A stakeholder approach towards hospital accreditation in India

SUNIL NANDRAJ, ANAGHA KHOT, SUMITA MENON AND RUAIRI BRUGHA
'Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, India and 'London School of Hygiene and Tropical Medicine, London, UK

Accreditation has been recommended as a mechanism for assuring the quality of private sector health services in low-income countries, especially where regulatory systems are weak. A survey was conducted in Mumbai, India, in 1997-98 to elicit the views of the principal stakeholders on the introduction of accreditation and what form it should take. There was a high level of support for the classical features: voluntary participation, a standards-based approach to assessing hospital performance, periodic external assessment by health professionals, and the introduction of quality assurance measures to assist hospitals in meeting *these* standards. Hospital owners, professional bodies and government officials all saw potential – though different - advantages in accreditation: for owners and professionals it could give them a competitive edge in a crowded market, while government officials reckoned it could increase their influence over an unregulated private market. Areas of disagreement emerged; for example, hospital owners were opposed to government or third party payment bodies having a dominant role in running an accreditation system. The growing strength of a health service user representative lobby in Mumbai is an additional reason why this would be a suitable place for piloting such a system. The biggest obstacle to introducing accreditation in poorly resourced settings, such as India, is in how to finance it. The provisional support of the principal stakeholders for such a development, demonstrated in this study, will require a commitment from government and policymakers if the potential benefits of accreditation to the health of the population are to be realised.

Introduction

In India, 60-70% of outpatient cases and 40-50% of hospital in-patient cases are managed in the private for-profit sector, which includes an estimated 57% of hospitals and 32% of all hospital beds (Duggal and Amin 1989; NSSO 1989; Kannan et al. 1991; NCAER 1992; George et al. 1993; Bhat 1999). Private hospital bed complements range from less than five to 1000, with a median of seven in Mumbai (Nandraj 1994). There is increasing evidence of poor quality private sector care in India, as measured by reported and actual diagnostic and treatment practices; inadequate facilities and equipment; over-prescribing and the subjecting of patients to unnecessary investigations and interventions; and failure to provide information to patients (Yesudian 1994; Uplekar etal. 1998; Bhat 1999). Factors that contribute to the poor quality of care in private hospitals include: lack of monitoring by statutory authorities; outdated and inadequate legislation; and the inability or failure of government to enforce existing regulations (Jesani 1996). These serious deficiencies exist in the context of international and national policies promoting increased involvement of the private sector in the delivery of health services (World Bank 1993, 1995). Legislation that would open up the health insurance sector to private participation, including domestic and foreign organizations, is being considered by the Indian parliament *(Economic Times* 1997). Furthermore, there is a growing demand from consumers for better quality health care, especially from the middle classes, as reflected in growth in the use of consumer protection legislation to

substitute for the inadequacies of the existing health care regulatory system (Bhat 1996). In this context, there is a need to explore the potential of other mechanisms for ensuring safe, high quality health care.

Accreditation has its origins in the United States in the early 20th century, where it developed as a mechanism for medical profession to improve the quality of clinical practice in hospitals, so as to maintain professional standard provide a safe and suitable environment for training practice (Scrivens 1995 a, b). The aim was educational, rather then regulatory, but was also partly to protect the status and independence of the profession through ensuring that the state would have no cause for intervening to prevent harm being done to patients. From an early stage the focus began to widen from monitoring standards of practice to the need improve health outcomes (Stephenson 1981). Scrivens (1996) has defined accreditation as 'the procedure by which an authoritative body gives formal recognition that a body or a person is competent to carry out specific tasks'. It is concerned with 'assessing quality of organizational processes and performance using agreed upon standards, compliance with which is assessed by surveyors' (Scrivens 1995a). Lewis (1984) defines accreditation as the awarding of 'professional and national recognition to facilities that provide high quality of care. It is implicit that the particular health facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them.'

In accreditation systems, standards are clearly defined, compliance is assessed by intermittent external review by health professionals, accreditation is awarded for a time limited period, and health professionals usually have a dominant position in the accrediting bodies. The evolution of accreditation systems in different countries has been determined by the characteristics and level of development of their health services (WHO 1993). The longest experience of them is found in high-income countries, such as the United States, which have strong central controls and sophisticated health care systems. In these settings, accreditation systems have evolved from relying on simple structural and process indicators of safety and good practice towards setting standards that are based on health care outcomes (Scrivens 1995b). Despite the widespread interest in exploring the potential of accreditation for promoting quality health care in low-income countries with weak regulatory systems (World Bank 1997; Brugha and Zwi 1998), there is little published guidance on how this can be done. This paper reports a study conducted in Mumbai city, from August 1997 to June 1998, which surveyed the various stakeholders as to their willingness to participate in an accreditation system, which stakeholders else should be involved, how such a system should function, and the dimensions of quality it should monitor. The aim was to determine levels of interest and the acceptability of accreditation to the interested groups in urban India, and to provide guidance to policymakers.

