# ACCREDITATION OF HOSPITALS
# A NEW INITIATIVE

**Sunil Nandraj**
**Anagha Khot**
**Sumita Menon**

January, 1999

CEHAT

# Contents

# *Acknowledgements*

**Introduction**

Health care delivery in India is rather complex with disparate practitioners and institutions, mixed ownership patterns and diverging systems of medicine. Yet, these different elements have never been coalesced into a system. In other words, the public and private health sectors work largely in a mutually exclusive fashion. So too are practitioners of allopathy, homeopathy and the "Indian Systems of Medicine" governed by separate bodies and legislation.

Health planners and policy makers have consistently failed to take a holistic view of the health services in the country. While the public health services have received the full attention of policy makers, the private sector has functioned outside the framework of planning. There have been very few attempts in the post-independence period to restructure health services in the country to meet the needs of the people. Instead, inequities have been strengthened and perpetuated.

Some of the contradictions are worth mentioning. Firstly, although a great majority of the population resides in rural areas, health care services are concentrated in towns and cities. Secondly, although the government has the responsibility of providing free health care to all its citizens, the public health services have been consistently under-funded. Even these funds have been utilised in a lopsided manner (Duggal, Nandraj and Vadair 1995,  ICHSR 1997). Cuts in monetary transfers from the centre to the states have weakened public health care even further (Tulsidhar 1993). Indeed, the Structural Adjustment Programme, which advocates compression in spending on social security and subsidies, has given an added impetus to privatisation in varied forms. This means that far from being free, health/medical care has become an extremely expensive commodity.

Private practitioners and institutions have long been dominant in the health care sector. Private household expenditure on health exceeds government health expenditure (of Rs. 85 per capita) by nearly four to five times (Duggal, Nandraj and Vadair 1995). The share of the private health sector is between 4 to 5 per cent of the Gross Domestic Product. This share at current prices works out to between Rs.160,000 million to Rs.200,000 million per year. Not only that, studies on utilisation patterns and household health expenditures show that 50 per cent of people seeking indoor care and around 60 to 70 per cent of those seeking ambulatory care (or out-patient care) go to private health facilities in the country. These studies also make it abundantly clear that households have to bear a substantial financial burden for meeting health care needs (Duggal with Amin 1989, Kannan et. al. 1991, NCAER

1992, George et. al. 1993). And yet, private health care remains unregulated in India. Herein lies a third contradiction and the rationale for this study.

**PRIVATE HEALTH SECTOR**

The private health sector comprises of the 'not-for-profit' and the 'for-profit' health sectors. The not-for-profit sector includes health services provided by voluntary organisations, charitable institutions, missions, and charitable trusts among others. And the for-profit health sector consists of practitioners ranging from general practitioners to consultants, from quacks to super specialists, from RMPs (or Registered/Rural Medical Practitioners) to licentiates and nurses employed in private health institutions. Also included in the non-governmental/private sector are traditional health care practitioners like faith healers, traditional birth attendants, priests and local medicine women and men.

The institutions falling within the ambit of the private health sector are hospitals ranging from small nursing homes with fewer than five beds to large corporate hospitals and medical centres as well as medical colleges, training centres, dispensaries, clinics, polyclinics, physiotherapy and diagnostic centres, blood banks, and the like. In addition, the private health sector includes the pharmaceutical and medical equipment industries that are predominantly multinational.

In India, the differences between hospitals, maternity homes and nursing homes are not clear. The Bombay Nursing Home Registration Act (1949) defines a nursing home as "any premises used or intended to be used for the reception of persons suffering from any sickness, injury or infirmity and the providing of treatment and nursing for them and includes a maternity home and the expression 'to carry on nursing home' means to receive persons in a nursing home for any of the aforesaid purposes and to provide treatment or nursing for them" (GOM 1949). According to this definition, all maternity homes and hospitals are also nursing homes. Institutions providing exclusive outpatient care are excluded, however. In other words, the size of the institution does not matter; what is crucial is the service provided. For the purpose of the study, we have defined hospitals as "any institution providing indoor care." And in this report, we will refer to all nursing homes, maternity homes as hospitals.

These hospitals could be classified in terms of their size, services provided, ownership and so on. On the one hand, there are tiny hospitals with fewer than five beds. On the other, there are huge hospitals with 1000 or more beds. Hospitals could provide specific services in one speciality or they could provide a wide range of services in many specialities. For

example, maternity care, medical termination of pregnancy and other services fall under the speciality of obstetrics and gynaecology. Moreover, hospitals set up by corporate bodies could be run as business ventures. And hospitals registered as charitable trusts could also be treated as business ventures. Clearly, the possibilities are enormous.

Although a dominant sector, data on private health care is insufficient and inaccurate. Various studies have shown that the number of private hospitals is actually much larger than what is recorded in government data (Nandraj 1994). The findings of a study conducted recently in an average district of the country illustrate the functioning of smaller hospitals (Nandraj and Duggal 1996). In terms of their ownership, as many as 92 per cent were individual proprietorships. Only 6 per cent were run on a partnership basis. Three fourths of the hospitals were operating from premises that they owned. The doctor was also the administrator or the sole individual in-charge. Not only that, the doctor-owner of as many as 86 per cent of the hospitals admitted their own patients. In only 14 per cent of the hospitals could other doctors admit their patients. About 71 per cent of the doctors were qualified allopaths. The others, though trained in the ayurvedic and homeopathic systems of medicine, nevertheless treated their patients with allopathic drugs. Some 10 per cent of the doctors trained in the allopathic system of medicine were specialists, with a MD or MS degree and the rest had an MBBS degree. The average number of beds in each of the hospitals was 11. All the hospitals in the study had an OPD (or out patient department) with an average attendance of 40 per day and 186 per week. The average number of patients admitted was 12 per week and 42 per month. The average length of stay of patients in the hospitals was 13 days during the month. The average occupancy rate was 51 per cent of the available beds per month (ibid.).

In addition to the very small private hospitals described above, smaller towns have one or two medium sized hospitals that are owned by leading doctors of the area. Since the last decade, the incidence of such hospitals has increased in many towns. Medium sized or big (for-profit) hospitals continue to be scarce in these parts.

Another growing trend witnessed since the 1980s is the rise of the corporate hospital. This is one of the important developments in the private health sector. During the last decade and a half, the growth of these hospitals has been very brisk. In 1983, Apollo Hospitals Enterprise Ltd. set up the first corporate hospital in India in Madras. Today, the group has hospitals in far flung locations like Hyderabad, Delhi, Ranchi, Madurai and Nellore among others. It has, moreover, 2010 super-speciality beds in over 50 medical disciplines and gross revenues of Rs.1.6 billion. Following the example of Apollo were other corporate groups like United Group, Standard Medical Group, Surlux Diagnostic Ltd. and so on. Several large business

houses have diversified into the field of health in addition to their regular business. NRI (or Non Resident Indian) doctors have also joined the bandwagon.

This rapid expansion is due to the high profitability of such ventures. Suffice to say that with the rise of the corporate sector, the cycle in health care does not start with a sick person in search of a trained medical person but with an investor in search of a profitable investment in the share market (Phadke 1993).

QUALITY OF CARE

Despite their considerable presence in the country, information about the role, nature, structure, functioning, type and quality of care of private hospitals remains grossly inadequate. Attention has been focused only recently on the serious anomalies in their functioning. This has happened due to the role played by consumer organisations, non-government organisations and victims of malpractice in raising awareness on issues related to the quality of care in the private health sector, especially in hospitals.

In 1985, the Calcutta High Court appointed the speaker of the West Bengal legislative assembly to prepare a report in response to a petition regarding the dismal condition of private hospitals and nursing homes. This report found that nursing homes lacked adequate floor space, ventilation, lighting, water, bathroom facilities and qualified doctors and nursing staff. Then in 1991, the Chief Justice of the Bombay High Court issued a order to the Bombay Municipal Corporation to set up a permanent committee to oversee and supervise the implementation of the Bombay Nursing Home Registration Act 1949, and make further recommendations. As one of its tasks, the committee examined the quality of care provided in terms of physical standards, human power, sanitary conditions, equipment and functioning of private hospitals in Bombay (Nandraj 1994). In 1995, a study carried out by CEHAT for the UNDP and the Government of India also examined physical standards of private hospitals and nursing homes in an average district of the country (Nandraj and Duggal 1996).

The last two studies revealed that the standards in private hospitals were poor. Most of them were located in residential premises. Many lacked space: passages were congested, entrances were narrow and crowded and it was impossible to manoeuvre either a trolley or stretcher. Many of hospitals that were supposed to have an operation theatre actually did not have one. Some had converted kitchens into theatres and labour rooms that sometimes leaked. Many of the hospitals were ill equipped, especially those providing maternal care.

For instance, many did not have resuscitation sets for newly born babies in the labour room. Supportive services like ambulance services, blood, oxygen cylinders, generators, etc. were inadequate. Most had unqualified staff. Few had doctors round the clock. Most hospitals used the services of visiting consultants and employed unqualified nurses. Sanitary conditions of the hospitals left a lot to be desired. The number of toilets and bathrooms were not in keeping with the number of beds in the hospital. Many of the hospitals did not have continuous supply of water; some of them procured water from tankers or by other means. Far from incinerating infectious waste material, hospitals dumped waste in ordinary municipal bins.

In addition to low standards, several irrational and unethical practices like unnecessary investigation, tests, consultations and surgeries also flourish in private hospitals. One study revealed that 70 per cent of the hospitals, in which caesarean sections were routinely conducted, were privately owned (Kannan et. al. 1991). In Maharashtra, the Mangudkar committee set up by the government found that the average rate of caesarean sections in private hospitals was 30 per cent as compared to 5 per cent in government institutions (The Week 1992).

Ultrasound investigations, amniocentesis, epidural anaesthesia and the like are done unnecessarily when facilities are available and an investment has been made towards it. Unnecessary investigations, referrals and hospitalisation also inevitably occur when there are kickbacks between referring practitioners, hospitals and laboratories. In many hospitals, doctors are under pressure to see that the beds are occupied all the time and the equipment utilised fully. Many hospitals fix the amount of 'business' a physician or surgeon has to bring over a certain period. Over-supply of doctors in the private health sector has also created unhealthy competition that has led to unnecessary – or  over – medication of otherwise healthy people.

In short, the major complaints against private hospitals are that of over-charging, irrational therapeutics, not providing the personalised care they claim to provide, not providing information about diagnosis and treatment, subjecting patients to unnecessary tests, consultation and surgery. Further, the hospitals have defunct equipment, unqualified doctors, nurses and technicians. The welfare of patients is generally disregarded while commercial considerations take over. Taken together, the functioning of private health practitioners – and private health care – is determined largely by a supply-driven market situation. This would inevitably be an urban reality where choices, at least in an ideal sense, abound. The poorer and less accessible villages would have a different story to tell.

REGULATION AND MONITORING

The dismal state of private hospitals could be attributed to there being practically no monitoring and accountability to the people or to any concerned authority. Until recently, only the states of Maharashtra, West Bengal and union territory of Delhi had some legislation for private hospitals. However, the Acts are only meant for registration of the private hospitals. They do not include details on the standards to be maintained for space, facilities, staff employed, sanitary conditions, equipment and other supportive services. The states of Tamil Nadu, Madhya Pradesh, Kerala, Assam and Bihar are now in the process of enacting legislation for hospitals and nursing homes thanks largely to pressure from various consumer organisations. However, these efforts are set against stiff opposition from hospital owners and medical associations. It should be said that despite long standing legislation in two states and one union territory, standards of medical practice in private hospitals (in terms of qualification of staff, required equipment, administration, treatment, etc.) are as yet not applied in India.

This is because the existing Acts are far too few, outdated, inadequate and remain unimplemented. In Bombay, it took a Public Interest Litigation to compel the authorities to implement the provisions of the Bombay Nursing Home Registration Act. The Chief Justice of the Bombay High court remarked, "The writ petition has served the purpose of activising (sic) the concerned authorities who seem to have woken up and taken certain steps in the direction of implementation of the various provisions of the law." This case raised questions about the standards of medical practice in private hospitals, quality of the staff, treatment, equipment as well as the general administration of these hospitals and their accountability to people at large. During the proceedings of the case it was found that the Municipal Corporation, the registering authority in Bombay, was not enforcing the Act. It admitted that for three years prior to the case it had not taken action against any hospital or nursing home nor collected fines. Moreover, the Corporation could not submit a complete list of private hospitals in Bombay to the court. Although the Bombay Nursing Home Registration Act is applicable to the whole of Maharashtra, its implementation was found restricted to the cities of Bombay, Pune, Nagpur and Sholapur. Clearly, the private health sector has remained blissfully outside the purview of legislation for the greater part of the last 50 years. Only recently did private practitioners and hospitals come under the purview of the Consumer Protection Act amidst great resistance from the medical fraternity.

In sum, the private health sector in India has continually grown through 50 years of independence while continuing to be unregulated. In fact, efforts to regulate it have

consistently been opposed by vested interests. Although a majority of the population utilises the services of the private health sector, they have no control on the quality or pricing of care.

## ACCREDITATION IN THE PRESENT SCENARIO

The Structural Adjustment Programme currently underway has given an added impetus to the process of privatisation. At the same time, in its reports and recommendations, the World Bank recommends regulation of the private sector. Indeed, even a market driven economy like the U.S.A. has some regulation. The need for regulation has been an enduring concern for us too, although we feel that regulation would have to be part of a wider agenda designed to bring quality health care within the reach of all. Accreditation is one possible way of ensuring good quality – there could be other mechanisms too – but it cannot tackle inequities in the distribution of health care. This would require re-distribution of health facilities as well as a unifying framework of financing and regulation. But discussions on these vital aspects are only in an early stage in some circles. And they are clearly out of the purview of World Bank interests.

### DIMENSIONS OF ACCREDITATION

Better quality of health care could be pursued in various ways. One method is regulatory, wherein the state takes the initiative and responsibility of setting standards. Another one is accreditation, wherein an independent body with the support of professional organisations defines and monitors standards on a voluntary basis. Both are not mutually exclusive, as the accreditation system itself could be regulatory in nature. C.E. Lewis (1984) defines accreditation as "a 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." Simply put, accreditation refers to a voluntary process wherein the functioning of a participating health care institution is assessed against set standards by external review.

There are four basic elements of an accreditation system: first, it is voluntary; second, standards are laid down; third, compliance is measured by external review and fourth, outcome of standards denotes compliance (good/bad, rating scale). The broad objectives of the accrediting system would be to develop and update standards to cover various areas of hospital functioning. It would also aim to monitor hospital compliance with the standards prescribed, assist hospitals that need to upgrade their levels and award accreditation to those institutions demonstrating them.

There are various models of accreditation being followed. One of the accreditation models is 'standards-based'. In other words, hospitals are rated according to their compliance with different sets of standards or norms regarding facilities, equipment, humanpower, space and so on. Another approach is based on a quality assurance programme. This mainly involves implementing a process of accreditation based on quality assurance in those institutions that are striving to improve quality. A third model of accreditation is based on "citizens' charter". This approach emphasises making hospitals more user-friendly, providing information to users about the services available, setting up procedures for redressing grievances and so on.

Standards are the cornerstone of an accreditation system. Four definitions of standards prevail. Firstly, standards are a degree of excellence. Secondly, standards serve as a basis of comparison. Thirdly, standards are a minimum with which a community may be reasonably content. And, finally, standards are recognised as a model. Standards can be broadly classified as written or explicit standards, and unwritten or implicit standards. Ideally standards should be written and explicit as these allow both the data collection process and the assessment of care to be based on clearly delineated agreed upon bench marks rather than relying on the discretion of assessors (Fooks and Rachlis 1990).

There are different levels of standards. There are minimum standards, which generally represent a level of acceptability. Minimum standards are necessary to meet. Beyond the minimum, there are desirable or optimal standards. A hospital, while meeting a minimum standard, should seek to achieve a desirable or optimum standard. Conformity to specified requirements is based on collective judgements. Standards have to be developed and maintained and would include the organisation and the management's standards as well as standards for clinical and professional practice. Standards may be directed towards structure, process or outcome. Structure standards apply to human, financial and physical resources. Process standards apply to activities that constitute care, service or management. Outcome standards refer to the results of care, clinical as well as non-clinical.

Standards could be national, regional or specific to certain services provided. In recent times, there is an increased interest not only in formulation of standards but also in the process of measurement of compliance with them. Avedis Donabedian, the *guru* of quality assurance in his contribution to the assessment of health care, laid emphasis not only on the technical (defined as knowledge, judgement and skill of providers) but also on the interpersonal domain (Donabedian 1988).

ACCREDITATION SYSTEM IN OTHER COUNTRIES

Accreditation of hospitals is not a new phenomenon. Many countries have been developing and setting up bodies for accreditation, the primary aim of which is to have hospitals of higher standards that provide quality patient care. The efforts to set up accreditation bodies/organisations have been determined by the development of health services in each of the countries.

*United States of America:* The first initiative was taken in the United States by the medical profession. In 1910, Dr. Earnest Codman developed the 'end result system' of hospital organisation. The system aimed to enable a hospital to track every patient it treated in order to determine whether the treatment was effective (Scrivens 1995). The result was the founding of the American College of Surgeons in 1913 which was firmly in favour of hospital standardisation. In the U.S.A., there were three clear phases in the evolution of the accreditation process: the era of minimal standards (1917-1965); the era of optimal achievable standards (1966-1987); and the era of performance evaluation and beyond from 1988 to the present day (Brooks 1990). Thus, the Joint Commission historically has used compliance with contemporary standards as its basic measure of health care quality in the accreditation process. In recent years, however, there has been a growing interest in monitoring and evaluating the actual results of care (Loeb and O'Leary 1995).

The American College of Surgeons took the initiative in setting up a system. In 1918, it began to implement two Congress decisions, namely, that standards be developed for awarding fellowships to surgeons and allowing hospitals to be evaluated. The development of standards for hospitals became known as the Hospital Standardisation Program. It aimed to ensure that those institutions having the highest ideals might have proper recognition before the profession, and that those of inferior equipment and standards should be stimulated to raise the quality of their work. In this way, patients will receive the best type of treatment, and the public will have some means of recognising those institutions devoted to the highest ideals of medicine (Roberts, Coale and Redman 1987). The American College of Hospital Standardisation Program received interest beyond all expectation: by 1945, some 94 per cent of hospitals had met minimum standards and by the late 1940s, the College realised that the Program had grown too large for one organisation to handle. This led in 1952 to the formation of a larger organisation namely, the Joint Commission on Accreditation of Hospitals. The Joint Commission, as a national accreditation programme, currently accredits 80 per cent of hospitals in the United States. In 1987, the Joint Commission

changed its name to the Joint Commission on Accreditation of Healthcare Organisation (or JCAHO).

JCAHO shares a very interesting relationship with the federal government. The introduction of Medicare and Medicaid in 1960s led to a compromise between the JCAHO and the federal government. Because of this compromise, hospitals accredited by the JCAHO were given 'deemed status', that is, they were deemed to have met the conditions necessary for participation in Medicare. At present, 42 states allow hospitals exemption from their own regulatory processes if they have received the accredited status of the JCAHO. Of the approximately 7000 hospitals meeting the conditions for deemed status for Medicare, about 77 per cent do so through the JCAHO programme.

