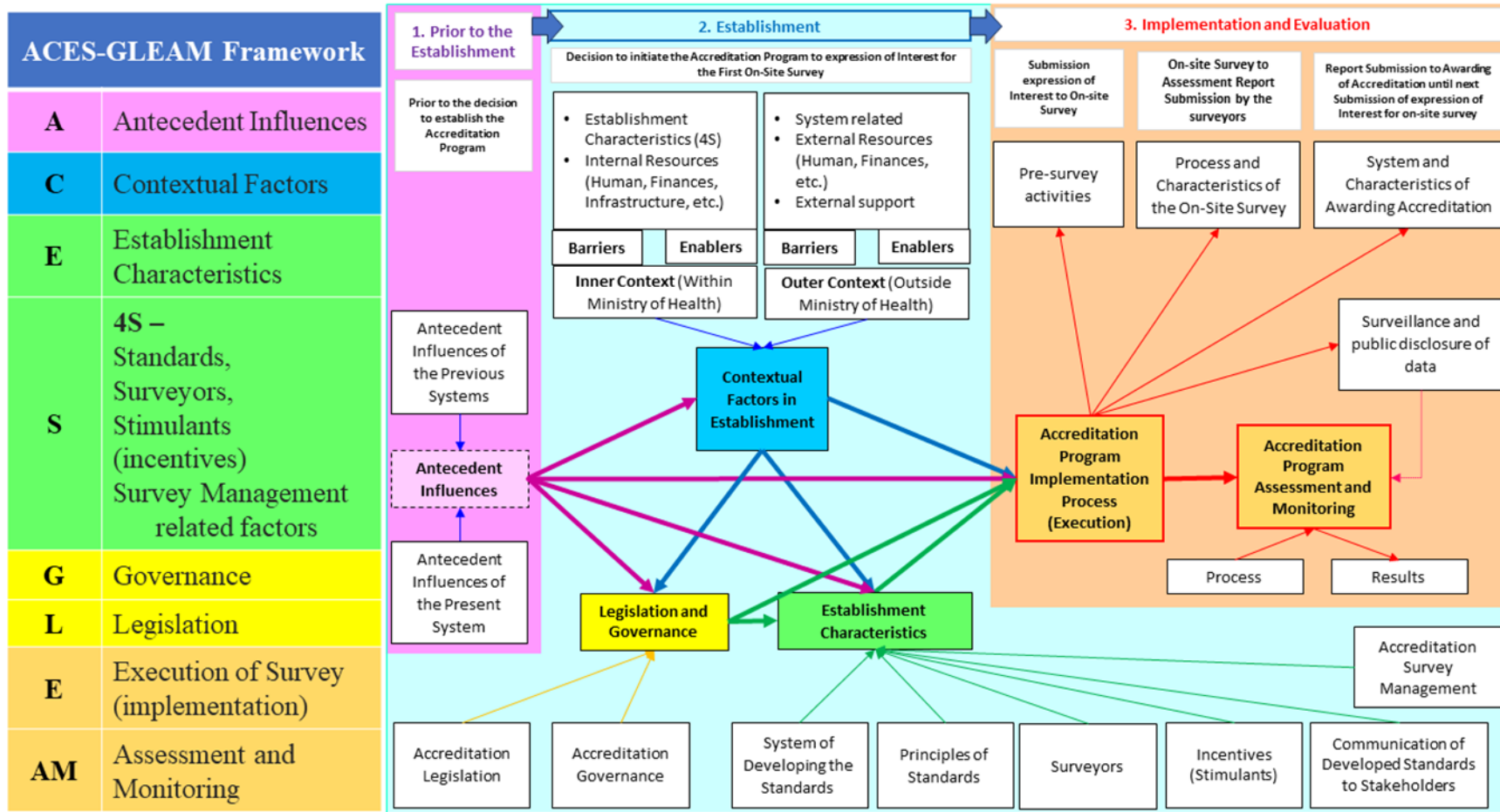
considerable training and preparation costs [10]. Accordingly, many commenced or implemented accreditation programs, including in Sri Lanka, have been discontinued without producing clear benefits [11, 12, 13, 14]. This makes the sustainable implementation of hospital accreditation programs an important global Q&S priority. This case study aimed to elicit in-depth, first-hand information on factors associated with the accreditation program establishment processes in Sri Lanka, where the country's accreditation program was initiated in 2015 and discontinued in 2019. This research note presents preliminary reflections on the results.