Study design and methods

A sampling frame of 1157 private hospitals was constructed from lists obtained from the municipal authorities, professional associations and telephone directories. In many cases, information was not available on hospital characteristics such as bed number. Structured questionnaires were posted to all the hospital owners/administrators and responses were received from 94, an 8% response rate. With the questionnaires was a covering letter that defined and explained the main features of accreditation. A sub-

sample of 25 non-responding hospitals was purposively selected to represent a broad geographical distribution, ownership and range of hospital size. The selection of the 25 hospitals was from the 725 hospitals where data on the number of beds were available. Nineteen (76%) of their owners/administrators agreed to a semi-structured face-to-face interview. The questionnaire included questions with closed response answer sets (the same as used in the postal survey), which allowed multiple responses, and open response questions to gain insight into the reasons for, and conditions attached to, respondents' views on accreditation. The face-to-face interview was also to determine if those who did and did not respond to the postal survey had similar opinions.

The office bearers (president or secretary) of eight professional associations (including five specialties of medicine), two professional representative associations and one association representing the interests of hospital owners agreed to face-to-face interviews. Before the interview, a copy of the semi-structured questionnaire was posted to each so that it could be considered within their associations. Similar interviews were conducted with the presidents of two of the three consumer organizations working on health issues in Mumbai, the third being excluded, as its president was a consultant to the study. Six government officials with responsibility for public health and/or private hospitals, three each at the municipal and state levels, were interviewed. One official from each of two insurance companies with health insurance schemes, a multi-national bank and a government financial institution offering loans for hospital owners, were also interviewed. Frequency tables and cross tabulations were computed from the quantitative data, and qualitative data were analyzed by content analysis of key issues. Two workshops involving representatives of the above stakeholders were held, the first during the period of data collection and the other on completion of the draft study report. These explored, in greater depth, issues addressed in the interviews and, in addition, how to finance and develop an accreditation system. Detailed minutes of the proceedings of the workshops were recorded.

Results

Existing mechanisms for promoting quality of care and willingness to consider accreditation

There was consensus among consumer organizations, government, insurance and financial companies about the poor quality of care and lack of standards for private hospitals. One government official remarked: "In a suburb of Mumbai, my brother constructed a house and rented it to a doctor, who started a hospital in the flat which just consists of two bedrooms, one small hall and a kitchen. I cannot imagine what arrangements he will make." Apart from representatives of insurance and financial companies, who were unaware of legislation governing private hospitals, there was a high level of awareness of the 1949 Bombay Nursing Home Registration Act (BNHRA) and the 1984 Consumer Protection Act. Hospital owners (the term here includes administrators) and professional associations viewed the existing legislation as a hindrance to them and called for its re-examination. Government officials and consumer organizations perceived that the BNHRA was outdated and 'toothless' and that regulatory enforcement was of low priority and was not being carried out.

Respondents were presented with a description of the key features and alternative models for an accreditation system; the covering letter explaining the features of accreditation, which was supplied with the postal questionnaire, was supplemented by explanations in the face-to-face interviews. Of those who responded, almost all hospital owners (83/94 in the postal survey and 16/19 in the administered survey) agreed on the need for accreditation; most (74/94 and 14/19) indicated their willingness to participate in such a system. There were no significant differences in responses among the total sample of owners by hospital size, which had the following distribution: up to 10 beds (42/94 in the postal survey and 4/19 in the administered survey), 11 to 25 beds (38/94 and 3/19), and more than 25 beds (11/94 and 12/19). There were no data available on bed number from four hospitals (three in the postal survey and one in the face-to-face interview). Hospital owners reckoned that accreditation could be a useful marketing tool: it would "help differentiate between average, good and excellent hospitals", "weed out bad hospitals" and "doctors would be on their toes to provide good treatment". However, some raised doubts about whether smaller hospitals would be able to afford the cost of upgrading standards. When it came to considering their willingness to participate in an accreditation system, some of the hospital owners said that this would be conditional on: participation being voluntary, health professionals being represented on the accrediting body, the system being financed by the Municipal Corporation or government, and on participation not being be a 'headache' for them.