*Canada:* The Canadian Council on Hospital Accreditation (renamed the Canadian Council on Health Facilities Accreditation in 1988), was a breakaway from JCAHO. It was a result of the Canadian Declaration of Independence to meet the needs of the newly established Canadian National Health System. The initiative for accreditation came from the medical profession and the Hospitals' Association. In 1952, the Canadian Medical Association met with representatives of the Canadian Hospitals Association, the Royal College of Physicians and Surgeons and L'Association Des Medicins de Langue Francais du Canada. Together they established the Canadian Commission on Hospital Accreditation (Scrivens 1995). This is the sole authority to accredit hospitals in Canada and has the monopoly of accreditation activities that now encompass long-term mental health and rehabilitation facilities as well as general hospitals. In terms of its relationship with the government, it has an arm's length relationship. There are government observers on its board, but no formal relationship exists. It is an autonomous body that has received official recognition early in its existence: its patent letter from the Secretary of State arrived in 1958. The CCHFA's history is one of steady expansion. By the end of the 1980s, it was accrediting something like 1,300 facilities (or over 94 per cent of hospital beds). The Council recognises that the current system for monitoring quality solely through structure and process standards is rapidly becoming inadequate (CCHFA 1990). In its efforts to provide the best possible standards to guide facilities in the provision of quality care, the council has presently begun to examine outcome measures and how such measures can be incorporated into the accreditation process.

*Australia*: Australia introduced hospital accreditation as early as 1926 but succeeded only in the 1970s. It began as a state initiative but did not take off until it managed to receive national funding. Part of the initial development of the Australian Council was the formation in 1960s of the Representation Committee which included members of the Australian

Medical Association, the Australian Hospital Association and Royal Colleges and Postgraduate Committee in Medicine. In 1974, the Australian Council on Hospitals Standards (subsequently renamed the Australian Council on Healthcare Standards) was established. The accreditation programme was designed to assure interested groups that the health professionals consider it a responsibility to monitor the standards of performance of their members. In addition, the Council must emphasise both utilisation of resources and the quality of care provided by those resources (The Australian Council on Hospital Standards 1978). The medical profession forms a majority in the 22 member board, although nurses, allied health professionals and consumers are represented, albeit sparsely. Since the beginning it has stressed that its role is evaluative and educative rather than inspectorial or judgmental (McCue and Wilson 1981). The system has not yet achieved the extensive coverage, in terms of numbers of hospital beds, as in the other countries. The highest coverage achieved by 1994, namely 60 per cent of the beds, was in Victoria (The Accreditor 1993). The ACHS, in co-operation with the medical colleges, has developed a set of clinical outcome indicators, the first of which were used in accreditation reviews during 1993. In terms of its functioning, the ACHS system has a number of different accreditation decisions: full accreditation that lasts for three years, partial accreditation for one year or no accreditation at all. A new five-year level of accreditation status is to be introduced, should an organisation be awarded three years accreditation for three consecutive years.

*United Kingdom:* Though accreditation has been on the agenda of the National Health Services (NHS) for a decade, there has been no national response to calls for national bodies to set and monitor standards. The result is an uneven distribution of attempts to devise and measure standards. Existing accreditation systems include the King's Fund Organisational Audit, the Hospital Accreditation Programme, Pathology, Trent Community Hospital, South Western Health Records. Struggling to find an approach to accreditation are the speech therapists, radiologists, specialists in head injuries, nursing (national and South East Thames), South East Thames Regional System, South Western Regional System, child health computing, estates and a number of local systems run by purchasers. In addition, the growing interest to adopt accreditation systems has caused the NHS to borrow assessment approaches from the private sector. An accreditation system designed to promote staff training and development, known as Investors in People, promoted by the Department of Trade and Industry, has become very popular. Other systems based upon the Department of Health's standards for patient services, known as the Patient's Charter also took off. In addition, a number of purchasers began to develop assessment system, based on standards, which were referred to as accreditation systems. The Regional Health Authorities have supported many of these in an attempt to encourage monitoring processes (Scrivens

1995). Among them, the King's Fund Organisational Audit Programme and the Hospital Accreditation Programme are the significant players. King Edward's Hospital Fund for London, an independent foundation whose mission is to improve the quality of management in the NHS, has developed the nearest thing to a national accreditation system in the U.K. This programme has its antecedents in the U.S.A., Canada and more particularly the Australian models. It offers a framework of organisational audit standards, which are concerned with the systems and processes for the delivery of health care and the evaluation of compliance with those standards by means of a survey carried out by health care professionals. It has evolved as a developmental approach and does not have the pass or fail element (Brooks 1994).

The review of literature suggests that over time accreditation systems has moved away from a single system focusing on entire hospitals towards more complex patterns. Moreover, each of these accreditation systems has a slightly different approach to implementation, which demonstrates further the options available to those wishing to construct accreditation standards or system.

*China:* A formal programme of hospital accreditation has begun recently in China. Initiative and responsibility for this programme came from the government, particularly from the Ministry of Public Health. Appropriate accreditation standards have been developed for the three levels of hospitals as designated by the government: neighbourhood or township level; district, country, industrial complex levels; and large municipal and teaching hospital level. For each of the three levels, standards cover the same four areas of treatment as defined by the government: prevention, health care reconstruction, support and participation in disease prevention and care and health care activities. The goal for the accreditation programme is that each hospital be accredited every three years. The hospitals, which are accredited, will get their license to operate. Those who are not able to achieve accreditation status immediately will be encouraged to continue to improve until they have met standards. It will be possible for the government to close hospitals that do not meet standards after a reasonable period of time. One of the major challenges for accreditation in China is to acquire and deploy the number of trained surveyors necessary to complete accreditation site visits to all hospitals. It has been estimated that, using Canadian accreditation teams as a model (three to four surveyors for three days per hospital) and assuming that surveyors would be asked to do five surveys per year, approximately 120,000 trained surveyors will be needed for a national accreditation programme in China (WHO 1993).

*Latin America and the Caribbean:* A move towards accreditation has recently begun in Latin America and the Caribbean. In September 1991, the Pan American Health Organisation and

the Latin American Federation of Hospitals released a set of hospital standards, the necessary pre-requisite to what is hoped will be a large scale accreditation programme. The Ministry of Health of Argentina and the Argentina Society of Medical Auditing prepared the original draft of the standards. The draft was subsequently expanded upon expert opinion from hospital associations in several countries, social security institutions, Ministries of Health and other interested groups. The Region of Latin America and the Caribbean has approximately 14,000 hospitals, the great majority with fewer than 70 beds. The standards themselves have two major dimensions: compulsory minimum standards and non-compulsory standards. Compulsory minimum standards are, in turn, grouped under five major headings: organisation of medical care, technical and support areas, building documentation, functional physical structure and installations. Non-compulsory standards include such things as critical care, neo-natology, nuclear medicine, etc. What is especially, interesting about these standards is that there are levels of standards to be achieved within each department or service. Thus, the lowest level of standards must be successfully achieved before reaching progressively higher levels and each progressive level becomes more demanding. In order to receive minimum accreditation status all standards at the first level must be met. The remaining levels of the standards are used to encourage the comprehensive development of the establishment. The public is only informed that the facility is accredited or not accredited. The level of achievement is for the information of the facility itself (WHO 1993).

Other countries that have an accreditation system and some that are in the process of setting up one are Spain, France, Pakistan, South Africa, Italy, Taiwan, Netherlands, and Israel among others. These countries are learning from the experiences of other countries. An overview of various country experiences with accreditation systems reveals certain common trends as well as contrasts in the manner in which accreditation as a concept has developed across the globe. A study of the pioneering systems highlight that in the late 1980s all of them began to consider ways of revising standards to make them more patients focused rather than professionally focused. In the 1990s, they have revised their standards to reflect the changing functions of hospitals, seeking to move away from departments towards patient experience of hospital systems. They have all moved towards trying to find standards, which would reflect the integration of hospital services rather than examining them in isolation. Finally, they have all begun to examine outcome measures instead of simple process standards for good practice. However, each country's experience is unique and should be viewed against the social, economic and political context of the health services within which it operates.

**DEVELOPMENT OF STANDARDS AND ACCREDITATION SYSTEM IN INDIA**

In India, the issue of accreditation of hospitals has not been taken up seriously. The Indian Hospital Association (IHA) at both Bombay and Delhi had made efforts to promote a voluntary accreditation system. The response to the scheme was lukewarm as it did not involve the various stakeholders in evolving the accreditation system and tried to impose pre- determined issues of standards, membership fees and assessment mechanism and so on.

The efforts in India have primarily been to evolve standards for hospitals and services provided for ensuring quality of care. The Bureau of Indian Standards (BIS) has laid down standards for hospitals having 30, 100 and 250 beds (BIS, 1988, 1984). The National Institute of Health and Family Welfare (NIFHFW) had laid down standards but mainly for more than 50 bedded hospitals and only for equipment (NIHFW 1992). Most of the standards laid down by BIS and NIHFW are meant for relatively larger hospitals located in major urban areas. In Maharashtra, the government hospitals have to follow the Hospital Administration Manual for the running of the hospitals. The Andhra Pradesh Vaidya Vidhana Parishad has laid down standards for secondary level hospital in the government sector, which comes under it. Presently under the World Bank funded project for four States in the country, for improvement of secondary referral hospitals, there is an initiative to develop protocols and standards for hospitals. These are meant for the government secondary hospitals.

There have been efforts undertaken by consumer bodies, groups of health professionals, hospital organisations, and non-governmental organisations for drawing up standards. In Pune, the health committee of the Lok-Vignyana Sanghatana took the initiative in preparing minimum standards for anaesthesia before surgery and came up with 'Routine Preoperative Investigations for Minor surgery in A.S.A. Grade 1 patients'. CEHAT, a non profit health research organisation in Mumbai as part of its project on physical standards in private hospitals, evolved standards for 30 bedded private hospitals and came up with a document "Proposed Minimum Standards for 30 bedded Private Hospitals and Nursing Homes".

In the present scenario, there is a demand for quality health care services. There have been many reasons for this. Firstly, consumers have been becoming increasingly aware of their rights vis-à-vis the health care system. Secondly, the middle class has increasingly been demanding better quality of health care. Thirdly, the costs of health care services have been

spiralling. Fourthly, implementing authorities have failed to enforce existing legislation for health care services. Fifthly, the health insurance sector has now been opened up to private participation. In this context, there is a need to examine the need for a self-regulation model.

One needs to evolve a partnership and provide a platform based on the principles of sharing and transparency with the primary aim of providing quality care to the patients. With this broad vision, we undertook the present study titled "Self-Regulation of Private Hospitals and Nursing Homes in Mumbai City: Need for an Accreditation System?".

## OBJECTIVES

The overall objectives of the study are to document and analyse existing regulations and their implementation concerning private hospitals and nursing homes in India. The study also attempts to assess the need, views and willingness of various stakeholders to participate in such a system. Finally, the study hopes to evolve a framework for an accreditation system for private hospitals and nursing homes in Mumbai.

SPECIFIC OBJECTIVES

1. To document the existing regulation and their implementation with specific reference to private hospitals and nursing homes in the country.
2. To study the accreditation system (or similar kind of work) in other states of India.
3. To document other country experiences about accreditation system.
4. To undertake a stakeholder analysis with regard to their perceived need for an accreditation system, views for designing the framework and ascertain their willingness to participate and examine the pro and cons of perceived higher cost due to an accreditation system.
5. To develop a framework with guidelines (functioning of the system) for the efficient and effective functioning of an accreditation system.
6. To disseminate the findings and advocate for the setting up of an accreditation system in the city of Mumbai.

## STRUCTURE OF THE REPORT

The present report is divided into seven chapters. The introduction gave an overview of the health care system in India, the functioning of the private health sector and its regulation. It further provided a broad understanding of the various dimensions of accreditation as well as

how systems function in various parts of the world. It also examined the attempts made in India to develop standards and an accreditation system as well as the rational and objectives of the present study.

The chapter on study design and methods provides a detailed account of the methodology of the study in terms of its location, design, the respondents, the process involved, the information elicited, the analysis of data, the problems encountered and the limitations of the study.

The findings of the stakeholders have been presented separately in each of the chapters namely: providers, consumers, government and insurance and financial companies. In each of the chapters, individual responses to questions about quality of care, regulations, the need for an accreditation system, the advantages and disadvantages of such a system for each of them and willingness to participate in such a system have been elicited and described.

The concluding chapter brings together the findings from each of the stakeholder analyses, examines them in terms of convergence and divergence of views and opinions and the reasons for the same. It examines the major issues thrown up the study.

The report culminates in a framework for an accreditation body based on the study findings.

## Study Design and Methods

The present study is unique in many respects. As far as we know, there are no other studies on accreditation in India. The concept of accreditation in the Indian context is gaining some attention nowadays. However, it continues to be an unexplored terrain of inquiry. This is an early effort to understand its many dimensions: an exploratory study. Given that it remains an unfamiliar concept for many, we were required to not only elicit information from the stakeholders who were covered, but to educate them as well. This proved to be a challenge for us as well as for those who were interviewed: it is not easy to air views on an abstract concept, especially when it has few parallels in the country.

In an attempt to achieve a holistic understanding of the situation in India, the study considers the viewpoints of a wide range of stakeholders; namely, owners of hospitals, specialists' associations, consumer associations, government, financial and insurance companies as

well as patients. The research design is eclectic, as we have employed methodologies from both the qualitative and quantitative realm.

LOCATION OF THE STUDY

The study is located in Mumbai, the city in western India previously known as Bombay. Mumbai is one of India's largest metropolises and an important commercial and industrial centre. In 1991, the city had a population of 9.92 million (RGI 1991). A well developed infrastructure and complement of health care services compared to other parts of the country, makes it a privileged place too. Health providers range from solo practitioners to super speciality tertiary hospitals.

Health schemes and services offered by a number of government agencies comprise the public health sector in the city. For instance, the central government runs dispensaries for its employees. Add to this, health care for employees of the organised sector under the Employees State Insurance Scheme. And then again, dispensaries and hospitals for employees of the government departments like ports, railways, defence, etc. Finally, six teaching hospitals (two of which are state-run), 16 peripheral hospitals, 26 maternity homes, 159 dispensaries and 176 health posts run by the Brihanmumbai Municipal Corporation (BMC) – the local authority body – for the public.

However, these services are outweighed by the size of the private sector. The database compiled at CEHAT records 1157 private hospitals or nursing homes, which are run by individuals, co-operatives, corporate bodies, religious bodies and charitable trusts. Apart from these larger institutions, the private sector also comprises solo practitioners, polyclinics, dispensaries, pathological and diagnostic laboratories, blood banks, etc. CEHAT – the organisation that conducted this study – has already done considerable work on the issue of quality of care and regulation of private hospitals and nursing homes in the city. The interaction between the organisation and major stakeholders is therefore a long-standing one. This is one of the main reasons why we conducted the present study in Mumbai.

THE STUDY

During the first phase of the study, we reviewed existing literature on the regulatory framework within which private hospitals functioned in India and how such systems were implemented. We also examined scientific papers, published guidelines, media reports to understand whether an accreditation system – or something resembling it – existed in India. We supported our initial search for literature in libraries with informal discussions with

bureaucrats and health researchers in some of the states. Our search for relevant literature led us to other countries too as we sought to document their experiences of accreditation. We did this by seeking information on Internet, ploughing through the catalogues of a number of libraries and by corresponding with people directly and indirectly involved in accreditation systems. Information thus gathered has been incorporated in the first chapter.

During the second phase (namely, August 1997 to June 1998), we collected information on four themes from each of the stakeholders. These were:
1. The perceived need for an accreditation system;
2. The broad framework of such a system;
3. Their willingness to participate in an accreditation body, if it were to be set up in the future;
4. The pros and cons of an accreditation system from their point of view.

The team drew on the experience and expertise of a select group of individuals. A committee of five consultants, in addition to a consultant assigned by the World Health Organisation, was appointed to guide the study and to examine the ethical issues emerging at every turn.

**The Tools**

A number of tools generated the data for this study. These included a mailed questionnaire, a semi-structured interview schedule, a structured interview schedule and two workshops. These tools were discussed with the team of consultants and their comments and suggestions were incorporated. Before finalising the tools, we conducted a pilot test of the semi-structured schedule with three hospitals.

THE RESPONDENTS: NUMBER AND PROCESS

The respondents were from among the different stakeholders in the health care services. There were providers of health care; namely, hospital owners/administrators and their associations, associations of specialists like surgeons, obstetricians and gynaecologists, anaesthetists, etc. There were consumers of health care; namely, actual users of indoor and ambulatory care as well as consumer organisations. There were elected and appointed government officials at the state and municipal levels. And finally, there were financial and insurance companies.

*Hospital Owners and Administrators*

Two tools were employed to elicit information from the owners and administrators of hospitals: a mailed questionnaire and a semi-structured interview schedule. The mailed questionnaire helped us to approach a large number of private hospitals with information about our study so that some exchange on various aspects of accreditation could be initiated. It also helped us to identify the enthusiasts who could be usefully involved at a later stage.

In an attempt to widen our scope of coverage, we decided to expand the area of data collection to private hospitals in the extended suburbs of Mumbai and in New Bombay. We also included government hospitals. Since the objective of the study was to elicit views on the accreditation body, we reduced information about the characteristics of the hospital (like staffing patterns, equipment, etc.) to a minimum and focused on the main issues instead.

As no comprehensive and updated directory of private hospitals in the city exists, one of the first tasks of the research team was to compile such a list from various sources. Most of the individual lists that we obtained were incomplete and suffered from many deficiencies. The team spent a substantial amount of time cross-checking the names and addresses of the hospitals in the lists with the telephone directory as well as other available directories, the yellow pages, etc. Put together in this way, we were able to create a database that we could use.

The other task that we accomplished before mailing the questionnaire was to sound out the different provider associations about our study. They were very supportive and willingly wrote out letters of endorsement, which we attached to the questionnaire. In this way, we were able to reach out to 1204 hospitals (of which 1157 were privately owned). Out of these 1157 hospitals, 492 were in the western suburbs, 300 in the eastern, 365 in the central, and 12 in the extended suburbs. In the end, 94 private hospitals replied; our efforts yielded a response rate of 8 per cent.

After our mailed questionnaire was filled and returned to us, we selected 19 hospitals from among those that did not respond or who were added to our list only later and interviewed their administrators or owners with a semi-structured interview schedule. We tried to achieve as broad – and as true – a cross section of hospitals in terms of size and ownership in different geographical zones as possible. To a large extent, however, our choices were governed by the willingness of the hospitals to participate in the study.

The semi-structured interview schedule was necessary for a number of reasons. Firstly, as this is an exploratory study, we had few pre-conceived ideas on the subject. Moreover, what

we were asking respondents to do was to visualise an accreditation body with its many facets. So, we had to allow as much space for the responses as possible without being fettered by too rigid a research tool. Finally, we wished to go beyond the literal and understand the real reasons and motives that informed people's responses. Interviews with the owners and administrators of hospitals were expected to provide information about their need, willingness and views on the accreditation body. In fact, we believed that in-depth interaction with these stakeholders would be important for the study. By adding these 19 hospitals to the 94 respondents to our mailed questionnaire, we achieved a sample size of 113 private hospitals. Out of these, 26 were in the eastern suburbs, 46 in the western, 38 in the central and 3 in the extended suburbs.