METHODS

A qualitative case study method [15, 16, 17] was used. Document reviews and key informant interviews were used for the data collection. Based on the results from a scoping review, an interview guide was developed using the constructs of the ACES-GLEAM Framework (Figure 1). Subsequently, the guide was validated by relevant experts and pilot-tested with independent Sri Lankan healthcare administrators. The main constructs of the ACES-GLEAM framework are Antecedent influences, Contextual factors, Establishment characteristics (sub-themes (4S) – standards, surveyors, stimulants (incentives), survey management), Governance, and Legislation, Execution of the survey, and Assessment and Monitoring of the program.

Interviews were conducted in English with 18 participants in April 2024 (Sri Lankan Ministry of Health (MoH) officials – 6; Sri Lankan Hospital Administrators – 3; Surveyors from Australian Council on Healthcare Standards International (ACHSI) – 3; Sri Lankan accreditation surveyors – 3; Postgraduate medical trainees and medical officers who were involved in the process – 3). Transcripts and data from document reviews were thematically analysed using a critical review method [18]. Ethical clearance was obtained from the Human Research Ethics Committee of Queensland University of Technology, Australia (Ethics Approval Number 6951).

FIGURE 1: THE “ACES-GLEAM” FRAMEWORK



FINDINGS

These findings are the preliminary review from the interviews and document reviews that were conducted. The classification based on the constructs of the ACES-GLEAM Framework (Figure 1) is used to present the findings.

ANTECEDENT INFLUENCES

A need to go beyond the existing long-standing quality assurance program was the main reason for change mentioned by the senior officers of the MoH. The Sri Lankan quality assurance program was initiated in 1988, and two hospitals (Castle Street Hospital for Women and District General Hospital, Ampara) gained international recognition for their quality initiatives by winning international quality awards. Subsequently the "National Policy on Healthcare Quality and Safety" highlighted implementation of hospital accreditation processes as one of the strategies for enhancing the managerial systems and process improvement [19]. This need, combined with the personal interest, enthusiasm, and international exposure of senior officers, fuelled the initiation of the new accreditation program.

In addition, a few Sri Lankan private hospitals were accredited by the Joint Commission International (JCI) and the ACHSI as a strategy for promoting medical tourism [20, 21]. The involvement of the ACHSI and its experts in private hospital accreditation was one of the influences mentioned by the interviewees. The document reviews and interviews completed illustrated that international donor agencies (mainly the World Bank) extended financial assistance for the establishment of an accreditation program through the "Health Sector Development Project" [22], aligned with the global trends of Universal Health Coverage (UHC), Millenium Development Goals (MDGs), Sustainable Development Goals (SDGs).

LEGISLATION AND GOVERNANCE

The document review identified that the "National Policy on Healthcare Quality and Safety" was approved by the Sri Lankan Cabinet of Ministers on 27th May 2015 as the main guiding document for this accreditation initiative, [19] and "National Council for Accreditation (NCA)" was initiated with technical assistance from the ACHSI [23]. NCA had representation from medical administrators, academia, and professional colleges but with no representation of the non-medical community. According to the documentary evidence, only a few meetings of the NCA were held. Almost all the study interviewees had the impression of

minimal impact from legislation for the establishment of the new accreditation program. Interviews and documentary evidence highlighted that there was a positive operational governance by the Directorate of Healthcare Quality and Safety (DHQS) [23], and initiatives were implemented through available institutional structures, termed Quality Management Units (QMUs)

ESTABLISHMENT CHARACTERISTICS – STANDARDS

Interviews revealed that initial attempts were made to adapt JCI, Indian National Accreditation Board of Hospitals (NABH), and ACHS standards to the Sri Lankan context, and later, it was decided to adopt the accreditation process and the program structure of the ACHS standards, "EQulP6" [24]. Document reviews reported that two workshops on standards development were held for the members of NCA by the ACHSI experts, and 32 committees (each composed of a leader, convenor, and members representing medical administrators, academics, and clinicians from professional colleges) were formed. These committee members were approved for higher remuneration payment compared to the standard government rates.

After 18 months only 17 committees finalized their respective standards and the attempt to design national standards through a multi-stakeholder participatory approach failed due to the inability to meet the project deadlines. Therefore, the final accreditation project implementation used "EQulP6" Standards [24]. This approach aligned with the perceptions of some study interviewees, that healthcare provision should be of equal standard for every system and as the Sri Lankan private hospitals and Australian remote, resource-constrained healthcare facilities and settings were using the same "EQulP6" Standards. In contrast, other interviewees had many concerns about employing standards that do not match the Sri Lankan context. They proposed that there should be a clear road map with a robust monitoring and evaluation process and a long-term plan for incremental implementation, if "EQulP6" standards are to be implemented within the Sri Lankan public sector hospitals, as there were concerns about achievability of this direction.