All of the professional associations, government officials and consumer organizations agreed on the need for accreditation and indicated a willingness to participate. Among the financing bodies, three of four agreed on the need but none indicated willingness to participate. Consumer organizations felt that the manner of its implementation would determine if accreditation would benefit patients. Government officials were of the view that it was an opportune time to consider such a system, that it would make it easier for government to exert control over private hospitals, and that it would be helpful if an outside party initiated the process. Despite their initial lack of interest, one financial company commented that a hospital rating system would make it easier for the company to determine whether or not to provide loans. The general support and willingness of stakeholders to participate in the design and establishment of an accreditation system for Mumbai city was evident in the formation of an adhoc committee (subsequently named the Forum for Health Care Standards) at the end of the first workshop on February 8, 1998. This committee has continued to meet each month since February *1998* to develop standards for private hospitals, and to consider issues concerning grading, method and period of assessment, and how to finance an accreditation system.

Composition and scope of an accreditation system

The majority of stakeholders agreed that representatives of hospital owners and professional associations should be involved and play a leading role in the formation of an accreditation system (Table 1); and most stakeholders, except owners, agreed that consumer organizations should also be involved. Generally, only government and consumer organizations wanted the government to be involved, believing it would lend credibility to the system. Many hospital owners opposed this due to a fear that

government involvement would result in unnecessary bureaucratization; they believed that government was out of touch with the economic practicalities of providing care in private hospitals. Most stakeholders believed that financing companies should not be involved, as they were likely to create obstacles, think only in terms of business and look after their own interests. Some owners feared that these companies would start dictating terms and promote corruption and favoritism. The majority of each category of stakeholder, except financing companies, saw a major role for themselves in the running of an accreditation system. A typical comment from hospital owners was that they themselves were "the most motivated to make result-oriented efforts as we know the practical realities, the problems faced and the plausible solutions in the existing context." Almost all hospital owners (17/19) and government officials (4/6) and all other stakeholders wanted the accreditation system to also cover government hospitals, as this would ensure a level playing field and quality of service to the people. The general opinion was that, as public hospitals are financed by taxpayers' money, they should be accountable.

Role of accreditation and dimensions of quality

There was consensus among stakeholders, when presented with the different roles that an accreditation system can play, that in Mumbai such a system should assess hospitals for compliance to set standards, and provide assistance to them in upgrading their standards and in providing continuous quality assurance (Table 2). Most suggested that hospitals that do not comply with minimum standards need to be assisted to achieve these through a process of consultation, education and training. There was a lack of consensus about whether to incorporate patient redressal procedures within an accreditation system. Some of the hospital owners and professional associations favoured their incorporation, suggesting that they would solve problems and misunderstandings between doctors and patients, thereby reducing litigation. Others felt that mixing the two roles would lead to unnecessary confusion. The majority of stakeholders did not favour an accreditation system playing a punitive role, which should remain a government function.

There was a high level of consensus that assuring quality health care should be the prime focus of an accreditation system, through monitoring various indicators of quality, including consumer satisfaction (Table 3). Hospital owners believed that the existence of agreed standards would provide both protection from lawsuits by patients and their relatives, and useful guidelines for providing better medical care. Only government officials were generally in favour of monitoring the number of hospitals and beds in a geographical area. All stakeholders, except hospital owners and professional associations, wanted professional fees and hospital charges to be monitored. Those not in favour of this considered fee-setting to be a personal matter between the doctor and patient; they believed the level of user charges should depend on the professional skill, investment, seniority and experience of the doctor.

Functioning of an accreditation system

Respondents were asked if the assessment of hospitals should be as 'good or bad', i.e. assessing if they had reached a minimum standard, on a graded scale (below minimum, minimum, optimum, excellent), or by some other method. The majority of each category of stakeholder, including all 19-hospital owners interviewed face-to-

face, wanted hospitals to be rated on a graded scale (Table 4). Those hospital owners, professional associations and consumer organizations in favour of graded standards believed that they would inform patients about the level of quality they could expect from a specific hospital. People would be able to choose where to go for a particular kind of treatment, being assured of the standard of care they could expect to receive. Hospitals would also gain because competition, based on informed consumer choice, would encourage them to maintain standards. Most stakeholders favoured self-assessment by the participating hospital, followed by external assessment; although professional associations and government officials were evenly divided on this point (Table 4). Some respondents indicated the need for mechanisms for reconsidering assessment findings. They viewed this as essential, given the constructive purpose and nature of the accreditation process, which emphasizes assistance to and voluntary participation by health care providers. Most stakeholders wanted assessment findings to be disclosed to any individual or body, on demand. The exceptions were hospital owners and professional associations who generally believed that disclosure should only be made to participating hospitals. There was no consensus as to what should be the periodicity of assessment.