*Associations*

As in the case of hospital owners and administrators, the various medical associations were sent mailed questionnaires before being interviewed. The absence of a comprehensive list meant that the team had to first compile one in this case too. This was done through personal contacts, by making inquiries with doctors from a number of specialities and by contacting the association of medical consultants.

We mailed the questionnaire to the office bearers of 12 associations and planned to interview them only later as this would give them time to discuss it with other members. However, there was no response to the mailed questionnaire; so the team conducted in-depth interviews with eight associations. These were associations of nursing home owners, medical consultants, obstetricians and gynaecologists, anaesthetists, general surgeons, cardiologists, ophthalmologists and nurses. We chose those specialities that were practised and based mostly in hospitals.

*Consumer Organisations*

Three organisations were involved with health issues in Mumbai. The team approached two of these organisations and interviewed their office bearers with the semi-structured schedule.

*Patients*

To elicit the views of patients, we interviewed them while they sought care in the outpatients' clinic or during hospitalisation. We selected these patients from each of six hospitals, which in turn were selected from the 19 hospitals whose owners/administrators agreed to participate in the study. We interviewed patients after we had successfully interviewed the

owners or administrators of these hospitals. This is because we had to get their permission first.

As before, four variables guided our selection of the hospitals in which we conducted patient interviews; size (bed strength), ownership pattern, number and type of services provided and geographical location. Our choices were also crucially determined by the administrators' or owners' decision to permit the interviews. Totally, we interviewed 100 patients; 70 of these were indoor patients and 30 were outdoor patients.

We formulated two separate interview schedules for indoor and outdoor patients. The differences between them were minor and related chiefly to information about the reasons for their present and earlier visits. Through our interviews, we sought to understand how patients made decisions about which health care provider to go to and how they chose to come to the hospital they were in. What information did they use in their decision making? And ideally, what information would they have liked to have? We also documented their views on the usefulness of a "rating system" for hospitals.

We selected patients randomly while ensuring that a representative sample across all the wards was achieved. We conducted the interviews on days and at times that were convenient for the hospital staff as well as the patients. In case the patient was a child or someone unable to answer, we interviewed the person accompanying him or her.

*Government*

We interviewed government functionaries in the state government and municipal level with a semi-structured interview schedule. The officials at the state government level were the Deputy Director and Director of the Directorate of Health Services, also the Deputy Health Secretary. The officials at the municipal level were the Chairperson of the BMC Public Health Committee, the Executive Health Officer and the Deputy Executive Health Officer. Altogether six government functionaries were interviewed.

*Insurance Companies*

At present, insurance companies in India are state owned. The General Insurance Corporation oversees the insurance business, including health. The General Insurance Corporation has four subsidiaries, namely, New India Assurance, Life Insurance, Oriental Insurance and United India Insurance. We interviewed concerned officials with the help of a semi-structured interview schedule in two of these subsidiary insurance companies.

*Financial Institutions*

The team had to collect information about which financial institutions offered loans or financial assistance to the owners of private hospitals or to medical professionals. After compiling a list of such institutions, both government and private, we chose two – one multi-national bank and the other, an government agency – and interviewed officials there.

*Workshops*

We held workshops instead of focus group discussions. The purpose of these workshops was to bring together various stakeholders in the health care services. We held two workshops: the first during the process of data collection and the other after it was completed. The participants included representatives of hospital owners, consumer organisations, government, specialist associations, insurance companies, financial institutions and individuals concerned with the accreditation issue.

The first workshop was held in Mumbai on 8 February 1998, during the data collection phase. The objective was to discuss the issue of accreditation of hospitals. Is such a system needed in the city? How essential is it? The workshop provided an opportunity and a platform for the stakeholders participating in the study to interact with each other. The discussions were in small groups, which were followed by a panel discussion.

The second workshop was held after the data collection was completed on 25 to 26 July 1998 in Mumbai. The workshop invited not only those who participated in the study but also other individuals and organisations interested in the issue. They came from Bombay and from other regions of the country. The objective of this workshop was to discuss the preliminary findings of the present study with a larger audience as also the idea of accreditation system and its future prospects not only Mumbai but in other parts of India too. The discussions and viewpoints expressed in these workshops have been incorporated in the report. Another outcome was the creation of the Forum for HealthCare Standards.

Information Elicited

As stated before, we outlined four questions, which we put to each of the stakeholders. Firstly, the perceived need for an accreditation system. Secondly, the broad framework and guidelines of such a system. Thirdly, the willingness of concerned parties to participate as well as the terms and conditions and levels of participation. And finally, the advantages and disadvantages of such a system from the perspective of each of the groups of stakeholders.

We sought information on the profile of the institutions or individuals, their rationale, need, reasons and opinions about an accreditation body. We also asked for information on existing regulations, problems and difficulties that they faced, and about their relationship with other stakeholders. Concerning the framework of the accreditation system, we asked for information on the initiative, structure, constitution, role, functioning, management, autonomy of such a system as also what it should monitor, assess and grade. What standards would be applied? And how could consumers seek redress? The interview schedules for each of the groups of stakeholders were different in view of their positioning in the health care services.

Analysis of Data

The information generated during data collection was both qualitative and quantitative. The quantitative data was coded and tables were generated for analysis. The qualitative data, on the other hand, was categorised after lists of individual responses were compiled. The qualitative data in the semi-structured interview schedules was more in the nature of in-depth information on the broad areas that were already defined. Detailed minutes of the proceedings of the workshops as recorded by rapporteurs constituted the other source of qualitative data. This data was analysed too and the perceptions, positions, opinions, stands and decisions of the stakeholders were incorporated in the findings.

PROBLEMS ENCOUNTERED AND LIMITATIONS OF THE STUDY

The first problem stemmed from the fact that accreditation is a new concept and a difficult one to grasp. It took the stakeholders a long time before they could understand what it meant. Often, the study was mistaken as "market research" for the promotion of such a system. Some stakeholders were apprehensive about our motives and perceived the interview as a "surprise check" by government regulatory authorities.

Another problem was the limited availability of time. Compiling lists of each of the groups of stakeholders was extremely time-consuming and could have been a project in itself. Too few respondents in some of the groups of stakeholders (as for instance, just two consumer organisations) also posed problems in analysis and presentation of qualitative findings. During the course of the study, we also discovered that it was quite impractical to get together stakeholders and hold focus group discussions with them. This led us to conduct workshops instead.

One of the major limitations of this study is that it does not cover solo general practitioners, specialists and consultants. Although it would be necessary to study them in future, as they form the major link between patients and hospitals, it was unfeasible to include them at this point. Further, some of the stakeholders could not be interviewed. An association of hospital owners, one of laboratory technicians, another of x-ray technicians, a consumer organisation, as well as one elected representative from the BMC and officials at the level of the central government were left out. One hospital owners' association did not respond despite repeated requests by the team. One consumer organisation was not interviewed because its President was also a consultant on the project. Officials from the central government were contacted but they informed us that accreditation of hospitals is not presently on their agenda. We could not meet other concerned officials in the central ministry, as they were busy with the budget session in the parliament during our visit to the capital.

The main reason why we could not cover some of the stakeholders was because they were not willing to give time for the interviews. The same holds true of hospitals too. We had intended to interview the administrators or owners of 25 hospitals. Actually, we succeeded in covering only 19 of these.

**Providers**

Providers of health care from individual practitioners to institutions like hospitals constitute one of the major stakeholders of the accreditation system. Hospitals provide indoor and ambulatory care. Since they comprise an important sub-sect of the group of providers, it is imperative that they be involved in any process of quality improvement and standardisation of care.

Given their diversity, providers have their own associations to represent and safeguard their specific interests. These associations can be divided into three major categories; namely, those representing institutions like hospitals, nursing homes, laboratories, diagnostic clinics, and the like; those representing specific group of professionals like doctors, nurses, technicians, among others; and those representing medical specialities like general surgery, paediatrics, cardiology, ophthalmology, anaesthesia and so on. Apart from this, there are associations for each of the systems of medicine like homeopathy, allopathy and those grouped under the title "Indian Systems of Medicine." Moreover, associations have a regional basis and Mumbai has its fair share of representation.

Membership to these associations is voluntary. In fact, providers could have multiple memberships given their specific affiliations. These associations have been quite active and vocal in the past. They have been able to air their views and press their demands on issues that have concerned them at different levels. Therefore, they cannot be ignored in an accreditation system. In the present study, providers mainly refer to hospitals and the associations representing the interests of the medical establishment. Findings about each of them are presented in two separate sections.

## HOSPITALS

As mentioned earlier, we mailed a questionnaire to 1204 hospitals, of which 1157 were privately owned. Ninety four private hospitals replied and another 19 agreed to semi-structured interviews. The views of these 113 hospitals are presented below.

### Profile

Mumbai is divided into 16 wards for administrative purposes. We have classified these wards into three regions; namely western, central and eastern regions. Table 3.1 provides an overview of the hospitals in our sample. Some 41 per cent (or 46 hospitals) were located in the western suburbs, 34 per cent (or 38) in the central suburbs, 23 per cent (or 26) in the eastern suburbs and three hospitals in the extended suburbs. As many as 61 out of 113 hospitals – that is, more than half the sample – were established after 1981. As suburbs grew, so did private hospitals spring up in newly developed areas. Thus, around 80 per cent of the post-1981 hospitals in our sample were in the suburbs: 19 in the eastern suburbs and 30 in the western suburbs. The growth of private hospitals in the post-1981 period is corroborated by findings of another study conducted in an average district of India (Nandraj and Duggal 1996).

Out of the 113 hospitals in our sample, 87 had fewer than 25 beds while only 23 hospitals had more than 25 beds. Three hospitals did not provide this information. Most of the hospitals with more than 25 beds were in the suburbs. The average (that is, the mean) bed size of hospitals in the sample was around 20. In terms of their ownership, 65 hospitals were individual proprietorships, 26 were partnerships, 16 were trust hospitals and one was a corporate hospital.

Individual proprietorships and partnership-based hospitals were essentially small: 56 of the former and 15 of the latter had less than 25 beds. On the other hand, the trust hospitals were larger institutions. This is an interesting feature of the big hospitals in Mumbai. Many of them are registered as charitable trust to avail of concessions provided by the government for land, electricity, customs duty waiver, etc. while continuing to function as any profit-making corporate hospital.

Individually owned and partnership based hospitals are also essentially run as business ventures. Doctors are usually the owners of these institutions. This becomes clear when we examine the qualifications of main owner: allopathic doctors with post-graduate degrees ran as many as 72 out of 91 such hospitals. When doctors with graduate degrees are added to this group, we find that doctors, either individually or in partnerships, ran most of the hospitals in our sample. This is quite prevalent in the Indian context as private hospitals offer certain kinds of care that is determined by the doctor owner's post-graduate training.

Only five hospitals were providing specialised health schemes in collaboration with private companies. In all, 21 hospitals had their own health schemes. Most of the bigger hospitals with more than 25 beds were the ones having their own health schemes or collaborating with private companies. A few smaller hospitals were also involved.

In the total sample, 86 hospitals were admitting only patients admitted by the doctor owner. As regards to the type of services 78 hospitals were providing more than one service. This is an important area to be noted as the doctor owner's function independently in many respects as there is no monitoring of them.

As most hospitals in the private health sector tend to have fewer than 25 beds, any system that aims to improve the quality of health care would have to take into account this segment. As mentioned earlier, other studies have highlighted the dismal quality of care provided by smaller hospitals. Two important related issues emerge with regard to accreditation. Is compliance to minimum standards a viable proposition for smaller hospitals? And how viable would it be for owners to run smaller hospitals when compliance to minimum standards becomes an essential pre-requisite for better patient care? These issues need to be examined in depth.

**Table 3.1: Profile of the Hospitals**

| Area | Total |
|---|---|
| Eastern suburbs | 26 |
| Western suburbs | 46 |
| Central suburbs | 38 |
| Extended suburbs | 3 |
| **Year of establishment** | |
| Prior to 1950 | 9 |
| 1951- 1970 | 19 |
| 1971-1980 | 18 |
| 1981-1990 | 14 |
| After 1991 | 47 |
| No response | 6 |
| **Beds** | |
| Less than 10 | 46 |
| 11 to 25 | 41 |
| 26 to 50 | 8 |
| More than 50 | 15 |
| No response | 3 |
| **Ownership** | |
| Individual proprietorship. | 65 |
| Partnership | 26 |
| Trust | 16 |
| Corporate | 1 |
| Any other | 5 |
| **Qualification of main owner** | |
| Graduate allopathic | 13 |
| Post graduate allopathic | 72 |
| Any other | 3 |
| Administrator | 11 |
| No response | 14 |
| **Health scheme** | |
| Collaboration with Pvt. Companies | 5 |
| Having own schemes | 21 |
| No health schemes | 87 |
| **Admission of patients** | |
| Admitting only self patients | 86 |
| Open to other doctors who are attached/not attached | 18 |
| No response | 9 |
| **Services provided** | |
| Multiple services | 78 |
| OB/Gyn, Maternity | 21 |
| Any other (eye, ENT, orthopaedic, paediatric, etc.) | 14 |

Figures are actual, N=113

AWARENESS OF EXISTING REGULATIONS

In India, many states do not have any regulations or legislation under which private hospitals are governed. Mumbai is one of the few places that have long-standing legislation. The Bombay Nursing Home Registration Act, which was passed in 1949, is concerned with the registration of private hospitals but its implementation needs to be vastly improved. Hospitals additionally come under the purview of other legislation such as the CPA, Shops and Establishment Act, Minimum Wages Act and, for charitable hospitals, the Public Trusts Act.

Most of the hospital owners and administrators were aware of Bombay Nursing Home Registration Act. They felt that regulations were useful as long as they were directed towards proper care without creating unnecessary paper work. Many owners and administrators felt that rules and regulations were a hindrance, as they remained largely unimplemented while breeding corruption. They complained that dealing with rampant corruption in the health department consumed a lot of their energy and time. They also stated that the attitude of municipal officials actually hindered their day-to-day functioning. Most felt that laws have no influence in our country, as there was "no control and punishments are slow to come". They called for the re-examination of many regulations in view of the ground realities and changes taking place in the present environment.

## NEED FOR AN ACCREDITATION BODY

The owners and administrators of 96 out of 113 hospitals stated the need for an accreditation body. They called the establishment of such a body a "good idea." It would do "no harm", they said, and would be "ideal." They stressed the need for uniformity in basic standards and called for upgrading the quality of health care. Six of the hospitals, which did not feel the need for an accreditation system were small with less than 10 beds. They were all individual proprietorships; four of the owners in fact had no more than the MBBS degree. One of them was against the idea, as he felt that several considerations like location of the hospital, the class of patients, charges, and so on need to be kept in mind. Several feared that favouritism and petty politics might creep into the body. Some expressed doubts about the functioning, effectiveness and financing of the accreditation body.

Those who responded positively to the idea of an accreditation body mentioned various benefits. Most of them were of the opinion that it would help improve standards and institute continuous quality assurance. Half of them felt it would be a useful marketing tool. It would regulate competition and create a level playing field among the hospitals. Most of those looked upon accreditation as a marketing tool and the regulator of competition were individually owned and partnership-based hospitals and were run by postgraduate doctors.

Clearly, those with higher qualifications perceive that accreditation would greatly benefit them in the face of increasing competition among private hospitals in the city. (Table 3.2)

TABLE 3.2: BENEFITS OF ACCREDITATION BODY

| Benefits | Yes |
|---|---|
| It would help improve standards | 95 |
| Aid in continuous quality assurance | 94 |
| Help compare performance with other hospitals | 66 |
| Would be a useful marketing tool | 48 |
| Regulate/manage competition between hospitals | 41 |
| Create a level playing field among hospitals | 40 |

Figures are actual, N=113

Owners and administrators strongly believed that the body would be very useful if it has a balanced, holistic and realistic attitude, if it is based on ground realities and if it has the power, will and courage to disqualify sub-standard hospitals and publicise such information in the media. Another strong view was that irrespective of whether the assessment is done internally or through an external team, it should be objective and the patients' point of view should be given utmost priority.

## VIEWS ON THE ACCREDITATION BODY

In this section, we present the views of hospital owners and administrators about the accreditation body. We have included the views of even those who did not feel the need for such a body, if they had something to say on the subject.

*Initiative and constitution:* Most of the owners felt that they should be involved in such a body, as they primarily are the 'involved party'. (Table 3.3) According to them, they are a group "most motivated to make result-oriented efforts as they know the practical realities, the problems faced and the plausible solutions in the existing context." Moreover, they felt that they could justify and define the limits of their involvement. Also, involving them would ensure internal control and monitoring and help maintain the "balance of the system". One of them stated that nobody could force the owners or administrators of hospitals to improve their institutions. They would have to realise it for themselves. Around 10 of them did not want hospital owners and administrators to be involved. They may take a biased view of the situation, they said. Also, favouritism may creep in. The patients' viewpoint may not be taken into account and professional rivalry may come in. Not only that, they may frame rules to suit them. Moreover, the hospital owner may not be from the medical field. Interestingly, this view was expressed by the individual proprietorships.

**Table 3.3: Initiative & involvement by stakeholders**

| Stakeholders | Yes |
| --- | --- |
| Hospital owners | 79 |
| Specialist associations | 75 |
| Consumer organisations | 43 |
| Government | 29 |
| Insurance companies | 37 |
| Private corporate bodies | 25 |

Figures are actual N=113

The owners and administrators offered similar reasons for the involvement of specialists' associations. In addition, they felt that associations could work out guidelines to set standards, upgrade and maintain the accreditation system since their members have the experience and qualifications that would let them assess things with the right perspective. Moreover, as they are aware of minimum requirements and the limitations of standards they can formulate enforceable systems. Perhaps we encountered these views because most of the hospital owners (who had post-graduate degrees) were also members of the specialists' associations.

Around 43 owners and administrators favoured the involvement of consumer organisations and patients since they are the "clients" using the nursing home services. They believed that their involvement would allow their opinions to be heard and these would be taken into account. This is essential, they felt, as patients and consumer organisations would be motivated to make result-oriented effort. Another view expressed by several of the owners and administrators was that it would help patients become aware of the limitations of any service and could avoid a lot of litigation. Moreover, they felt that patients would be able to choose "where to go" as they would have a fair idea about the standards and quality of care in each of the nursing homes. One owner believed that while consumer organisations should be involved, they "should not be allowed to interfere in technical management." On the other hand, the owners and administrators who did not favour the involvement of patients and consumer organisations said that they have idealistic expectations, which could escalate costs and thus become self-defeating. They went so far as to say that their involvement would be dangerous as they do not fully know or understand the complexities of medicine. Another view expressed was that consumers were biased. So, involving them would undermine the doctor-patient relationship. Some were convinced that consumers were always against the medical professional.

Overall, the owners and administrators were against government involvement in the accreditation body; only 29 were in favour of involving them. On the other hand, the 29

owners who favoured government involvement felt that it was actually merited in view of the fact that it was the registering authority. They should be involved in ensuring that standards in hospitals are maintained. Also, involving them would provide a statutory base to the accreditation body. However, few others were of the view that inspite of the government being the ultimate authority; their role should be advisory.