ESTABLISHMENT CHARACTERISTICS – SURVEYORS

This study found that a combination of local surveyors, who were trained by ACHSI and ACHSI surveyors, were utilized for the accreditation surveys. Local surveyors were purposively selected by the MoH for the ACHSI training and

were mainly composed of medical administrators and clinicians. They were trained in a 5-day workshop, and 12 surveyors were selected after an examination and assessment process conducted by the ACHSI.

ESTABLISHMENT CHARACTERISTICS – STIMULANTS (INCENTIVES)

No financial or non-financial incentives could be identified during the scrutiny of documents or from the interviews.

ESTABLISHMENT CHARACTERISTICS – SURVEY MANAGEMENT

Accreditation survey management was handled by the DHQS and almost all the interviewees were very positive about the meticulous coordination and facilitation undertaken. At the institutional level, the surveys were coordinated by the QMUs. Some of the Sri Lankan interviewees had concerns about the poor communication of the standards to the participating hospitals and the lack of awareness of “EQulP6” standards at the institutional level. This was believed to be due to the provision of a one-day training program on standards only for hospital administrators and the distribution of standards only two weeks before the survey.

EXECUTION (IMPLEMENTATION) OF THE SURVEY

The initial accreditation surveys were conducted as a gap analysis approach in six pilot hospitals, and it was

considered valuable as training for local surveyors (identified in the document reviews). The ACHSI surveyors interviewed mentioned that the surveys employed standard international accreditation methodologies. They had positive perceptions of the facilitation by the local trainee surveyors and engagement from the local hospital staff. However, they identified issues due to language barriers and cultural mismatch and mentioned many important gaps in implementing standards, especially in relation to infection control. All Sri Lankan interviewees were extremely positive about the surveys as a learning exercise.

ASSESSMENT AND MONITORING OF THE PROGRAM

The interviewees mentioned that the gap analysis report regarding the initial surveys was delayed by the ACHSI, as there was a contract payment amount due from the Sri Lankan government. The report was later available but was not disseminated by the DHQS to the stakeholders and was not publicly made available. Senior officers from the MoH mentioned that the survey report results were presented and discussed at the higher-level committees (i.e. the National Health Development Committee).

CONTEXTUAL FACTORS

The contextual factors identified through this study have been initially classified as internal and external factors and then as enablers and barriers (Table 1).

TABLE 1: ENABLERS AND BARRIERS REPORTED THROUGH DOCUMENT REVIEWS AND PERCEPTIONS OF THE INTERVIEWEES

	Enablers	Barriers
Internal		
Resource-related – Human Resources	<ul style="list-style-type: none"> • Commitment of senior officials of MoH • Engagement and willingness to learn from the involved institutional staff 	<ul style="list-style-type: none"> • Frequent changes in the leadership at the focal point of implementation • Decision-making by only a few senior officials at the MoH • Not involving multidisciplinary and non-medical teams and experts • Institutional staff were not aware of the standards or the objectives of the gap analysis • Competencies of the health staff in regard to accreditation – confined mainly to staff of central-level structures

	Enablers	Barriers
		<ul style="list-style-type: none"> Inclusion of only medical staff and inclusion of purposively selected individuals, as local surveyors,
Resource-related – Financial		<ul style="list-style-type: none"> Financial constraints at the institutional level to implement the standards
Resource-related – Others		<ul style="list-style-type: none"> Infrastructure constraints at the institutional level to implement the standards (mentioned mainly by ACHSI assessors)
System-related	<ul style="list-style-type: none"> The “National Policy on Healthcare Quality and Safety” approved by the Cabinet of Ministers Availability of institutional structures for quality assurance and quality improvement – Quality Management Units with required human resources – Medical Officer, Nursing Officer, and Development Officer, equipment and infrastructure 	<ul style="list-style-type: none"> No legislative backing or not integrated with legal or governance reforms Sudden and frequent changes to the strategic plans, presumed to be done to meet the project’s financial deadlines Frequent changes and diversions to the program Enormous workload of the hospitals with quality not a priority (mentioned mainly by ACHSI assessors) Non-alignment of standards with the local working environment or context Non-utilisation of incentives
External		
Resource-related – Human Resources	<ul style="list-style-type: none"> Training from international ACHSI experts for surveyors and leaders from MoH International exposure of leaders through external collaborations Training on standards development for members of NCA by ACHSI experts 	
Resource-related – Financial	<ul style="list-style-type: none"> Financing from international donor agencies (The World Bank), as the second “Health Sector Development Project” 	<ul style="list-style-type: none"> Discontinuation of donor funding by the World Bank in 2019 National economic crisis during 2022
System-related		<ul style="list-style-type: none"> EQUIP6 based standards were outdated, with the lengthy project