Almost all stakeholders responded that the accrediting body should operate on a non-profit basis, and most that it should be independent and autonomous of any authority. However, government officials, consumer organizations and financing companies also wanted the system to be underpinned by legislation. One government official commented: "society is not mature enough to take on such responsibility on its own. If there were no legislation, there would be no enforcement". There were divergent responses from hospital owners to the question on legislation in the postal and face-to-face interviews, the latter favouring legislative underpinning. The issue of how to finance an accreditation system was addressed in one of the workshops: one suggestion was that the stakeholders involved in the initiation of the system could contribute towards setting it up; another was that payment towards its running costs should be made by the participating hospitals. Most agreed that, in the long term, an accreditation system should aim for self-sustainability.

Discussion and conclusions

The private health sector in urban India provides the bulk of in-patient and outpatient care, as well as primary care; public health goals will not be achieved if the quality and safety of its services are not assured. There is a general consensus that existing; mainly regulatory mechanisms are generally ineffective (Yesudian 1994; Bhat 1996; Nandraj and Duggal 1996; Bhat 1999), a view shared by the broad range of stakeholders, including government officials, in this study. The study introduced the concept of accreditation to them. The survey did not assess their prior knowledge and ideas about accreditation - it being a novel concept to India and one, which we assumed, was unfamiliar to them. Therefore they were presented with the key features in a covering letter and alternative options were included in the structured questionnaire. In some cases, it required considerable explanation and clarification of issues in the face-to-face interviews. The use of closed response sets of answers, including the option of
'other', enabled them to indicate their preferences for what form it should take in Mumbai. In general, there was a high level of support for the classical features of

accreditation: voluntary participation, periodic external assessment by health professionals, the introduction of quality assurance measures and the provision of assistance to hospitals to meet these standards. Preference for a graded rather than a minimum standards-based approach to assessing hospital performance, the latter being a commonly used approach in many developing countries, may have reflected a fear among hospital owners of the consequences of not reaching the minimum standard.

Suggestion bias and the desire to agree and please interviewers, can contribute to a high level of positive responses to questions which respondents have had little opportunity to consider. However, the provision of alternative approaches enabled them to identify the features they were most comfortable with. Responses showed disagreement among the different categories of stakeholder regarding who should be involved in running an accreditation system, whether the level of patient fees and the distribution of hospitals should be monitored, who should have access to hospital-specific information obtained through assessment visits, whether to incorporate patients' grievance procedures, and on the use of legislation to underpin an accreditation system. Where there was disagreement, the responses of different categories of stakeholder were plausible. For example, hospital owners/administrators and medical professional representatives had misgivings about the involvement of government and insurance and financial companies, who they feared might misuse such a system. These divergent opinions support the belief that most respondents had an adequate understanding of the basic features and principles of an accreditation system. Along with this, the open-response questions, and subsequently the workshops, allowed stakeholders to raise concerns and indicate the conditionality of their responses; for example, hospital owners had concerns regarding the cost implications for smaller hospitals in trying to achieve standards.

Responses showed the potentially conflicting advantages which the different stakeholders perceived accreditation would provide them: government officials viewed it as a mechanism to impose controls on private hospitals which could not be achieved through regulation, hospital owners perceived it as a tool which would give them a competitive advantage in the crowded terrain of health service provision, financing bodies saw it as a mechanism to control costs and increase their level of security in providing loans. Although responses to the questionnaire provided only initial stakeholder responses, the plausibility of responses and additional comments adds weight to the conclusion that these were valid indicators of stakeholder positions.