Most of them were representing smaller individual proprietorship hospitals with fewer than 25 beds. They feared that involving the government would inevitably lead to corruption. Some felt that the government was out of touch with the practical economics of medical care in nursing homes. Another view was that "government officials are lethargic, bureaucratic, not up-to-date and always have a negative outlook." Moreover, red tape and unnecessary paper work would come in, which could deter the proper functioning and improvement of the hospital.

One view that was strongly expressed was that insurance companies should not be involved as they are likely to create obstacles, think only in terms of business and look after their own interests. They should also not be involved, as they would not offer their schemes and services to all hospitals. Moreover, they felt that insurance companies are of no help during times of emergency: "They only collect premiums and dilly-dally when it comes to settling accounts." Some feared that these companies would start dictating terms and that corruption and favouritism would creep in. Another view was that they should not be involved since "they do not know the difference between practical and ideal aspects." Around 37 hospitals wanted the insurance companies to be involved. They pointed out that the insurance companies would assist in the provision of insurance-based health care. They emphasised that the companies should be 'reputed and non-corrupt.' They would cover costs for patient treatment in the form of reimbursements and by settling claims. Moreover, it was felt that as money is required for improving any system, insurance companies should be involved. The concept of group insurance would help the middle class. Most importantly, involving the insurance companies would help one to obtain a fair opinion about standards being maintained in hospitals.

*Role:* More than three-fourths of the hospital owners and administrators wanted the accreditation body to assess hospitals for compliance of standards, assist them in upgrading the standards, have continuous quality assurance and play an educative and informative role. Only 31 hospitals wanted the accreditation body to take punitive action. (Table 3.4)

**Table 3.4: Role of the accreditation body**

| Role | Yes |
|---|---|
| Assess hospitals for compliance of standards | 93 |
| Assist hospitals in upgrading standards | 90 |
| Assist hospitals in continuous quality assurance | 87 |
| Play an educative & informative role | 84 |
| Serve as a forum for consumer redressal | 42 |
| Take punitive action against hospitals | 31 |

Figures are actual N=113

As to what the accreditation body should monitor, most of them wanted it to monitor standards related to the physical aspects, equipment, personnel employed, type of treatment provided and follow-up of care. Some 50 per cent (or 57 hospitals) wanted the accreditation body to monitor all hospitals and beds in a given geographical area. Only 44 hospitals wanted fees and hospital charges to be monitored. The rest were against the idea. Three-fourths of the hospitals were in favour of monitoring consumer satisfaction. (Table 3.5)

**Table 3.5: Accreditation body should monitor**

| Aspects | Yes |
|---|---|
| Physical aspects (space, operation theatre, wards, etc.) | 101 |
| Equipment | 99 |
| Qualification & number of personnel employed/attached | 91 |
| Type of treatment | 75 |
| Follow up of care provided | 75 |
| Number of hospitals in an geographical area | 57 |
| Number of beds in an geographical area | 57 |
| Professional fees charged | 44 |
| Various hospital charges | 49 |
| Consumer satisfaction | 84 |

Figures are actual, N=113

In response to whether the accreditation body should be limited to Mumbai or whether it should be implemented in other districts and states, there was a consensus that accreditation system should be implemented universally. There were many who believed that such a system should first be introduced in Mumbai. After seeing how it functions here for a period, it could be implemented in other areas of the country. The owners and administrators felt that the body should take into consideration the ground realities of each place keeping in mind its geographical location and other aspects. A vast majority – or 102 hospitals – believed that the accreditation system should cover government hospitals. They felt that this would ensure a certain quality of service to the people. Moreover, as government hospitals have minimum facilities, they should be used judiciously and should, therefore, be accredited. Another view was that as these hospitals are run by public money, they should be made accountable. Those opposing accreditation in government institutions

felt that they already adhere to certain norms; accrediting them would only lead to duplication.

Out of 113 hospitals, only 45 wanted patient redressal to be incorporated. Those who wanted the incorporation of patient redressal felt that only when people participate would the system acquire true relevance. Moreover, it would be convenient to approach the same organisation for grievance redressal. To make this possible, power should be given to the body to assist in litigation, offer compensation and punish the guilty. They felt that if steps were already set out then institutions would have to go through – and incorporate – them. They also believed that primary patient redressal should be done by the body, as it would help improve the doctor-patient relationship. Furthermore, this would help solve problems at the root.

Another view was that such involvement should only be encouraged if it is genuine in nature and in very specific circumstances. One of them stated that "patient redressal could be incorporated, provided one also involves the insurance companies vis-à-vis the issue of professional indemnity insurance." The hospitals that did not want patient redressal to be incorporated mentioned that the focus of the accreditation body should be on maintaining standards in the hospitals. They believed that patient redressal contained an inherent risk of the entire process getting politicised. Some believed that patient redressal procedures cannot be generalised to all hospitals. Another view was that as redressal through the Consumer Protection Act, the Indian Medical Council and the judiciary already exists, new procedures should not be added. Moreover, it was felt that accrediting hospital would in itself be a big task.

*Functioning:* Concerning the autonomous role of the system, 75 hospitals wanted the accreditation body to be independent of any authority. Only 21 hospitals favoured legislative support. Legislation would lend support to the body and make it more effective it was felt. Moreover, it would also increase its creditability and would enable it to take punitive action. In terms of functioning of the body, 92 hospitals wanted it to be a non-profit organisation.

*Standards:* Of the 113 hospitals, 97 were in the favour of laying down standards while 12 were not. Those who were in favour of laying down standards commented that it would serve as useful guidelines for better medical care apart from providing protection from lawsuits. It would also help improve patient care by laying stress on the physical conditions of the hospitals. Few hospitals pointed out that "small hospitals are not fit even for minor surgery – their standards of hygiene, equipment availability is poor." One of them commented that "it would help differentiate between average, good, excellent hospitals. Patients would come with full knowledge of the type of hospitals and will understand the relative fee structure of

the hospital. They would have the privilege to choose between excellence and cost." It was strongly felt that standards should be set in view of the existing ground realities and practical situation governing private hospitals. These include the cost of equipment, availability of qualified staff, the position and location of hospitals. Moreover, it was felt that standards would help prevent complications and justify fees and service charges. It would lead to optimum utilisation of existing resources. Non-medical quacks can be prevented from running hospitals. It would help reduce non-healthy competition among various providers and help maintain uniformity.

Those opposing the introduction of standards were mostly smaller hospitals run by individual proprietorships. They believed that standards would depend on individual skill and could not be standardised. Another reason given was that standards would increase the costs of treatment, which would adversely affect people from the lower economic strata. One of them commented, "In private practice, there is a direct contract between patients and doctor. The patient comes to the doctor due to various reasons such as experience of the doctor, choice of place, location, behaviour of staff etc. How can this be standardised?"

*Grading and Assessment:* Out of 113 hospitals, 79 favoured a grading system while 34 did not. Those who wanted grading believed that patients would know what to expect from a hospital. A certain basic minimum requirement for care would be ensured to the patient. The hospital would gain, as a competitive element would help them to keep up the standard and would improve their image. At the same time, it would lead to provision of better care to the patient, as they would be accountable to people. Grading would also provide a good service incentive.

Some owners and administrators offered insights on how grading could be done. The basis of gradation was extremely important they felt. Hospitals should be graded on their facilities such as primary, secondary, tertiary and specialist care. Or they could be graded on their comforts and luxuries. Out of the hospitals that favoured grading, 62 per cent (or 49) wanted it to be a rating scale based on various criteria such as size of hospital and services provided.

The hospitals that did not favour grading were mainly those with fewer than 25 beds and owned by individual doctors. They believed that grades give a connotation of a hotel. The building, equipment, instruments cannot in itself guarantee care of patients. Physical structures could be graded but one cannot grade an individual's expertise. Moreover, grading would lead to outside interference. They asked, "what if the hospital is graded 'A' and the competence of the doctor is 'C'?" Some felt that to implement such a system would be difficult, as Mumbai is a vast city where the nature and quality of practice would vary from area to area. In addition, the

socio-economic conditions, literacy rates, and so on differ within short distances. They mentioned that gradation would provide an opportunity for the government to levy more taxes.

The owners and administrators were quite open to assessment of their hospitals' standards against set standards. A majority – that is, 62 hospitals – wanted it to be done by a self-evaluation followed by external assessment. Around 24 hospitals favoured assessment by an external team only. Three wanted it to be done only through self-assessment and two wanted it done by specialist associations. The rest did not respond. Most of the hospitals were willing to have external evaluation of their hospital. More than 66 per cent (or 75 hospitals) felt that accreditation should provide recognition to those meeting standards and assist hospitals in upgrading them.

In terms of periodicity of assessment, 35 hospitals wanted it every year, 34 hospitals every two years, and 29 hospitals every three years. The rest wanted it every four years. Moreover, fewer than half the hospital owners and administrators wanted the assessment findings to be disclosed to the consumers and public (Table 3.6). Only two hospitals wanted the findings to be disclosed to any legal body.

**Table 3.6: Assessment findings disclosure**

| Stakeholders | Yes |
|---|---|
| Participating hospitals | 77 |
| Consumers & public | 49 |
| Insurance & financial  companies | 31 |
| Legal bodies | 2 |

Figures are actual, N=113

Almost all the hospitals believed that reconsideration of assessment findings should be allowed. They offered various reasons in support of their claim. They felt that the purpose of accreditation was to improve the hospital and to have good standards. Therefore, reconsideration of assessment findings would reward those hospitals that improve their standards and provide accreditation. Another view was that appeals must always be allowed as a subjective element may be involved. Moreover, if hospitals object to the findings, then they must be heard and reassessment must be done, as one must always be given a chance for improvement. They should be allowed to put forth their position or problems that may or may not get solved. Furthermore, making any kind of improvement is an on-going process. Standards tend to vary and each institution may be improving or deteriorating, so the assessment made about that particular institution could not be permanent. Few of the hospitals felt that such reconsideration should not be allowed as it might lead to malpractice.

**Advantages and Disadvantages to Stakeholders**

In terms of its advantages to hospitals, the owners and administrators mentioned many. It would help the hospitals in a continuous process of quality assurance. They would become

aware of their shortcomings and in turn, make relevant changes to redress the situation. Moreover, there would be a "weeding out of bad hospitals" and "doctors would be on their toes to provide good treatment." Furthermore, this system could also become a useful marketing tool. It would also provide some form of legal protection for the hospital owners. It would become easy for the management to help their staff to achieve optimum level, as they would then know what is expected from them.

In terms of disadvantages, the owners and administrators mentioned the possibility of standards becoming impractical and too high. Subsequently, the costs incurred by the hospitals to meet these standards would escalate. Corruption and unhealthy competition could also possibly set in due to vindictiveness as "big fish would swallow small fish." Also, the information could be misused: destructive criticism and the risk of being downgraded in the eyes of the patient would have a negative implication in the provision of health care by hospitals. Doubts were expressed that the accrediting body may only become a faultfinding organisation.

On the other hand, they could envision many advantages of an accreditation body for patients. They would be assured of better service and quality of care they said. They would be aware of the facilities available in a hospital. They would be confident of the health care facility, as information regarding the cost of treatment, services available, qualification of staff and hygiene would be easily available. This in turn would result in a more trusting doctor-patient relationship. The only disadvantage that they could perceive for patients was in terms of rising costs of treatment that would cut further into their already scarce budget.

According to the owners and administrators, the advantages for specialist associations were that they could provide relevant inputs pertaining to various aspects of health care provision. This in turn would improve the performance of hospitals, as they would be provided with an environment that would ensure quality provision of health care. Moreover, there would be uniformity in the quality of care provided in the hospitals. The owners and administrators could not foresee major disadvantages for the specialist association.

In terms of advantages for the government, the owners and administrators felt that part of their burden to provide efficient and effective health care to the consumers would be considerably offloaded. Secondly, they would be able to objectively lay down rules and regulations for different categories of hospitals keeping in mind the existing ground realities. Thirdly, the accreditation body would also provide the government with a database that would help them control quality in an organised fashion. On the other hand, the government could also misuse the body for politically driven motives and create hindrances for the hospitals in the provision of health care.

The owners and administrators believed that an accreditation body would be advantageous to the insurance companies as it would help them upgrade their outdated policies and provide a package of insurance with minimum premium. It would reduce their burden of formalities to be completed, as they would have access to readymade medical records and

other details of the hospital. They would have a common guideline to base their judgement and claims. This would help in easier disposal of patient claims. Also, they would have the liberty to send their patients to accredited hospitals. Lastly, the body would help improve their relationship with the hospitals they collaborate with and financial companies who would be able to make informed decisions on certain criteria. This would ensure a greater guarantee for recovery of loan. The only disadvantage visualised for hospitals in relation to insurance and financial companies was that their conduct would come under scrutiny.

In terms of advantages for the judiciary, the owners and administrators felt that they would have some common guidelines to base their judgements. They would also be more objective in deciding about negligence which would reduce the burden of medico legal cases. It would result in a better communication between the doctor, judiciary and the patient. Apart from a possible increase in workload, the owners and administrators did not foresee any disadvantage for the judiciary.

<center>WILLINGNESS TO PARTICIPATE</center>

As many as 97 out of 113 hospitals in the sample were willing to participate in an accreditation body for hospitals. Those agreeing to be part of this system called it "good work for a good cause." Some were willing to participate on certain conditions. They would participate if it was a voluntary body; if the specialists' body were part of it; if it were financed by the Municipal Corporation or government and if it did not prove to be a "headache" for hospital owners and administrators. Many wanted more details before joining the accreditation body.

## ASSOCIATIONS

We interviewed eight associations with semi-structured schedules. Five of these associations covered specialists like obstetricians and gynaecologists, cardiologists, surgeons, anaesthetists and ophthalmologists. Associations of consultants, nurses and the owners of nursing homes were others.

Many doctors have multiple memberships. For instance, a surgeon who owns a hospital could be a member of the hospital owners' association, the surgeons' association and consultants' association. Multiple memberships enable certain categories of doctors to widen their spheres of influence. At the same time, not all members of the specialists' or medical consultants' associations are owners of hospitals and nursing homes. In many respects, they have views independent of the hospital/nursing home owners.

We explored the viability of establishing an accreditation body in the light of practicalities governing the functioning of private hospitals. The problems that private hospitals face while

obtaining adequate space, qualified humanpower and equipment as well as their equation with the government are some of the factors that affect their functioning. We asked for opinions about the institution of standards and the grading of hospitals: were they relevant? How apt were existing regulations? Were office bearers of the associations aware of them? Above all, we also asked the office bearers about the role, functioning and implications of an accreditation body for the various stakeholders.

*QUALITY OF CARE AND AWARENESS OF EXISTING REGULATIONS*

The office bearers of the hospital owners' and the consultants' associations outlined some problems that have confronted private hospitals. Acquiring space was a major hurdle given the absurdly high prices of real estate in Mumbai. The levying of commercial rates for space, water and electricity also made day-to-day running of hospitals in Mumbai an expensive business. So, the owners of hospitals and nursing homes felt that "though there are regulations for space, these need to be specially modified for metropolitan cities." Space is a severe constraint and doctor owners are often compelled "to squeeze as many patients in as possible."

Another problem that they identified was the "lack of purely trained staff, especially nurses." They disagreed that money was the only factor motivating the appointment of staff. They said, "though the owners would like to appoint qualified staff, they are not available." The owners of small hospitals felt that the nurses' expectation of high pay was a problem. The nurses' association did not share this view however. They stated that private hospitals were paying less than government hospitals. Due to this, many qualified nurses did not join private hospitals. They also complained that the nurses, ward boys and technicians were overworked in private hospitals due to shortage of qualified humanpower.

The associations shared the opinion that hospitals were ill-provided with proper equipment. The greater problem was lack of knowledge about how the available equipment could be utilised optimally. They also felt that quality of care itself was compromised due to inadequate equipment in hospitals and/or their maintenance. One of the specialists' associations was of the view that one of the main constraint vis-à-vis equipment was monetary.

The wider issue of the doctor-patient relationship and more specifically, the issue of information sharing between the doctor and the patient were mentioned. The office bearers felt that "patient education was not proper. Doctors mainly see themselves as advisors to the patient and the faith between doctor and patient has been eroded in recent times." The specialists' associations cited malpractice as one of the causes for this trend.

Another issue identified was the "cost effectiveness of treatment." They considered this to be important as most patients come from the middle class and are unable to afford escalating costs of medical care.

Most associations were aware of existing legislation and regulation of private hospitals. Some felt that though regulations have some influence, they are not properly implemented. They roundly criticised the implementation and content of existing regulations. They stressed the need to effect changes in their standards in view of the existing reality. A few associations specifically cited the Shop and Establishment Act, the CPA and the Bombay Nursing Homes Registration Act. However, they did not fill in details.

*NEED FOR AN ACCREDITATION BODY*

The associations were united in the view that an accreditation body was needed. However, the owners of hospitals raised doubts about whether smaller hospitals would be able to afford the cost of upgrading standards and whether "voluntary accreditation" would be viable in the present circumstances. The specialists' associations believed that they should play a leading role in the establishment of such a body. They suggested that a draft proposal for the body first circulated among the relevant stakeholders could form the basis for future course of action and creation of goodwill among health care providers.

*VIEWS ON THE ACCREDITATION BODY*

*Initiative and constitution:* Most of the associations felt that the hospital owners and government should play a leading role in the formative phase of such a system. Two of the specialists' associations felt that insurance companies could be included in the years to come as it would give them choices in selection of a hospital while one specialists' association felt that insurance companies should not be involved in setting the specifications for an accreditation body. Most of the associations believed that consumers should be involved in the accreditation body, as it gives the body some legitimacy.

*Role:* Most associations strongly felt that an accreditation system should assess and assist hospitals in maintaining and upgrading standards which would ensure a continuous process of quality assurance. The system should also play an educative and informative role they said. All associations, except one specialist association, felt that consumer satisfaction should be monitored. It was seen as the best certificate that one could get.

At the same time, they felt that consumer satisfaction should be measured after careful observation. Many associations did not favour punitive action. The associations held differing views on whether patient redressal should be a component of the accreditation body. The hospital owners and some of the specialists' associations favoured the incorporation of patient redressal mechanisms. They felt that this would help build confidence between doctor and patient and help in patient education. It would also solve problems and misunderstandings between the doctor and the patient and reduce litigation. On the other hand, some specialists' associations felt that patient redressal should remain outside the ambit of the accreditation body. Mixing the two issues would lead to unnecessary confusion they felt. The opinion of patients could also be biased. They felt that the doctors should be driven by the motivation to improve oneself and not just protect oneself from consumer courts.

In response to the issue of monitoring, most of the associations felt that physical aspects, equipment, qualification and number of personnel employed or attached as well as type of treatment and follow up of care provided should be monitored. Two specialists' associations felt that the type of treatment and follow-up of care provided cannot be monitored as this could only be done by self or by people from that speciality. Another view was that standards should be monitored if "the accreditation body is capable in all walks of the medical field." Interestingly, the hospital owners and medical consultants did not favour the monitoring of the (number of) beds and hospitals in a geographical area while two of the specialists' associations and the nurses association did. Of the remaining associations, one specialists' association believed that such standards were already existing while another felt that quantity should be monitored only from a statistical point of view.