	Enablers	Barriers
		duration, and EQUIP7 became the most up to date version
Other		<ul style="list-style-type: none"> COVID-19 pandemic during 2020 and 2021

DISCUSSION

This case study for Sri Lanka analysed the document reviews and perceptions of key informants, to identify multiple factors that contributed to the accreditation program establishment in Sri Lanka from 2015 and its subsequent discontinuation in 2019. The preliminary results for this study were classified using the novel ACES-GLEAM framework, which revealed similarities and contrasting features of the Sri Lankan accreditation program establishment process to other LMICs.

The Sri Lankan hospital accreditation program establishment was financially and technically supported by international donors and accreditation agencies (which is similar to most other LMICs) [12, 25, 26, 27, 28]. Despite these initial international collaborations, the program was discontinued once the support had concluded, reflecting a spectrum of resource (mainly financial constraints, followed by infrastructure) [11, 12, 27, 29, 30], contextual (failure to adapt standards to the local working environment) [12, 31, 32] and governance (frequent changes in leadership at the focal point of implementation) [11, 28, 29, 33] challenges, which are common to most LMICs [8, 11, 12, 27].

Sri Lanka had a long-standing quality assurance program, an established national focal point for quality (DHQS), and a widespread established network of institutional QMUs. This contrasted with the initiation of accreditation in some LMICs, where accreditation programs were initiated by international agencies as a remedy to strengthen weakened health systems [11, 28, 34, 35]. However, the COVID-19 pandemic and economic crisis have weakened the Sri Lankan health system to a certain degree and contributed to the discontinuation of the program.

Another contrasting feature in Sri Lanka, which was not reported in the literature relevant for other LMICs, was the frequent changes in strategic plans presumed to be done to meet the financial deadlines of foreign-funded projects.

Accordingly, accreditation standards development to align with the local context had to be abandoned prematurely, and standards were inadequately disseminated to the participating hospitals. This is one of the weaknesses of the short-term project approach in accreditation program establishment in LMICs, where long-term planning and stepwise approaches are more beneficial when considering the resources, contextual, and governance limitations [27, 28, 33, 36]. Therefore, foreign collaborations should target long-term improvement of the capacities of LMICs for establishing tailor-made accreditation programs aligned with the country-specific contexts rather than short-term coercive transfers of externally developed accreditation programs and standards.

The main limitation in this study was the risk of recall bias, but the timing of informant interviews three years after discontinuation was considered a sufficient period to enable participants to speak honestly about their experiences.

CONCLUSION

This case study highlights the challenges associated with developing a sustainable accreditation program in LMICs, where the local context (resources, system, capacity for implementation) may not always be well understood by global accreditation and donor agencies. Frequent changes in Sri Lankan leadership and strategies, financial constraints, non-alignment of accreditation standards to the local context, and lack of capacity to integrate the international accreditation system in terms of competencies, infrastructure, and resources contributed to the ineffectiveness and poor sustainability of the Sri Lankan accreditation program. The findings from this case study highlight opportunities for accreditation stakeholders to refine the processes used to design and implement hospital accreditation programs in LMICs and, in this way, strengthen the quality and safety of healthcare globally.

AUTHORSHIP

DD did the initial conceptualization, design of the research, analysis, interpretation, and prepared the initial draft of the manuscript. PB contributed for reviewing initial conceptualization, study design, and methodology. MA refined the interpretation of results and co-reviewed the initial draft of the manuscript. DG reviewed the design and interpretation of the results. RH reviewed the initial conceptualization, design of the research, analysis, and final approval of the manuscript. All authors reviewed the manuscript before final submission.

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CONFLICTS OF INTEREST

DD is currently engaged as an international assessor for the Australian Council on Healthcare Standards International (ACHSI). MA is the Editor-in-Chief of APJHM.

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