One serious problem was that of non-response bias among the hospital owners/administrators, with only an 8% response rate to the postal questionnaire. Support for the belief that this did not seriously bias the results was that substantially similar responses were elicited in the follow-up face-to-face interview of a similar group of 19 initial non-responders, where there was a response rate of 76%. A notable difference was in the responses on accompanying legislation (Table 4), suggesting that the face-to-face interview may have clarified or provided reassurance as to the implications of legislative support. Respondents, including those in the postal survey and face-to-face interview, also had a similar hospital size profile to the citywide estimate (Nandraj 1994). Another issue is that of the reliability of responses

from representatives of stakeholder organizations and bodies, i.e. whether their views reliably represented organizational positions. As organizations would not have explicit policy positions on what is (in the Indian context) a relatively novel concept, and because respondents such as professional body office-holders are in temporary elected positions, their responses were inevitably provisional. However, the aim of the study was only to provide initial information on likely organizational positions and concerns, as a first stage in identifying how to proceed. Participation from the range of stakeholders at two workshops, and the formation and regular convening of a representative committee to consider contentious and difficult issues in greater detail, suggests a commitment to the process and their initial responses.

There is considerable interest internationally in the potential and future direction of accreditation (see for example. *International Journal for Quality in Health Care* 1998, volume 10). However, most of the attention has been on high-income countries with sophisticated health services with strong central controls. Much of the debate on accreditation has been around the limitations of the classical, organizational structural and process measurement approaches to assessing quality (Schyve 1995), on the need to consider more sophisticated approaches such as 'continuous quality improvement' (CQI) and on the need to shift the focus to client/patient centred care processes and outcomes (Collopy 1995; Heidemann 1995; Scrivens 1995a, 1998). However, outcome monitoring requires well-developed management information systems and is unlikely to be feasible in resource-poor settings where patient record and information systems are rudimentary or non-existent. Within this debate on the need
for more uniform approaches and indicators of quality, there is emerging recognition of the need for accreditation systems to be appropriate to the level of development of existing health services, national and local contexts, and priorities (Arce 1998; Schyve 1998).

In a country such as India, with a clearly dominant private sector and relatively weak central control over the bulk of health service delivery, there is a need to develop the accreditation process in a way that takes into account the different positions of various powerful interest groups. This study has initiated the process in a major urban centre, utilizing a bottom-up stakeholder-approach. The hypothesis underlying the study is that a process of consensus building that includes hospital owners/administrators and professional bodies, alongside government and consumer body representatives, has the best chance of charting the way forward towards a sustainable system. Top-down prescriptive approaches are unlikely to be acceptable where government capacity is limited, its financial commitment to health services has been relatively weak, and there exists a level of mutual distrust between the private sector and government, as was shown in this study from Mumbai. Obtaining the views and support of the majority of hospital owners was not considered essential at this early stage of the process; and the study did not attempt to achieve this. Participation of a small number of the more committed hospital owners - and the limited evidence is that they were broadly representative of the wider sampling frame - was secured through the surveys and workshops, and the subsequent establishment of the Forum for Health Care Standards to define such standards. Therefore, the study, as well as providing useful information to policy- makers, has helped to kick-start the process.

Existing evidence of the Indian context and health system, supported by the results of

this study, provides pointers to what form accreditation should take. Voluntary participation will be the cornerstone, in a context where government and third party payment organizations occupy relatively small segments of the health care purchasing market, and hence have little leverage over private providers. Only a non-punitive approach, whereby government does not attempt to utilize accreditation as a mechanism for implementing regulatory control, will be acceptable to the private health sector. It would also not be realistic for government to view accreditation as an alternative regulatory tool, as initially one would expect only the more committed and better performing hospitals to participate. Hospital owners and professional bodies need to be centrally involved in the setting of standards which are feasible within the resource constraints they face, and in the assessment of compliance with such standards. The willingness of the private sector to participate will also be contingent on the incorporation of quality assurance support mechanisms that will assist them to meet such standards. Sustainable commitment is only likely if participating hospitals foresee a future competitive advantage from their participation.

The growth in the importance of the consumer lobby, especially in Mumbai, means that there is potential to not only include a consumer quality of care perspective, but also to explore the potential of using accreditation status as a way of signaling service quality levels to potential users; thereby service user choice could be used to drive the accreditation process. An incentive to hospitals' participation would be if this signaling resulted in an increased share of the service user market. Insurance companies in India still have only a marginal role in financing the health care market. As this sector grows, their involvement and support for such a system will become more important.