The nurses' and one of the specialists' associations felt that prices should be monitored even though doctors would like to recover quickly the large investments that were made towards their medical education. The remaining associations did not favour monitoring of prices as they considered this to be a personal matter between the doctor and the patient that would depend on professional skill, investment, seniority and experience of the doctor.

*Functioning:* Most of the associations believed that the accreditation body should be an independent and autonomous organisation. One of the specialists' associations felt that it should be supported by legislation. The other specialists' associations felt that the accreditation body should be independent even if it were supported by legislation. Most of the associations felt that the accreditation body should function as a non-profit organisation. The consultants' association and one of the specialists' associations believed that the concerned hospital going in for accreditation should pay the required charges. Another suggested that the system should function as a regulatory body that would lay down different specifications for different types of care provided.

*Standards:* All the associations felt that it was imperative for standards to be laid down. They strongly felt that the standards should be patient focused as it should then help people have

access to "certain basic necessities." However, there were differences as to what aspects of service delivery should be covered under the issue of standardisation. They felt that certain basic aspects like definition of a hospital, classification of staff, equipment, etc. need to be examined.

The hospital owners felt that standards should be laid down only for equipment and not space while one of the specialists' associations felt that standards should also be laid down for space. One specialists' association felt that "standards should differ according to geographical location." In relation to the concerned speciality, they maintained that "standards should be excellent." The need for a "state-of-the-art" facility was emphasised. Standards would be helpful in initiating a process of quality control they felt. This assumes importance in light of the fact that due to lack of standardisation, private hospitals are mushrooming in Mumbai. Some of the associations emphasised the fact that having standards would allow comparison and competition and would give the providers a chance to improve. Most of all, the ultimate beneficiary would be the patient.

*Grading and assessment:* The associations responded positively to the idea of a grading system for hospitals. Some felt that "grading would help the patients realise whether the kind of treatment she or he needs is available or not." In addition, the patient would be able to choose where (s)he wants to go for a particular kind of treatment. Hospitals could be graded in a number of different ways. They could be graded on equipment and services provided. Or they could be graded in qualitative terms – "satisfactory and upward"– as it would have no negative connotations and health care providers would not shy away from accreditation. Hospitals could be graded in terms of the number of patients who were treated, cured or sent to government hospitals. Or in terms of minor, semi-major, major, supra-major conditions that have been treated. Others felt that where provision of health care is concerned only one grade should exist – the top grade. It was perceived that grading a hospital would have a psychological effect on patients and their families when they want to choose a hospital to go to: they would hesitate to go to a grade 'C' hospital for treatment.

Most of the associations felt that the assessment of compliance against set standards should be done by the participating hospitals and then by an external team. Consumer participation in this process could be encouraged it was felt. The hospital owners' association was of the opinion that assessments should be done through self-evaluation only. Another view expressed by one of the specialists' association was that the assessment should be sudden, uninformed and done by an external team. Individual members from specialist associations with a firm grip of practical realities should be involved in assessing hospitals offering same

speciality services. There were divergent views on the periodicity of assessment. The hospital owners' and consultants' associations believed that the assessment should be done every two years while one specialists' association felt that it should done after every three years. One of the specialists' associations felt that the period should be every year. Another suggestion was that the assessment should be done every two years on demand and that it should be decided amongst the hospitals and the surveyors. Regarding follow-up, most associations felt that the process should be three fold: providing recognition to those meeting standards, assisting in upgrading standards and taking punitive action. Others felt that it should only recognise hospitals meeting the set standards and if necessary should assist them in upgrading their standards.

The associations believed that the assessment findings should be disclosed to the participating hospitals, consumers/public, insurance companies, financial institutions and to any individual or body on demand. The hospital owners' and one of the specialists' associations were of the opinion that the findings should be disclosed only to the participating hospital and to any individual or body with the permission of the participating hospital. Reconsideration of assessment findings was seen as being essential given the fact that there could have been some restraints during the initial assessment. Moreover, given the constructive purpose and nature of the accreditation process – such as, assistance, voluntariness, the objective of public education and the scope to improve among participating hospitals – a process of reconsideration was considered to be an important component of such a system. On the contrary, another association was of the opinion that "this should not be done, at least in India as these kind of processes could be misused and system could lose its creditability."

*ADVANTAGES AND DISADVANTAGES TO STAKEHOLDERS*

All associations agreed that the accreditation body would be beneficial in many ways. It would help improve standards in hospitals and provide them with an opportunity to have a continuous process of quality assurance. Further, it would enable comparisons between hospitals in terms of their performance and serve as a useful marketing tool. It would regulate and manage competition between hospitals, create a level playing field for them and also help insurance companies to collaborate with hospitals. Two specialists' associations remarked that the system should not be used merely as a marketing tool since it ought to keep the welfare of patients in mind.

Almost all associations were willing to participate in an accreditation body. They were willing to be involved in setting up committees to lay down minimum standards, upgrade the standards of hospitals and ensure that their members come up to a certain level of standard. In fact, one of the associations felt that "a specialists' association should take the lead in forming an accreditation system." One of the associations said that they could help in generating patient awareness while the nurses' association was willing to participate in any manner that would help improve nursing care and ensure personal welfare of the nurses. One of the specialists' associations was of the view that it had little or no role to play especially in the implementation of standards.

## Consumers

We are consumers not only when we buy goods or eat in restaurants but when we seek the help of doctors too. Our role as consumers in health care is becoming ever more critical by the day. Medical care is becoming increasingly complex in view of scientific and technological advancements. Expensive and inaccessible too. We need to be aware of our rights and know how to safeguard them.

Consumer campaigns, like the one for a rational drug policy or those against food adulteration or misuse of medical technology among others, have brought to the fore some of the critical issues in health and medical care. Growing litigation against medical malpractice and negligence have also demystified a once-sacred relationship between doctors and patients. Media coverage of health and medical (mis)demeanours has helped to make consumers aware of issues related to quality of care and the need for accountability. But they would form a small group, most likely middle/upper class and possibly literate.

The rights and interests of all consumers received a shot in the arm when the Consumer Protection Act (or CPA) was passed. Despite many debates and protests from the medical fraternity, the Act covers medical services in both the private and public sectors. Thus, the CPA has been one of the major gains of the consumer movement in India, especially for those organisations dealing with health issues.

The interests of consumers of medical care will also be supported by another recent development. The National Human Rights Commission recently assumed the responsibility of examining the functioning of private health facilities. It was prompted to do so because of increasing litigation against medical negligence in such institutions. The Commission will

now examine issues related to the registration of private nursing homes in Delhi and their facility-based grading and monitoring. The employment of qualified medical practitioners and availability of adequate infrastructure are some of the related issues that it will examine. This is just one of the attempts to examine the functioning of the private health care providers. An accreditation body will help consumers too as their wellbeing is partly influenced by the quality of formal care they receive when ill. Also, consumers would become conscious of facilities, costs and treatment since hospitals would now have to provide such information.

In the present study, consumers refer mainly those who avail of the services provided by private hospitals. These include patients who use both ambulatory as well as indoor care. The organisations that represent the interests of the consumers are included too. We interviewed two consumer organisations and 100 patients from six hospitals. The findings for patients and consumer organisations are presented in two separate sections.

## PATIENTS

In principle, an accreditation body for hospitals should help providers to ensure that certain essential standards of health care are maintained and offered to patients. In order to understand what constitutes essential standards, we elicited the viewpoint of patients about the same. As accreditation is an abstract concept, we asked certain specific questions. How do patients decide which hospital to go to? On what considerations do they base their decisions? What information do they treat as important for decision making? This further helped us comprehend the kind of information they would ideally like to have about a hospital. Moreover, we attempted to document their views on the usefulness of grading of hospitals and standardisation of costs of hospital care.

As outdoor patients were unable to give much time for the interview, we limited the question about the need for an accreditation system to indoor patients. Before data collection, we oriented the owners or administrators of the hospital to the objectives of our study and the interview schedule for the patients. We based our selection of six hospitals on certain indicators like the number of beds, the services provided, ownership pattern and, more crucially, the owners' or administrators' willingness to participate and permit the research team to interact with their patients.

Five out of the six chosen hospitals were located in the western suburbs and one was in an eastern suburb. In terms of bed strength, one hospital had fewer than 10 beds, three hospitals had 11 to 20 beds, one had 75 beds and one had more than 100 beds. In terms of ownership, two hospitals were individual proprietorships, two were run by partners and two

were charitable trusts. Two hospitals provided maternity services exclusively while the rest provided multiple speciality services.

**Profile of Respondents**

Out of 100 patients whom we interviewed, 70 were indoor patients and 30 were outdoor patients. In all, 58 patients fielded our questions themselves. In 39 cases, the persons accompanying the patients responded to our questions while three patients refused to respond. Totally, we interviewed 47 male and 50 female patients. As seen in Table #, most patients were young adults or middle aged.

**Table 4.1: Age–wise profile of the respondents**

| Age groups (in years) | No. of patients |
|-----------------------|-----------------|
| 0-15                  | 6               |
| 16-30                 | 36              |
| 31-45                 | 26              |
| 46-60                 | 12              |
| >60                   | 17              |
| No response           | 3               |
| **Total**             | 100             |

Figures are actual, N=100

Six out of the 100 patients were illiterate, 42 were educated up to anywhere between the 5th and 10th class, 17 were graduates and nine had undergone professional courses. Those educated until the 12th standard and post-graduates were scanty. Thirty patients were homemakers exclusively, 30 were employed in the organised and unorganised sectors and 15 had their own business. The remaining were students, retired, unemployed or children.

**Basis for Selection of the Hospital**

In order to understand how patients chose to come to the hospital they were in at the time of our interview, we listed possible reasons from which they could choose. At the same time, if they found these multiple choices inadequate, they were free to discard them and state their own reasons.

The reasons that we listed for their present choice were many. Being acquainted with a certain doctor, being referred to this facility by a family doctor or general practitioner and following suggestions made by family, friends or relatives were some options that we offered. Also, favourable experience with this particular health facility in the past and proximity to ones residence. And then again, facilities, tests or specialised investigation

offered at this hospital. Or the attachment of certain doctors to the hospital. Or costs, quality of care in terms of staff behaviour, treatment, and so on. Or reputation of the hospital and the doctor.

The basis for selecting a particular hospital differed between outdoor and indoor patients. Out of 30 outdoor patients whom we interviewed, 15 stressed the facilities, services and the specialised investigation offered in that hospital, 14 were guided by their (or their family's) past experience with the hospital and 12 were attracted by the proximity of the hospital to their residence. Among the indoor patients whom we interviewed, 28 emphasised the location of the hospital vis-à-vis their residence, 23 mentioned referral by their family doctor or general practitioner and 21 were guided by their (or their family's) past experience with the hospital.

This brings to light the fact that outdoor patients lay greater emphasis on the kind of facilities and tests available in a hospital while indoor patients would go to a hospital nearer to their residence. This reflects the basis on which patients have made their choice in selecting a particular health care facility.

**Criteria Used for Selection of A Hospital**

What are the three most important criteria that a patient would ideally keep in mind while selecting a hospital for treatment?  We asked both indoor and outdoor patients to chose and prioritise three possible responses from the options that we offered. The options are listed in Table 4.2

**Table 4.2: Prioritising of criteria for selection of hospital**

| Criteria | Outdoor patients | | | Indoor patients | | |
|---|---|---|---|---|---|---|
| | 1st | 2nd | 3rd | 1st | 2nd | 3rd |
| Quality of care | 9 | 4 | 5 | 21 | 9 | 10 |
| Kind of facilities | 3 | 10 | 5 | 14 | 18 | 8 |
| Proximity to residence | 3 | 2 | 5 | 2 | 17 | 11 |
| Suggested by family & friends | 4 | 1 | 5 | 5 | 2 | 4 |
| Reputation of doctor or hospital | 4 | 0 | 0 | 11 | 3 | 2 |
| Own or family's past experience | 2 | 3 | 1 | 1 | 6 | 4 |
| Cost involved | 3 | 4 | 3 | 2 | 5 | 10 |
| Acquainted with doctor | 1 | 4 | 2 | 7 | 2 | 2 |
| Referral by general practitioner | 0 | 1 | 1 | 1 | 0 | 0 |
| No response | 1 | 1 | 3 | 6 | 8 | 19 |
| Totals | 30 | 30 | 30 | 70 | 70 | 70 |

Figures are actual, N=100

From the above table, it becomes evident that indoor and outdoor patients would ideally choose a particular hospital by its quality. Other criteria would be the facilities it offered and

its proximity to one's residence. Outdoor patients would additionally go by suggestions made by their family and friends. In reality, a host of practical considerations like presence of particular facilities or specialised investigations as well as the family's past experience and proximity determine the choices of outdoor patients. And considerations like the location of the hospital as well as referrals by the family doctor or the family's past experience determine choices for indoor patients. In other words, patients have limited choices in real terms.

**Expectations of A Patient From A Hospital**

Outdoor patients emphasised three major aspects of the hospital's functioning: the treatment provided, the doctor-patient relationship and the facilities offered. They maintained that treatment should be "effective" and "equal attention be paid to all patients whether (s)he is known to the doctor or not." The respondents felt that all the facilities provided by the hospital should be displayed. Guidance on where a particular service could be availed of in case the hospital did not offer it should also be given they said. Lastly, they asserted that the doctors' relation with patients should be based on trust and faith. The doctor as well as the nurses, ward boys and *ayah bais* (female helpers) should interact with patients. Moreover, the doctor should inform patients about their illness and the course of treatment.

Most of the indoor patients looked forward to experienced and well-qualified doctors. They also stressed regular visits by the medical personnel. They emphasised "good" staff and staff behaviour: the staff should be "kind, sensitive, caring and responsive to the needs of the patient. Some complained that the staff were often unresponsive. The accompanying relatives remarked that they had to care for the patient themselves. They said, "until money is paid to the staff, proper care is not taken." This might have happened because illness has become "a daily occurrence for them". They stressed the need for timely and prompt attention to patients. Moreover, they felt that there ought to be proper communication between the patient, the doctor and the staff wherein information about one's condition as well as the kind of care and precautionary measures to be taken are explained in simple terms. They also said that the hospital should have good facilities, equipment and the prices charged should be reasonable. Some patients remarked that all facilities should be available under one roof. Attention should be paid to other amenities such as the amount of space available, the kind of ventilation, the cleanliness of toilets and rooms, the changing of linen, the kind of food being served and the facilities for entertainment.

In sum, the outdoor and indoor patients laid great emphasis on the fact that as the patient coming to a hospital is already in pain, (s)he should be treated as a human being and not merely as a source of income for the hospital. The treatment should be good and sensitive to patients' needs is what our respondents were saying.

**Information Hospitals Should Provide**

Patients emphasised information sharing at various levels. They believed that information pertaining to the doctors employed or attached – their area of expertise and timings – should be made available to patients. So too must information about the facilities and services and their cost. Also, the availability and price of rooms and wards. And various administrative, pre-operative or post-operative procedures to be followed. Hospitals should provide proper instructions about "where patients should go and who they should meet".

Each hospital should have an efficiently run information/enquiry desk from where patients could seek information about practical details – as, for example, the nearest chemist, phone booth, hotel, etc. – emergency services or any other matter. They may wish to learn, for example, about the treatment and medication given or the length of time for which the doctors propose to keep them in hospital. There could also be signboards in various languages they said. Patients felt that "every hospital should have its own visible standards, if not external. There should be a mission statement about services. Most of all, ensuring transparency should be of utmost importance." In other words, hospitals should be internally motivated to provide quality care irrespective of the presence of an external body.

**Grading of Hospitals**

Out of 100 patients (indoor and outdoor), 56 favoured gradation of hospitals. Of those in favour of grading, 21 were employed and educated up to the $5^{th}$ to $10^{th}$ standard. They felt that "getting admitted according to the grade of a particular hospital would be easy" for patients like them as they "would not have to doctor shop for treatment". Moreover, they felt that getting admitted into a hospital without prior knowledge of facilities and cost of treatment would be very inconvenient and problematic for patients. If the hospitals were graded then the patient would be assured of a certain standard of care in terms of services, qualified medical attendance, prices, staff response and behaviour, hygiene, infrastructure and equipment. Moreover, "the patient could then go to a hospital which meets his or her financial background", they said.

Some respondents suggested various ways in which a hospital could be graded. One view was that the grades should be given to individual sections rather than for the entire hospital. A contrary view was that the health facility should be graded as a whole. Votaries argued that the procedure followed for gradation was important. They laid maximum emphasis on the facilities that the hospital provided and proposed grading based on this. Others felt that the location of the hospital could also be considered.

Opposed to the idea of grading were 27 patients. Of these, 16 were homemakers and were educated up to the 5th to 10th standard. They believed that trust between the doctor and the patient was most important, irrespective of the doctor's hospital attachment. They asked what would happen to poor people if hospitals were graded. They felt that gradation would lead to increase in cost even if the treatment provided was the same. Seventeen patients did not respond to this question.

STANDARDISATION OF FEES, HOSPITAL CHARGES, AND SO ON.

Out of 100 patients, 64 were in favour of standardisation of fees and other hospital charges. Of these, 30 were homemakers and 30 were employed. Among these 60, 22 patients were educated up to the 5th to 10th standard while the others were spread out thinly in other categories. They asserted that costs should be standardised, as only then will health care become accessible and affordable to all, especially to people from the lower socio-economic class. One of them stated, "only then will middle class and poor people not be cheated and be assured of good treatment, irrespective of which hospital they go to". People would then be able to make informed choices they believed. One of them suggested that costs be standardised keeping in mind the location of the hospital. "A hospital located in a slum area should not charge the same as hospitals located in posh areas of south Bombay".

Although they supported the idea, many patients wondered whether standardisation would actually be feasible and how it would be implemented. Some of them advocated the setting up of a menu card system or a system where minimum and maximum costs for certain procedures/services are stated. They commonly believed that nowadays, costs vary from doctor to doctor and are often dependent on the patients' background and doctors' experience. Doctors in "big hospitals" often charge exorbitantly, they said. This makes their services unaffordable.

A small group of 25 patients were against standardisation of costs. Most of these patients were homemakers with education between the 5th and 10th standards. They reasoned that as

the kind of treatment and quality of services vary from hospital to hospital, so would the charges. One said, "as some hospitals take less money, if standardisation were to take place then they too would have no choice but to raise their charges" Another patient asked whether "treatment would be dependent on the amount paid." Others felt that each hospital and doctor should have the freedom to decide what to charge; these charges, in turn, would depend on services provided. Another view was that money is a secondary issue while the patients' recovery and their need to receive good treatment are all important. They also felt that the fees would depend on the doctor's expertise and specialisation. One of the patients felt that standardisation of costs "can not be done in Bombay due to the prevalence of the practice of kickbacks between the doctor, the hospital and diagnostic centres." Ten patients did not respond while one patient responded tentatively to this question.

**Recognition by an Authority**

Totally 54 patients stated that they would go to a hospital that is recognised by an authority. Some 28 said that they would not while 18 did not respond to this question. Of the 54 patients who favoured recognition, 19 were employed and were educated up to the 5th to 10th standard. Those supporting recognition felt that it would guarantee availability of facilities and a  certain quality of care. It would enable patients to chose between the various health care providers. Furthermore, they felt that recognition by an authority would mean that the hospital would be "well studied" and that there would be some basis for providing recognition to a hospital.

Of the 28 patients who did not favour recognition, nine were homemakers followed by eight persons employed in the formal or informal sectors. Respondents in both the categories had studied up to the 5th to 10th standard. Their view was that they would prefer to make decisions based on their own criteria and past experiences. Some of them said that they would give importance to the treatment provided in a hospital; not on whether the hospital is recognised or not. Some others feared that a nexus might develop between such a body and the hospitals leading to corruption. They felt that such a body ought to be trust-worthy. Towards this end, one patient felt that the government could perhaps provide such recognition itself.

Many of these patients believed that while they would go by recognition given to a hospital, they would tend to rely more on their own experience (if any) or on information that they would get from their own sources. They would rely on the suggestions of friends or relatives or, more importantly, the opinion of their family doctor. "If it was a sudden illness and if one

had no information or if one did not know any doctor then the second choice would be to go to a hospital recognised by some authority" was what one patient said. Much would depend on the creditability and transparency of such body they felt. Some said that they would be more interested to see whether their minimum expectation from a hospital is fulfilled or not than whether the hospital is recognised by an authority. They would give parameters like qualification of doctor, past experiences as well as hygiene and patient satisfaction more importance. Others felt that they would go to a sanctioned hospital only if the illness was major and if the hospital could guarantee good treatment. But there were also those who were aware of the benefits of such recognition, especially to people who are new in neighbourhoods or to those with no information base of their own.

TABLE 4.3: VIEWS ON GRADING, STANDARDISATION OF COSTS AND RECOGNITION BY AUTHORITY

|  | Housewives | | | Employed | | | Own business | | | Others | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
|  | Yes | No | NR | Yes | No | NR | Yes | No | NR | Yes | No | NR |
| Grading | 15 | 9 | 6 | 19 | 8 | 3 | 8 | 5 | 2 | 14 | 5 | 2 |
| Standardisation of cost | 16 | 11 | 3 | 21 | 8 | 1 | 11 | 3 | 1 | 16 | 3 | 2 |
| Recognition by authority | 14 | 9 | 7 | 18 | 8 | 4 | 11 | 4 | 0 | 11 | 7 | 3 |

Figures are actual, N=100

The above table clearly shows that while the different categories of patients may agree or disagree in varying degrees, one common denominator shared by most is the need for grading, standardisation of cost and recognition by authority. This clearly brings out the need for an accreditation body.

**Views on an Accreditation Body**

Patients expressed different views about an accreditation body. Many believed that accreditation is needed as it would ensure that certain standards are maintained. People would know how a particular hospital stands in comparison to certain set minimum standards. They would know what facilities are available at a particular hospital. Also, procedures and treatment would be standardised. Patients believed that "specifications would need to be different for the small nursing homes and big hospitals." Moreover, "the basis of an accreditation system is very important and needs to be spelt out clearly to the lay person" This would help educated people to make an informed choice. People would go to a particular hospital based on their capacity to pay. However, some feared that the cost of health care would rise. This would mean that the middle and higher classes would benefit a lot but not the lower class. However, if at the same time one were also looking at the issue of

standardisation of cost then such a situation would not arise. Some believed that accreditation by an external agency "would be a good idea." At the same time, they were apprehensive that a nexus between the accrediting body and the participating hospital might lead to biased results and corruption. Some questioned whether the grades or recognition provided by the accrediting body would reflect the existing reality in that particular health care facility. Also, "to what extent would doctors themselves agree to such a system?", they asked. One of them suggested that "if accreditation were done by a government organisation or if the creditability of the accrediting body were recognised by the government then the system might run." Another patient opined that "in today's situation where cut-practice is very prevalent, self-regulation would be useful: it would help in decision making and ensure transparency." Some were of the opinion that accreditation would be helpful as a kind of classification system. Also, "it would lead to competition among various hospitals and in the end the patient would get the best." Some asked: "inspite of knowing what is available and where, to what extent would people really use such a system as, in a state of emergency, people just go to a hospital which is nearby or known to oneself without considering the costs? Despite very high costs, people would get the money from anywhere in order to get treated especially if they have faith and confidence in the treatment provided." Others were more negative when they said, "inspite of its advantages to a patient, an accreditation body would not be followed and it would remain on paper."

## CONSUMER ORGANISATIONS

Unlike consumers of other goods and services, those seeking medical care are constrained by their lack of knowledge of the available choices and are dependent on professional expertise, especially in life-threatening situations (Allsop 1992, Flynn 1992). Consumer organisations in the country are aware of this fact and have been playing a major role in raising issues, educating people about their rights, filing cases in the courts, creating awareness and influencing policies at various levels. Mumbai, being a commercial city, has many consumer organisations taking up cudgels on behalf of the consumers. Many of them deal with a variety of consumer issues related to household goods, transport, financial services, health services, and so on. Some of them are instrumental in forming groups of consumers to demand better services from the market. Issues related to the health care services are handled by only a few consumer organisations. Some of these cover health services as part of broader consumer issues. As far as we know, only one organisation currently in existence takes up health related issues exclusively. We interviewed the office bearers of two organisations which takes up health related issues.

QUALITY OF CARE AND AWARENESS OF EXISTING REGULATIONS

The two consumer organisations that we interviewed strongly criticised the conditions prevailing in private hospitals in terms of standards of their physical structure. This was strongly reiterated in the statement that "most hospitals are run as shops rather than institutions providing health care and there are no standards being followed. Once a person enters the hospital, (s)he does not know what facilities are available there. Moreover, most hospitals are run in residential premises and are small. The entire set up is in a miserable condition."

There was great awareness about the CPA and the Bombay Nursing Home Registration Act applicable to hospitals in Mumbai City. While one of them did not comment on the implementation of existing legislation, the other organisation felt that the "existing legislations (sic) are not being enforced. Even if they are, it is done with an ulterior motive. Moreover, bribery is spoken of openly." Both organisations were of the view that the CPA has aided the rights of the patient. The reason given by them was that "hospitals have to be mindful about the care they provide." Another reason was that the CPA helps the patient as it provides an avenue for speedy and cheap justice, not like "courting and dating" in civil court. They said that one of the reasons why consumers go to consumer courts is due to lack of communication by the health providers. They favoured more communication and information sharing between the doctor and the patient. Further, they cited defensive medicine as a fallout of CPA and felt that consumers may have to risk paying more for medical care. How much more would the consumer have to pay for health care? And for how long would costs continually increase? They brought up these two issues.

NEED FOR AN ACCREDITATION BODY

The consumer organisations strongly felt the need for an accreditation body for hospitals. One of the organisations stated that the parameters underlying such a system should be first set and then the compliance of hospitals with them assessed. The other organisation took the view that "we cannot have one system for all. It would depend on the amount of fees received and the kind of people who go to the hospital."

VIEWS ON THE ACCREDITATION BODY

*Initiative and constitution:* Who should take the initiative and be involved in forming the accreditation body? One organisation felt that the government – that is, the health

department – should take the initiative. "In the initial stage the government should take the lead and then involve all the other actors." The other organisation advocated a voluntary body comprising professionals, social workers and consumer organisations. They founded this recommendation on the premise that the profession would raise its own standards and ethics by pursuing a system of 'self regulation'. In short, a voluntary organisation with different professionals. At the same time, they emphasised the need for professional honesty and ethics. Both organisations were non-committal about whether insurance companies should be involved in the initiation of such a system.

*Role:* In terms of role of the accreditation body, both organisations agreed that the accreditation system should assess compliance with standards, assist in upgrading standards and continuous quality assurance. They laid great emphasis on the educative and informative role that such a body should play. However, they wondered whether it would be possible for this body to take punitive action as only the government could do so. Both favoured the inclusion of government hospitals. Both also agreed that the accreditation body should be implemented in other districts and states after being initiated first in Mumbai. About patient redressal procedures, however, there were two divergent views. One group wanted patient redressal procedures to be placed within the ambit of the accreditation body, as lay persons would benefit the most. But the other felt that this function should be left out, as the accreditation body only provides recognition and should not become a instrument of patient redressal.

*Functioning:* Both the organisations believed that the body should be an autonomous organisation empowered by legislation. They favoured government backing in some form. They felt it should function as a non-profit but self-sustaining organisation. It may avail of grants from the government but not depend solely on government funds.

*Standards:* Both organisations agreed that the accreditation body should monitor standards, price and consumer satisfaction but not the issue of quantity. Apart from the list of standards that we drew up (including, for example, physical standards, equipment, qualification and number of personnel as well as type of treatment and follow-up of care), one of the organisations believed that facilities for emergency care should also be included. One organisation believed that the distribution of hospitals in different geographical areas should be monitored. The number allowed in a given area would depend on the "requirement of society". The other organisations felt that quantity per se should not be monitored, except when it comes to the number of beds vis-à-vis the available floor space. Regarding who should be involved in setting standards, they were of the opinion that government (namely,

the local/Municipal as well as state and central government), the medical councils, specialists' associations, consumer organisations, and owners/administrators of hospitals should be involved.

*Grading and assessment:* Both organisations were of the view that hospitals should be graded. This would help the patients to know what facilities and standard of treatment they could expect. Dissemination of such information was vital they felt. One of them responded by stating that "private hospitals are sometimes managed by charitable institutions. Therefore, they should be graded". One organisation was of the opinion that grades should be based on the services offered and the other favoured a rating scale. They said that the basis of this should be clearly defined.

How should compliance with standards be assessed? One organisation advocated self-evaluation by the participating hospital followed by external review while the other favoured the idea of assessment by an external team. Both organisations held the view that the accreditation body could provide recognition and assist in upgrading standards. They favoured the establishment of a 'forum for appeal'. Hospitals could approach this committee for reconsideration of the assessment findings. The committee would serve as a Grievance Redressal Forum while playing such a role. On the other hand, if hospitals agreed with the assessment findings they could still approach this committee for assistance in improving its standards. Both organisations wanted the assessment findings to be made available to all stakeholders in the health care services. Both felt that assessments should be conducted every year.

ADVANTAGES AND DISADVANTAGES TO STAKEHOLDERS

The consumer organisations accepted that such a system held many benefits for stakeholders. Accreditation would help improve standards, provide an opportunity for continuous quality assurance, help compare performance with other hospitals, regulate competition between hospitals and create a level playing field among hospitals. One of them added that it would be a complimentary system. Another advantage that they mentioned was that it would benefit society as a whole as health care would be streamlined.

When asked how advantageous such a system would be for patients, they mentioned that much would depend on its implementation. They cited increased health costs as a disadvantage. The accreditation body would benefit the specialists and consultant doctors, they felt, as they would know what to expect from a hospital. They also felt that accreditation

would help financial and insurance companies make rational judgements about hospitals. An accrediting system would benefit the judiciary as would help them decide whether hospitals given a rating were adhering to standards especially in adverse conditions.

There was great enthusiasm among consumer organisations about an accreditation system. They showed a willingness to participate in an accreditation body. "As it affects the consumer, we will stand for it" is what one organisation said. They expressed their willingness to get involved in any committee that would be set up for this purpose.

## Government

The Constitution of India has vested state governments with the responsibility of providing health care to its people. Clearly, the government should play a pro-active role; in reality though, its role is a restricted one, limited to its own institutions. The dominant private sector functions independently, outside the ambit of governmental regulation. This sector has participated in government health programmes and schemes but the collaboration has been limited to a few specific campaigns (like pulse polio). Private and public health institutions are, as yet, unlinked and no well-planned strategy seems to be in sight.

Whatever the scope of its role, the government functions at many levels: the centre, state, municipal and other local body levels. It has an elaborate structure. At the level of the central government, the Ministry of Health and Family Welfare has two wings: a secretariat or administrative wing staffed by civil servants and a technical wing staffed by medical doctors. The Secretary of Health heads the former while the Director General heads the latter. Both report to the health minister but the directorate enjoys a subordinate status compared to the secretariat. At the central level, additionally, the Department of Family Welfare with a Secretary supported by Additional, Joint, Deputy and Under Secretaries looks after various programmes of the two wings. The Director is in charge of the technical wing and a team comprised of Additional, Joint and Deputy and Assistant Directors supports him or her. Sometimes, programmes have separate directors, advisors and commissioners and their deputies and assistants. This administrative structure is more or less repeated at the level of the state government with a Health Minister, a Health Secretary and a Director of Health.

At the district level, a District Medical Superintendent assumes charge of a district hospital while a Chief Medical Officer or District Health Officer takes on rural non-hospital functions In

cities and in small towns, the municipalities have their own hierarchies. In Mumbai, the responsibility of health care provision is entrusted to a Deputy Municipal Commissioner directly under the Municipal Commissioner. An Executive Health Officer with the assistance of various Additional, Deputy and Assistant Health Officers carry out actual tasks. These duties are delegated to Medical Officers in each of the wards of the city. The latest development in the Bombay Municipal Corporation (BMC) is the institution of a mayor in council system wherein a health minister is appointed from among the elected corporators. S/he is wholly responsible and the final authority in the health department.

Our intention was to interview officials responsible for private hospitals at the central, state and municipal levels. We interviewed three officials from the state government, two from the municipal level as well as the Chairperson of the Health Committee of the BMC. Many of them were very co-operative and shared their views. Unfortunately, we were unable to interview officials from the central government, as they were busy with the parliament session.

QUALITY OF CARE AND AWARENESS OF EXISTING REGULATIONS

Nearly all officials felt that the quality of care provided by private hospitals was poor. These hospitals fell short in a number of areas like space, staff and equipment, they said. They also believed that these hospitals were managed poorly. Some officials differentiated between bigger and smaller hospitals and held the view that the bigger hospitals provide better care. One of them commented that "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." There was an understanding of the problems that private hospitals had with availability of space and waste disposal.

All officials, except one, were aware of the Bombay Nursing Home Registration Act, 1949. Those aware of the Act were uniformly of the opinion that it was not being implemented. One of them mentioned that the Act is a few decades old and its enforcement is "not a priority". It was also brought out that there was "passive implementation" of the Act in Mumbai. According to them, the existing machinery was insufficient to implement the Act. Many were quite concerned about the lacuna of the present Act in that standards were not laid down. One of the respondents called it "a toothless Act." They believed that the present legislation did not in any way influence the functioning of private hospitals.

NEED FOR AN ACCREDITATION BODY

Officials were unanimous in their view that an accreditation body is necessary. Moreover, they felt that the time was right for such a process to begin. One of them commented "An outside party doing it is very good and the city needs something like this in the present situation." All of them felt that standards should be laid down for space, equipment, qualification of staff, and so on. They reasoned that such an endeavour would help to establish good quality of care and improve standards. It would also help users to meaningfully compare different hospitals.

VIEWS ON THE ACCREDITATION BODY

*Initiative and constitution:* The officials believed that the government should be involved in some form or the other. Those at both the state and municipal level felt that the government should take the initiative and play an active role in the constitution of the system. They also felt strongly that consumer organisations should be involved. But none of them wanted insurance companies and private corporate bodies to be part of the accreditation body. Only two officials mentioned the need to have financial institutions in the body. An accreditation body should be the concern of the patients and providers and the government should support it was a general feeling among the officials.

*Role:* The officials felt that the role of the accreditation body should be to assess hospitals for compliance to standards, assist them to upgrade standards, help in continuous quality assurance, play an educative and informative role. Some felt that punitive action would not be possible, as this would require legal powers. There was no unanimity about whether patient redressal procedures should be incorporated. Some believed that while such a system would help patients, the accreditation body itself could not be individual oriented.

Only two officials at the municipal level did not want government hospitals to be included in the accreditation body. They cited funds as one of their reasons: it would cost hospitals money to upgrade standards and this would not be possible. Those who favoured the inclusion of government hospitals felt that it would help improve the standards and quality of care in government hospitals and bring them on par with private hospitals. Moreover, they believed that systems should apply equally to all hospitals providing care, whether they were publicly or privately owned. One official mentioned that such a system would make it possible to take punitive action against erring members of the staff, which in the present

system is very difficult. Most of them believed that such a system should be initiated in Mumbai and later extended to other parts of the state and country in a phased manner.

*Functioning:* All officials were of the view that the accreditation body should be an autonomous authority but supported by legislation. Legislation would empower it, they felt. Moreover, they felt that society is not mature enough to take on such responsibility on its own; if there were no legislation, there would be no enforcement. All of them felt that it should function as a non-profit but financially viable organisation.

*Standards:* All officials felt that the accreditation body should monitor physical standards of space, equipment, and the like as also standards related to qualification and number of staff, type of treatment and nature of follow-up and consumer satisfaction. All except one believed that monitoring of the number of hospitals and beds in a geographical area and professional and hospital charges should be the responsibility of the accreditation body. They felt that the government and consumer organisations should play an active role in evolving standards. Specialist's associations and hospital owners/administrators should also be part of the body evolving standards. One of them mentioned that they should be asked their opinion but not be involved as active participants.

*Grading and assessment:* All officials favoured the grading of hospitals. People would know what to expect in terms of facilities and services. It would benefit the patients as they could go to hospitals that suit their pockets. Some officials held the view that grades should correspond to attributes on a scale; for instance, grade A would reflect excellence, grade B would mean "optimum" while grade C would mean "below minimum." One official mentioned that grades should be based on the "satisfaction of the patient." Another suggested that they should be based on the level of care provided; for example, tertiary, secondary and primary.

Some of the officials felt that an external team should assess the participating hospitals after they have gone through a process of self-evaluation. After this, the accreditation body should provide recognition to the hospitals meeting standards and assist those that need to upgrade its standards. Officials were unanimous in their view that the findings of the assessment should be transparent and open to all. In case the hospital is not satisfied with the assessment findings, there should be mechanisms for reconsideration of the assessment. The periodicity of the assessment should be every two years.

ADVANTAGES AND DISADVANTAGES TO STAKEHOLDERS

All officials recognised the benefits that such a system would have. It would help improve standards, provide an opportunity to have continued quality assurance, compare the performance of hospitals and aid collaborations between hospitals and insurance companies. On the other hand, hospitals not meeting standards may have to close down. Monopoly may give way to corruption. And hospitals may loose their independence and authority.

An accreditation body would be advantageous to patients as it would help them to choose between hospitals. They would be the focus of treatment. The major disadvantage to the patients was that they might have to pay more for the services.

An accreditation system and body would also ease up several areas of governmental work it was felt. Municipal authority procedures would become easier and officials would have less work to do. Further, it would be easy for government to exert control over private hospitals. Moreover, they would be aware or the extent and quality of services provided. The private hospitals could also be involved in national programmes and schemes through this body. Officials anticipated no disadvantages for the government.

The advantages to insurance and financial companies were that it would help them to identify and tie up with hospitals and in case of mortgaging. That corporate bodies could tie up with accredited hospitals was another advantage that was envisioned. The advantages to the judiciary were that the methodologies would be clear for cases in consumer courts and it would aid them to make proper judgements.

WILLINGNESS TO PARTICIPATE

All officials were willing to participate in an accreditation body. They felt strongly that the government had a lot to contribute and would be interested in becoming active participants of the accreditation organisation. Two said that at this stage they could not comment on the terms and conditions of their participation in an accreditation body, as it is still an abstract concept. Others felt the government's participation would be unconditional.