Accreditation is no stand-alone panacea for the problems of poor quality, unsafe standards of care in urban India; nor is it an alternative to regulation, where weak governmental enforcement capacity exists. The biggest obstacle to overcome, with which the Mumbai Forum for Health Care Standards has begun to grapple, is how to finance and provide resources to such a system. The study results showed conflicting responses: some hospital owners indicated a willingness to participate if government financed the system, while others expressed reservations about government having a role in running the system; later, at the second workshop, participants recognized that participating hospitals would need to contribute to its running costs. The resource implications are considerable, whether external hospital assessment visits are conducted by full-time employed professionals or by using a larger panel of part-time volunteers, who would also need to be trained and recompensed (Bohigas et al. 1998). It is not conceivable, in a highly competitive health care market characterized by large numbers of small hospitals, that an accreditation system could be initiated and sustained without a financial as well as a policy commitment from government - municipal, state and/or central. The transaction costs, both for hospitals and an accrediting body, will mean that an accreditation system should initially focus on involving larger hospitals that have the capacity to
comply and improve standards. This may well mean that smaller, poorer quality hospitals - many of which are hospitals in name only - will gradually be eliminated from the market; or, alternatively, they will survive through offering cheaper, poorer quality services to those who can afford no better. The implications of this for equitable access for the poor are what pertain anyway in parts of urban and much of rural India, where the poor use the informal sector.

In deciding what standards to set and measure, and how often, a pragmatic approach will be necessary, acknowledging the likely rudimentary nature of most hospital information systems and the transaction costs to participating hospitals (Huang 1995). Initially, standards could be based on simple structural and process indicators, for example facility assessments, the availability of evidence-based guidelines and protocols for key public health priority diseases and programmes; and the presence of trained staff who participate in regular continuing medical education programmes, etc. Dichotomous ratings, indicating whether a facility has achieved specified minimum standards, would probably be simpler to apply than a graded scale. Assessments that attempt to quantify quality levels are unlikely to be feasible in the initial stages. This approach might be considered as having poor validity for assessing quality in well-resourced countries with sophisticated health services, where clinical outcomes can be measured. However, in India simple structural and process indicators would provide a starting point. Lessons learned through pilot projects are needed before more widespread programmes are attempted.

It is likely that minimum criteria will need to be set before any facility would be considered for accreditation, such as minimum bed complement and bed: facility/space ratio. The sheer number of small facilities (e.g. hundreds of hospitals with less than 10 beds) would make such a project unmanageable; facilities with only a few beds and low patient turnover would be unlikely to be able to contribute financially to the cost of accreditation assessment visits in the long term. The cost of setting up and running an accreditation system is only one obstacle; the results of this study show that the principal actors are aware of the potential dangers as well as potential advantages for them. The use of stakeholder analysis tools (Brugha and Varvasovszky 2000; Varvasovszky and Brugha 2000), to promote a collaborative approach to charting out a policy direction which would take into account the concerns of the different interest groups, would increase the chances of success. The establishment of an inter-stakeholder forum to guide the process shows that the principal interest groups are favourable, the stakeholder approach is bearing fruit, Mumbai is fertile territory for such a project, and generalizable lessons could be learned.

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Norwegian government.

Biographies

Sunil Nandraj is a public health researcher and development catalyst. His areas of interest include delivery of health care in the public and private health sectors, issues relating to financing and economics, health insurance, health sector reforms, evaluations of health programmes and reproductive health. He has spent a major part of his professional life working with non-governmental organizations on development issues.

Anagha Khot is a health researcher with the Centre for Enquiry into Health and Allied Themes (CEHAT). She holds a postgraduate degree from the Tata Institute of Social Sciences in medical and psychiatric social work. Presently she is working on issues related to violence against women and her areas of interest include public health, health care systems in developing countries, and health and human rights.

Sumita Menon is a health researcher with CEHAT. She holds a Postgraduate degree from the Tata Institute of Social Sciences in medical and psychiatric, social work. Presently she is working on issues related to violence against women and her areas of interest include public health, health care systems in developing countries, and health and human rights.

Ruairi Brugha is a public health specialist and medical doctor on the staff of the London School of Hygiene *and* Tropical Medicine. His principal area of research is to explore the role and potential of the for-profit private health sector in the delivery of services of public health importance in low- and middle-income countries, including for malaria, sexually transmitted diseases and TB. Other areas of interest are in health services in the context of health sector reforms and in exploring how to improve quality of care issues. He is a course organizer for the MSc Public Health in Developing Countries at the London School.

Correspondence: Sunil Nandraj, CEHAT, c/o Sai Ashray, Aaram Society Road, Vakola, Santacruz East, Mumbai 400 055, INDIA.
Email: cehat@vsnl.com

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