**Insurance and Financial Companies**

Insurance and financial companies are indirectly emerging as one of the important stakeholders in private health care. Banks as well as non-banking financial companies and government owned financial companies make loans available to various health care providers. Such assistance could go towards setting up or expanding the infrastructure of

hospitals and its facilities like equipment, instruments, etc. Apart from financial companies, insurance companies offer various health insurance schemes to health providers as well as the consumers.

Health insurance in India is government owned. The monopolistic company - the General Insurance Corporation (GIC) - provides health insurance cover through four subsidiary companies; namely, the New India Assurance Company Ltd., the Oriental Insurance Company Ltd., the Life Insurance Corporation of India and the United India Assurance Company Ltd. All these companies offer identical policies as their schemes are designed and priced by GIC on a uniform basis.

In addition to the above, the State provides health care for employees of the organised (public and private) sectors through the Employee's State Insurance Scheme (ESIS). The ESIS, which was instituted in 1948, is a statutory benefit under the Factories Act. It covers employees with incomes not exceeding Rs. 6500 per month and factories employing at least 10 persons. At present, this scheme covers seven million employees, who constitute approximately 28 per cent of the organised sector. If one includes their family members, the total coverage would be 27.3 million. The ESIS runs its own hospitals and dispensaries with a panel of doctors who are engaged on a capitation basis. It runs pharmacy stores too. Pooled resources from the state, the employers and the employees finance this scheme.

The health insurance sector was opened up to private participation recently. Joint ventures will now be permitted with equity from foreign partners. The ratio of foreign equity is still under discussion but is expected to be sorted out very soon. The Insurance Regulatory Authority is still awaiting approval from the parliament. The potential for health insurance in India is estimated to be quite large. According to Winconsult, a leading international consultant, the health insurance business in India could be taken on a stand-alone basis. It has estimated that around one million households in the "very rich" category, 27.6 million in the "consuming class" and 37.6 million in the "climbers" category could pay premiums totalling $4.19 billion per annum in return for assured good health. The consultants have estimated a 30 per cent annual growth rate in insurance income until the year 2009.

In anticipation of the opening up of the insurance sector there are tie-ups between Indian and foreign companies. The Industrial Credit and Investment Bank of India (ICIB) has entered into a 50:50 joint venture with Prudential Corporation of UK. ICIB plans to enter the non-life insurance sector too through another partner. Another tie-up between the Wockhardt Hospitals and Heart Institute and the Global Emergency Services Inc. of the U.S.A. will result

in Medipass Medical Insurance for corporate and leisure travellers. The Apollo Hospitals group has decided to enter the health insurance business in a big way too. Another insurance company in the U.S.A. – CIGNA International – has opened a liaison office in New Delhi and seven leading international players have approached this group for joint ventures. CIGNA plans to invite 100 hospitals all over India to participate in its business.

We need to understand the implications of the above in a situation where the private health sector is growing at an unmonitored pace. At the same time, the quality of services offered by this sector is increasingly coming under scrutiny. The insurance sector could be one kind of interest group in the issue of quality of care. As insurance companies strive to set up business in a liberalised environment, they are likely to step up their demand for well-equipped and efficiently managed hospitals providing services of good quality with which they can collaborate. It is, therefore, imperative for any system which monitors and sets standards for private hospitals to incorporate the views of these stakeholders.

In this context, we interviewed officials from two insurance companies and two financial institutions to elicit their views on an accreditation system and the role they envisage for themselves within such a system.

### Quality of Care and Awareness of Existing Regulations

Overall, insurance and financial companies responded very poorly to the issue of quality of care provided by private hospitals. They were either unable – or unwilling – to comment on this. Nor were they fully aware of legislation governing private hospitals.

Health care, at present, is not a priority for financial and insurance companies. Loans to hospitals contribute but little to their business. So, it appears as if officials have not studied the hospital system its entirety. They do not seem to know much about how hospitals function. Nor are they keen on it at present. They go by their own protocols to judge the viability of financial assistance or collaboration with a hospital. They focus more on individuals who run the hospitals than on the hospital itself. One respondent commented "we are only concerned with finance, in giving and recovering loans."

NEED FOR AN ACCREDITATION BODY

Most of the officials felt the need for an accreditation body as it would be useful and would benefit them. Only one respondent from an insurance company felt that "nobody is going to see the rating of a hospital, it is the word of family physician that counts."

## Views on the Accreditation Body

*Initiative and constitution:* Most officials felt that the hospital owners, specialist associations and consumer associations should take an initiative and be involved in forming the accreditation body. Those competent in this process should be involved they felt. The companies emphasised that consumer organisations should be adequately represented. However, most saw no role for themselves.

*Role:* Some officials felt that the accreditation body should be primarily concerned with assessing hospitals and assisting them in upgrading their standards. One company felt that such a body should additionally play an educative and informative role. One suggestion was that whoever takes the initiative should bring out a "document or a reference book about hospitals, services and specialities available." This would help patients to make reasoned choices. They were unanimous in their view that the accreditation body should also cover government hospitals. One company felt that it should not be involved with consumer redressal as various consumer organisations could do this work.

*Functioning:* Should the accreditation body be autonomous or supported by legislation? The representatives of the companies felt that it should be supported by legislation. The idea was that "if legislation could stipulate norms, there would be nothing like it." Most of them felt that it should function as a non-profit body. Only one company felt that it should function as a "for-profit private body."

*Standards:* The company officials felt that the accreditation body should monitor standards, quality, price and consumer satisfaction. One company agreed that this would be ideal but wondered whether its operationalisation would be possible in practice. One company mentioned that they were not in a position to comment on this aspect. The officials generally felt that the hospital owners, specialists associations, government and consumers should be involved in formulating and setting standards.

*Grading and assessment:* Should hospitals be graded? One company believed that grading hospitals would help from the "cost point of view." Another company did not agree. The official believed that "it would not help, as it depends on people's paying capacity, people

who can pay can go to any hospital." Only one company official had some idea about how hospitals should be graded. The suggestion was that they should be put on a scale from "good" to "bad".

The companies believed that the assessment should be conducted by the participating hospital followed by an external team. After this, the body should provide recognition to those meeting standards and assist those not meeting them. Most were of the opinion that assessment should be done every year. They did not respond, however, to the question about punitive action.

They were very clear that the assessment finding should be disclosed. They all favoured transparency. Moreover, they stressed that the findings of the assessment should be made available to any individual or body on demand. One company commented that "sharing of information is also recognised by law and should be open."

### Advantages and Disadvantages to Stakeholders

The insurance companies favoured an accreditation body, as it would help them tie up with hospitals. A financial company commented that "if a hospital has a rating, we could lend easily. The body would be doing part of our work." As far as private hospitals are concerned, some of the officials believed that it would be "good for large hospitals." They did not know what would happen to the smaller ones. They believed that patients would benefit the most from the rating of hospitals, as they could choose to go to one that was rated.

### Willingness to Participate

The insurance and financial company officials said that they would make known their willingness to participate in an accreditation system after they have first seen how it is implemented. They mentioned clearly that they would not be able to share the costs of the accreditation body. One of them asked, "what would the company get in return?" Another company categorically stated that it would not offer any financial assistance.

### Conclusion

For quite some time now, government policies have moved towards increased involvement of the private sector in the delivery of health care services. The government has been doing this by progressively divesting itself of the responsibility of providing general health care to its people. The state is more in tune with the recommendations of bilateral and multilateral

agencies presiding over the structural adjustment programme. One direct outcome of this policy shift is privatisation in various forms. However, the establishment of monitoring systems or other attempts to ensure accountability have been slow to come by. Attempts in many states to enact legislation for private hospitals have tended to get wound up in procedural and bureaucratic red tape. At the same time, it is imperative for the state to take a more pro-active role in the provision of good quality health care. This could be done in a number of ways. The state could enact and implement necessary legislation. Or the state could take on the prime responsibility of setting up an accreditation body with the participation of various stakeholders. Such a body would be regulatory in nature. Or the various stakeholders themselves could form an accreditation body that is voluntary in nature.

The present study is important in view of the health care situation currently prevailing in India. It has focused on a possible way to improve the quality of health care in the private sector. We believe that the involvement of various stakeholders is essential to the establishment of an accreditation body. Earlier attempts have failed because the major stakeholders were not involved. This study, therefore, has attempted to bring to light the views of various stakeholders regarding an accreditation body and to work out the framework of such a system. During the study, various issues related to accreditation, such as the need for such a system as well as standards, grading, functioning and role were discussed.

The authors of the study are not proposing an accreditation system as an alternative to the state's role in regulating health care, but see a more collaborative role for the state in the present situation. It is hoped that the accreditation body would have the necessary recognition and support from the government. This needs to evolve over a course of time.

This study has thrown up certain issues related to the accreditation body. There have been areas of agreements and disagreements among the various stakeholders. We have developed a matrix of the agreements and disagreements by various stakeholders, which appears at the end of this chapter. We have analysed their responses and tried to identify the crucial issues that need to be considered. We consider this to be of utmost importance, as any system cannot function unless essential points of difference are identified and sorted out in the initial stages.

## NEED AND WILLINGNESS FOR AN ACCREDITATION BODY

The functioning of the public and private health sector brings out the fact that there is an urgent need to prescribe and improve standards of health care especially in the absence of monitoring mechanisms. This would include in-patient care, diagnostic services, out-patient care among others. The issue of access and affordability of health care services assumes a greater significance in view of the structural adjustment programme in India. The opening of private insurance companies in the Indian health care market is also going to create its own dynamics in future.

It is no wonder then that all the stakeholders felt the need and expressed their willingness to participate in an accreditation body for hospitals. The accreditation body would benefit and meet the needs and requirements of almost all the stakeholders. With the exception of a few, most hospitals were in favour of an accreditation body. The hospital owners and administrators felt the need for an accreditation body for a number of reasons. Firstly, competition especially in metropolitan areas has increased substantially. Secondly, those who maintain certain standards enjoy no particular advantage over those who function without these and charge less. Thirdly, growing consumer awareness has made providers realise that standards need to be improved and updated. Lastly, the opening up of the health insurance sector is going to force providers to have certain systems and standards in place. The insurance companies would be tying up with hospitals that are of a certain level and who maintain certain standards.

The consumers wanted an accreditation body, as it is quite difficult for them to seek services in the absence of standards or monitoring mechanisms. Their need is magnified by the fact that they have to ultimately pay for health care. They are willing to participate since they are the ones who are at the receiving end. So, any accreditation body needs to understand the consumer perceptive.

The insurance and financial companies have been more inward looking as health is not a priority for them. Their business and interaction with the medical community is limited to recovery of premiums, reimbursements and loans. Due to this, they are not willing to participate in the accreditation body but would like a body to simplify their transactions with the medical community. At the same time, an accreditation system would help them choose the hospitals they would like to liaison with. The government felt the need for an accreditation body, as this body would be doing their job of monitoring the functioning of the private hospitals. This would be done in a way that is agreeable to the government as well as the hospital owners.

An important aspect that emerges is that the needs of the stakeholders should be channelled in a proper and collaborative approach. This is true not only of efforts in Mumbai but of other parts of India too. The representatives of other states who participated in the national workshops held as a part of the research study expressed this view. In fact, they were in favour of establishment of an accreditation body in their respective states.

## VIEWS ABOUT THE ACCREDITATION BODY

The views expressed by the various stakeholders covered different aspects of the accreditation body: who should be involved in setting up the system, the role it should play, how such a body should function, issues related to standards and grading, aspects of assessment and financing.

There was a broad agreement that the providers and consumer organisations should be involved and play a leading role in the formation of such a body. Apart from the hospital owners and administrators, all other stakeholders wanted the government to be involved in various capacities. They felt that government involvement would give the body certain legitimacy. At the same time, the owners and administrators of hospitals feared that the government's role could increase over a period, which would lead to the body getting unnecessarily bureaucratised. They were basing their apprehensions on their previous experiences with the government and its officials. The government functionaries, on the other hand, saw a major role for themselves along with consumer organisations. Most of the stakeholders felt that insurance companies should not be involved. The insurance companies themselves felt that providers and consumer organisations should be incorporated in the process. This means that the accreditation body should be able to represent varied interests of the different stakeholders with the government participating in it.

With reference to the role of the accreditation body, it was emphasised that ensuring quality health care should be the prime focus of the accreditation system. The standards set should be in terms of physical and functional standards. The criteria used to evolve standards should consider the existing documents and present ground reality. Standards should be developed with the size of the hospital and the type of service it provides in mind. At the same time, the set standards need to be viewed in the wider context of the health care services.

There was near unanimity among the stakeholders that the accreditation body should assess hospitals for compliance to set standards, provide assistance to hospitals in

upgrading their standards and in continuous quality assurance. Proper patient care should be the basic minimum requirement for any accreditation body. This could be broadened into a grading system in future based on notions of what are minimum, optimum and excellent. Hospitals that do not follow minimum standards need to be aided in upgrading their standards through a process of education, training and consultation. The provision of quality care does not exist in an economic vacuum. In this connection, there is a need to examine the viability of operating very small hospitals while maintaining minimum standards. Problems that the various stakeholders have should be tackled in a manner that does not compromise on patient care. Moreover, the accreditation body should not be intimidatory but play an educative and consultative role.

The stakeholders expressed doubts about whether this body should play a punitive role, as this aspect would solely fall under the ambit of government function. Though many of them did not want a punitive role, they suggested that the list of accredited hospitals should be publicised. There was no agreement about incorporating patient redressal procedures as part of this body. Factions existed within each constituent for and against this concept. But interestingly, the reasons cited were similar across all the constituents.

In response to the issue of monitoring, the four dimensions that were looked into were standards, quantity, price and consumer satisfaction. Most felt that physical aspects, equipment, qualification, number of employees or visiting professionals, type of treatment and follow up of care should be monitored. Other than government functionaries, none of the stakeholders favoured monitoring of quantity. The providers believed that prices should not be monitored while the other constituents favoured the same. This is due to the fact that other stakeholders believed that the pricing of professional fees and hospital charges were arbitrary and not based on services provided or any other rationale. At the same time, the issue of pricing needs to be examined in relation to the escalating costs of health care in present times. Regarding monitoring of consumer satisfaction, all the constituents unanimously agreed that consumer satisfaction should be monitored. In terms of enlarging coverage of the accreditation body, all the stakeholders wanted it to cover government hospitals too.

With regard to its functioning, all stakeholders were unanimous in their view that the body should operate as a non-profit organisation. The question pertaining to whether the accreditation body should be autonomous or supported by legislation evoked different responses. The providers believed that the accreditation body should be autonomous while the government functionaries, consumer organisations and insurance and financial

companies felt that apart from being autonomous, the body should be supported by legislation. Stakeholders had diverging views on processes such as the method of assessing compliance, disclosure of findings and reconsideration of findings that feed into the functioning of any system. In terms of method of assessing compliance with set standards, the providers were of the view that it should be done by the participating hospital followed by an external team. Among the consumer organisations, one of them agreed with the view of the providers while the other felt it should be done only by an external team. Within the government functionaries, two differing views emerged. One view supported the concept of self evaluation followed by external assessment while the other advocated for assessment by an external team. Overall, most of the stakeholders favoured external assessment and mechanisms for reconsideration of assessment findings. In terms of disclosure of findings, all stakeholders except the owners of hospitals agreed that assessment findings should be disclosed to all.

With respect to the periodicity of assessment, differing views emerged among the various stakeholders. Consumer organisations and nurses' association recommended assessment every year. Hospital owners, specialists' associations and government functionaries, on the other hand, felt that it should be done every two years.

In terms of financing, it was felt that financing such a body would not be difficult. The various stakeholders involved in the initiation of the accreditation body could contribute towards setting up the body. It was suggested that in the initial stages, the accreditation body could depend on such grants but in the long-term, the body would aim to achieve self-sufficiency. The costs could also be reimbursed in part by the participating hospital.

The pattern of responses clearly brings out the fact that consent or dissent on any particular issue seems to be very subjective depending on what each stakeholder stands to gain or lose. Any kind of self-regulatory system should necessarily have to take "a middle path" wherein the stakeholders meet their needs to some extent while contributing towards an effective and efficient health care service. This should be done while safeguarding the rights of health care professionals and consumers. Furthermore, the kind of processes that would evolve within the accreditation body should be based on a very sound foundation. We need to be clear about what the body stands for, why we need to establish certain procedures and processes, how we could set up policies which ensure a decentralised democratic mode of functioning and lead to transparency at all levels. Safety nets need to be built into the system to guarantee that policies formed would be all encompassing and responsive to the changing environment. Efforts at all times need to be made to assure the consumer that optimum quality health care would be accessible and affordable. Last but not the least, one needs to ensure that the accreditation body should not give rise to structures that will prove to be an impediment in its sustenance and progress.

## AN INITIATIVE IN MUMBAI

In Mumbai, we have already started the process of establishing an accreditation body. This was an outcome of the workshop that was held as a part of this research study. The participants consisted of representatives from among the various stakeholders. They discussed whether an accreditation body was needed and who should take the initiative in setting up one. Its objectives, functioning, structure, financing and its creditability were also discussed. The group felt that such a body would have a crucial role to play in ensuring quality health care in the private health sector. They said that instead of delving into the details of an accreditation body, concrete steps should be taken towards its formation. After much discussion, it was decided that an ad-hoc committee should be formed. This committee would meet at periodic intervals and work together towards the formation of the body. The group unanimously urged CEHAT to be the Convenor of this committee. The ad-hoc committee included:

1. Bombay Hospitals Association,
2. Bombay Society of Obstetrics and Gynaecologists,
3. Association of Medical Consultants,
4. Indian Medical Association (all branches),
5. Bombay Nursing Home Owners Association,
6. Association of Surgeons of India,
7. Nurses' Association,
8. Mumbai Grahak Panchayat,
9. Consumer Guidance Society of India,
10. Association for Consumer Awareness and Safe Health and
11. Representatives from the government.

Subsequently, the ad-hoc committee was named as the Forum for HealthCare Standards (FHS). The first task undertaken was to discuss the issue of standards. The discussion focused on the document 'Proposed Minimum Standards for Private Hospitals and Nursing Homes: Upto 30 Bedded Unit Providing Medical/Surgical/Maternity Services' prepared by CEHAT. Keeping in mind the ground reality and in the absence of standards for the smaller hospitals, the group felt the need to develop standards for upto 10 beds, 10-20 beds and 20-30 beds. The indicators for each were space, equipment and humanpower. Presently, the group is in the process of evolving standards for wards, labour room, operation theatre, essential drugs, waiting area or reception room, consulting room, changing room, pantry, medical records and waste management for a general hospital with an average of 10-12 beds. Once this phase of standard development is completed, the forum plans to develop

standards for different specialities and super-specialities Simultaneously, the forum is discussing aspects relating to systems, processes which are to be incorporated into the body once it is established. Issues pertaining to grading, period of assessment, registration of the forum and its financing are also being examined in greater depth.

Presently, the forum is at a very formative level in terms of its evolution. There exists potential for it to grow into a credible and transparent accreditation body. In fact, this is the first time in India that the various stakeholders have established a body, which tries to address the needs of all stakeholders through open dialogue. All the stakeholders involved are more responsive to each other's constraints and receptive to solutions, which could try to address all their needs. In the future, the forum aims at documenting the process of establishing such a body. This could be beneficial for other interested groups who may be interested in the establishment of such a body in their states. These groups would be aware of the problems and challenges that might emerge when they implement this body in their particular states.

**Matrix of agreements and disagreements among stakeholders regarding an accreditation system**

| | Hospitals | Associations | Consumer organizations | Patients | Government | Insurance & Financial |
|---|---|---|---|---|---|---|
| **Need for an accreditation body** | Agree | Agree | Agree | Agree | Agree | Agree |
| **Who should be involved** | | | | | | |
| Hospital owners/administrators | Agree | Agree | Agree | | Agree | Agree |
| Specialist associations | Agree | Agree | Agree | | Agree | Agree |
| Consumer organizations | Agree | Agree | Agree | | Agree | Agree |
| Government | Disagree | Agree | Agree | | Agree | No response |
| Insurance & financial companies | Disagree | Disagree | Disagree | | Disagree | Disagree |
| **Role** | | | | | | |
| Assess hospitals for compliance of standards | Agree | Agree | Agree | | Agree | Agree |
| Assist hospitals In upgrading standards | Agree | Agree | Agree | | Agree | Agree |
| Assist hospitals In continuous quality assurance | Agree | Agree | Agree | | Agree | Agree |
| Play educative & informative role | Agree | Agree | Agree | | Agree | Agree |
| Forum for consumer redressal | Disagree | Disagree | Disagree | | Disagree | Disagree |

| | | | | | | |
|---|---|---|---|---|---|---|
| Take punitive action against hospitals | Disagree | Disagree | Disagree | | Disagree | Disagree |
| **Cover government hospitals** | Agree | Agree | Agree | | Agree | Agree |
| **Accreditation should monitor** | | | | | | |
| Physical aspects | Agree | Agree | Agree | | Agree | Agree |
| Equipment | Agree | Agree | Agree | | Agree | Agree |
| Qualification & number of personnel | Agree | Agree | Agree | | Agree | Agree |
| Type of treatment | Agree | Agree | Agree | | Agree | Agree |
| Follow up of care | Agree | Agree | Agree | | Agree | Agree |
| Number of hospitals in an area | Disagree | Disagree | Agree | | Agree | No response |
| Number of beds in an area | Disagree | Disagree | Agree | | Agree | No response |
| Professional fees charged | Disagree | Disagree | Agree | Agree | Agree | Agree |
| Hospital charges | Disagree | Disagree | Agree | Agree | Agree | Agree |
| Consumer satisfaction | Agree | Agree | Agree | Agree | Agree | Agree |
| **Functioning** | | | | | | |
| Independent & autonomous of any authority | Agree | Agree | Agree | | Agree | Agree |
| Legislation supporting it | Disagree | Agree | Agree | Agree | Agree | Agree |
| Non profit organization | Agree | Agree | Agree | | Agree | Agree |
| **Standards should be laid down** | Agree | Agree | Agree | | Agree | Agree |
| **Grading should be based on a rating scale** | Agree | Agree | Agree | Agree | Agree | No response |
| **Method of compliance** | | | | | | |
| Evaluation by participating hosp. followed by external assessment | Agree | Agree | Agree | | Agree | Agree |
| **Follow-up of assessment** | | | | | | |
| Provide recognition | Agree | Agree | Agree | | Agree | Agree |
| Assist hospitals in upgrading standards | Agree | Agree | Agree | | Agree | Agree |
| Take punitive action | Disagree | Disagree | Disagree | | Disagree | No response |
| **Period of assessment** | | | | | | |
| Every year | Disagree | Disagree | Agree | | Disagree | No response |
| Every two years | Agree | Agree | Disagree | | Agree | No response |
| **Findings disclosed to** | | | | | | |
| Participating hospitals | Agree | Agree | Agree | | Agree | Agree |
| Consumers & public | Disagree | Agree | Agree | | Agree | Agree |
| Insurance & financial companies | Disagree | Agree | Agree | | Agree | Agree |

| Open to all | Disagree | Agree | Agree | | Agree | Agree |
|---|---|---|---|---|---|---|
| **Willingness to participate** | Agree | Agree | Agree | | Agree | Disagree |

Note: Agree : Majority of the stakeholders were in agreement.

   Disagree : Majority of the stakeholders were in disagreement.

      The agreements and disagreements are classified on after have been taken into account after examining the  overall

      data from qualitative and quantitative methods

      The patients were asked only some of the aspects and not all.

**Framework of an Accreditation Body**

The process of developing an accreditation body for hospitals should begin by getting the various stakeholders to meet and discuss issues related to this particular mode of self-regulation. Is such a system needed? What standards should be met in order to achieve uniformity in the quality of care? How should the accreditation body be constituted? What role should such a body play and what status would it enjoy? How would it function and how could it be financed? All these issues need to be examined in depth. The discussions could follow two methods. Either a framework already in existence could be discussed from the point of view of its feasibility and adaptability. Or an entirely new framework could be evolved.

In this section, we propose the framework of a workable accreditation body for hospitals. We would like to mention that this framework is by no means a blueprint but only the broad sketch of an idea. Various factors affecting the functioning of an accreditation system, such as the group dynamics among the stakeholders as well as the existing social, political and economic ground realities need to be taken into account while implementing it. Much would depend on the involvement and initiative of the stakeholders. The accreditation system itself should be an outcome of discussions and debates on issues of concern among all the stakeholders. Collaboration, transparency between related parties and open communication are the hallmarks of the system whose framework we are proposing. Only then would it be meaningful and viable.

**PROPOSED ACCREDITATION BODY FOR HOSPITALS**

OBJECTIVES OF THE ACCREDITATION BODY:

1. Assess whether hospitals comply with standards and provide recognition to those that do.
2. Upgrade standards in the light of a changing health care environment.

3. Assist hospitals to upgrade their standards.
4. Play an educative, consultative and informative role.
5. Act as a bridge between the various stakeholders and provide a platform for continued dialogue.

CONSTITUTION OF THE BODY:

The establishment of such a body calls for representatives from the various stakeholders involved in health care delivery. This is necessary in order to make the system acceptable to all and to ensure its creditability from the start. The specific groups that we have identified are as follows:

*Representatives from the hospital owners*

They should be involved as they have an important role to play in the provision of health care services. Moreover, they would be most affected if such a system were to be implemented.

*Representatives from specialists' associations*

The associations of specialists should be involved as they have the required expertise. These associations should be from the medical and non-medical fields. Obstetricians, gynaecologists, surgeons, and others would be examples of the former and hospital administrators, x-ray technicians, and others would be examples of the latter. Their involvement would help in the institution of standards and processes. At a later stage, they could help participating hospitals to upgrade their standards.

*Representatives from professional associations*

Representatives from the medical profession should be involved as they play a pivotal role in the provision of health care. The representatives could be from among the associations of consultants, general practitioners, nurses, technicians, and the like.

*Representatives from consumer organisations*

Any system that is concerned with the issue of quality should necessarily involve the users of health care services. The interests of this group ought to be represented and the growing public attention on the rights of patients as consumers makes the involvement of consumer organisations imperative.

*Representatives from Non Governmental Organisations (NGOs)*

An accreditation body should represent an amalgam of interests. There is a need to involve NGOs doing work related to hospital-based health care as they have the expertise and knowledge of the systems operating presently in the hospital.

*Representatives from the local and state governments*

There is a need to involve the government at the local and state government level to ensure legitimacy of the accrediting body.

We feel that once the system is functional, representatives from insurance companies, financial institutions as well as legal professionals could be included. This would further establish the creditability of the body.

STATUS AND STRUCTURE

We see the accreditation body as a non-profit, registered and autonomous entity. At a later stage, when the body has achieved stability and creditability, legislative support could be sought.

We visualise the body with a Governing Board at its helm. It would be a statutory entity entrusted with the responsibility of managing the body. It would be a final authority in decision making and an arbitrator of major issues. It would frame policies intended to develop the system and fulfil its stated objectives. Evolving a consensus would be the principle guiding all decisions. When serious differences of opinion occur, however, the majority would have to decide. The Governing Body would have to meet at least four times in a year.

The Board would comprise of nominees of representative associations and organisations as well as the government and other stakeholders. In its composition, it should allow each of the stakeholders to be equally represented. This would prevent the Board from being monopolised – and overtaken – by dominant stakeholders. The composition of the Board could be changed every two years with a fresh set of nominations. Totally, there would be 13 members. A Chairperson and a Secretary elected by this group would have tenures of two years each.

The composition of the Governing Board could be comprised of the following members:

1. One representative each from two hospital owners' associations;
2. One representative from a medical association of the area;
3. One representative each from two specialists' associations;
4. One representative from a consultants' association;
5. One representative from the nurses' association;

6. One representative each from two consumer organisations;

7. One representative each from two NGOs;

8. One representative from the local government; and

9. One representative from the state government.

Other than representatives of the hospital owners' association, none of the other nominees are associated with private hospitals.

FUNCTIONING

The main function of the body would be to assess whether hospitals comply with set standards, to assist them to upgrade their standards and to play an educative and informative role.

To carry out these functions in an efficient and effective manner, staff needs to be employed. The staff could work either full time or part time depending on the availability of finances. There would be a Director assisted in turn by four Assistant Directors in charge of handling specific aspects of functioning of the accreditation system. In other words, the four Assistant Directors would be individually responsible for the Assessment Division, the Educational Division, the Marketing and the Administration Division. The number of staff assigned to each division would be dependent on the nature of work. Each division would be responsible for the work in its own area.

This would be the constitution of the Executive Body. The Executive Body would be accountable and answerable to the Governing Board. It would be entrusted with the responsibility of implementing the decisions of the Governing Board.

*Assessment division*

This division would evaluate the compliance of hospitals. Two methods would be employed to assess compliance: self-evaluation by the participating hospital followed by an external assessment. Reconsideration of assessment findings would also be handled by this division but with a different team of assessors. Different assessment teams would assist this division. A team would consist of two post-graduate doctors, one health administrator and one health specialist. The assessors could work full time or part time, depending on the finances, but would need to undergo training in the method of assessment.

Standards with regard to physical aspects, equipment, qualification, number of personnel employed or attached, type of treatment and follow up of care would have to be assessed. The body should not only set minimum standards but also periodically review the same, considering the changing environment and the existing ground realities in which the consumer and provider co-exist.

One area of prime concern that the accreditation body should include in their assessment is consumer satisfaction. It is necessary to develop a framework or guidelines to measure consumer satisfaction in a scientific manner. The fees charged by the hospitals needs to be examined and linked to the size of the hospital and the kind of services and facilities that are available. Most importantly, the needs of the provider and consumer need to be balanced. Initially, the accreditation body could start monitoring physical standards but then gradually move on to process and outcome standards. A handbook for hospital standards, depending on the size, kind of service and facility offered should be developed. This, in turn, would assist in the process of accreditation.

*Educational division*

The accreditation body would assist hospitals to upgrade standards. They would be aided in this by a group of experts from various fields concerned with hospital management. A participating hospital wanting to upgrade its standards could avail of the services of this committee. The focus would be on educating and providing information to the interested hospitals. Furthermore, it would hold regular workshops, training sessions and seminars in fulfilment of the objectives of the accreditation body. It would also assist in disclosing the assessment findings to the public at large. Disseminating the list of accredited hospitals could be one way of doing this. This information would be educative for the providers and informative for the user.

*Marketing division*

This division would lie at the interface of the accreditation body and society. Among other things, it would be involved in public relations, advertising, consumer education and creating awareness among the stakeholders.

*Administration division*

It would be responsible for general administration, which would encompass finances, human resources, operations, documentation and legalities.

## THE ACCREDITATION PROCESS

### PRE-SURVEY

1. The hospital first submits an application to the accreditation body together with fees for survey.
2. The Assessment Division determines the appropriate standards for the participating hospital.
3. The Assessment Division provides self-evaluation schedules, forms, scoring guidelines etc. to the hospital and collects them after they have been completed by the hospital.
4. The Assessment Division analyses the self-evaluation schedules and forms filled and returned by the participating hospital.
5. The Assessment Division co-ordinates the assessment schedule and procedure or protocols to be followed. This includes setting the survey dates, assigning an assessment team, the length of the assessment and setting the survey agenda with the hospital.

### ON-SITE SURVEY

1. The assessment team gathers information by observing structures and processes in the hospital during visits to different units and departments, while on a tour of the building and by interviewing patients, the hospital owner or administrator, the clinical and support and, finally, by reviewing records and documents.
2. The team uses the information thus gathered to determine whether the hospital is complying with standards for various functions. These functions could be patient focused (for example, assessment of patients), organisation focused (for example, organisational performance improvement) or structure-and-function focused (for example, procurement of appropriate equipment and its maintenance)
3. The team identifies the areas of partial or non-compliance with standards.
4. The findings from the surveyors in the team are integrated into a single report.
5. The findings are reviewed and validated with the hospital owner or administrator.

### POST-SURVEY

1. The self-evaluation of the hospital and the findings of the assessment team are validated by comparing them to the scoring guidelines.

2. The accreditation status and the appropriate recommendations are determined through a number of stages. These are:

   2.1   The compliance findings are aggregated to generate an accreditation decision grid. This is essential as hospitals offer different kinds of facilities. Moreover, each facility would have an individual score of compliance to the set standards. If there is a high score in one facility and not in the other, the total average for that hospital would still be high. Would this then be truly reflective of the standard of that hospital? A decision grid would provide flexibility in determining the final score such that it would be as close to reality as possible.

   2.2   The level of accreditation as minimum, optimum or excellent is determined. Also, whenever necessary, recommendations are made.

   2.3   If indicated, the findings and final decision to be taken by the accreditation body is reviewed.

3. The Accreditation Report (containing the accreditation decision, accreditation decision grid and consultative recommendations) and the derived performance report (for public disclosure) are sent to the participating hospital.

4. Should a hospital challenge the accreditation findings or decision, an appeal may be sent to the assessment division.

PERIOD OF ASSESSMENT: The assessment could be done every two years.

FINANCING

During the initial period of three to five years, the accreditation body can depend on grants, but the long-term objective would be to attain self-sufficiency. Corporate houses, insurance groups and various associations could be approached for funds. The costs could also be reimbursed in part by the participating hospital, which in turn could be used for developing the system. The constitutive elements of the system, namely the representative associations or organisations, could contribute to a corpus fund. Thereafter, other incentives could gradually be offered to the participating hospital to help expand the coverage of the accreditation body.

**References**

Allsop, J. (1992), "The Voice of the User in Health Care" in E. Beck, S. Lonsdale, S. Newman and D. Patterson (Eds.) *In the Best of Health?*, London: Chapman and Hall.

BIS (Bureau of Indian Standards) (1984), *Recommendation for Basic Requirements of General Hospital Buildings. Part 1: Administrative and Hospital Services, Department Buildings*, New Delhi: BIS.

BIS (Bureau of Indian Standards) (1988), *Basic Requirements for Hospital Planning. Part 1: Upto 30 bedded Hospital*, New Delhi: BIS.

Brooks, T. (1990), *Standards and Accreditation: Quality Assurance Programme,* Kings Fund Centre for Health Service Development, Hospital Management International, International Hospital Federation, Sterling Publications:130-133.

Brooks, T. (1994), *"Quality Improvement and Organisational Audit"* in Hospital Management International, International Hospital Federation, Sterling Publications: 105-107.
CCHFA (Canadian Council on Health Facilities Accreditation) (1990), *Quality Assurance: The Future* (Outcomes Measures Project), Canada: CCHFA.

Donabedian, A. (1988), "The Quality of Care: How can it be assessed?" in *Journal of the American Medical Association*, 260 (12): 1743-1748.

Duggal, R. with S. Amin (1989), *Cost of Health Care. Survey of an Indian District*, Bombay: Foundation for Research in Community Health.

Duggal, R., S. Nandraj and A. Vadair (1995), "Health Expenditure across States – Part I" in *Economic and Political Weekly*, 30(15): 834-844, April 15.

Flynn, R. (1992), *Managed markets: consumers and producers in the National Health Service* in Burrows, R and Marsh, C (eds) Consumption and Class. Divisions and Change, Basingstoke: Macmillan
Fooks, C. and M. Rachlis (1990), *Assessing Concepts of Quality of Care: Results of a National Survey of five Self Regulating Health Professions in Canada*, CHEPA working paper series, Mc. Master University, Canada, p.90-97.

George, A., I. Shah and S. Nandraj (1993), *A Study of Household Health Expenditure in Madhya Pradesh*, Bombay: Foundation for Research in Community Health.

GOM (Government of Maharashtra) (1949), *The Bombay Nursing Home Registration Act*, Bombay: Law and Judiciary Department.

ICHSR (1997), Unhealthy Prescriptions: The need for health sector reform in India in *Informing & Reforming of the International Clearing House of Health System Reform Initiatives*, (2), April-June.

Kannan, K.P., K.R. Thankappan, V. Raman Kutty and K.P. Aravindan (1991), *Health and Development in Rural Kerala*, Thiruvananthapuram: Kerala Shastriya Sahitya Parishad

Lewis, C.E. (1984), "Hospital Accreditation" in *New Zealand Hospital*, September: 15-17.

Loeb, J. and D. O'Leary (1995), "From the Joint Commission on Accreditation of Healthcare Organisations" in *Journal of the American Medical Association*, 273(18), May 10: 1405

McCue, H. and L. Wilson (1981), "Hospital Accreditation in Australia: Evaluating Health Care" in *Medical Journal of Australia*, September 5: 221-226.

Nandraj, S. (1994), "Beyond Law and the Lord: Quality of Private Health Care" in *Economic and Political Weekly*, 29(27): 1680-1685, July 2.

Nandraj, S. and R. Duggal (1996), *Physical Standards in the Private Health Sector. A Case Study of Rural Maharashtra*, Mumbai: Centre for Enquiry into Health and Allied Themes.

NCAER (National Council of Applied Economic Research) (1992), *Household Survey of Medical Care*, New Delhi: NCAER.
NIHFW (National Institute of Health and Family Welfare) (1992), *Guidelines on Norms for Equipment for Hospitals for Different Sizes*, New Delhi: NIHFW.

Phadke, A. (1993), *The Private Health Sector*, Mumbai: Foundation for Research in Community Health.

RGI (Registrar General, India) (1984), *Census of India – 1981, Part 2, Special Series 1: Maharashtra Report and Tables based on 5% Sample*, New Delhi: Department of Home Affairs.

RGI (Registrar General, India) (1991), *District Census Handbook*, New Delhi: Ministry of Home Affairs

Roberts, J.S., J.G. Coale and R.R. Redman (1987), "A History of the Joint Commission on Accreditation of Hospitals" in *The Journal of American Medical Association*, 258(7): 936-940.

Scrivens, E. (1995), *Accreditation: Protecting the Professional or the Consumer?* Buckingham: Open University Press.

The Accreditor (Newsletter) (1993), "Funding for Accredited Hospitals in Victoria" in *The Australian Council on Healthcare Standards*, Winter: 1.

The Australian Council on Hospital Standards (ACHS) (1978), *The Accreditation Guide for Australian Hospitals and Extended Care Facilities*, Sydney: ACHS.

The Week (1992), "Deadly Deceit" in *The Week*, January 5

Tulsidhar, V.B (1993), *Structural Adjustment Programme: Its Impact on the health sector* , New Delhi: National Institute of Public Finance & Policy

WHO (World Health Organisation) (1993), *The Contemporary Use of Standards in Health Care*, Division of Strengthening of Health Services, District Health System.