

# Accreditation of hospitals in Lebanon: a challenging experience

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**ABSTRACT** The quality of hospital care in Lebanon has witnessed a paradigm shift since May 2000, from a traditional focus on physical structure and equipment to a broader multidimensional approach, emphasizing managerial processes, performance and output indicators. In the absence of an effective consumer voice, the impetus for change has come from the Ministry of Public Health, which has supported the development of an accreditation programme for hospitals. This paper describes and analyses the experience of Lebanon in introducing this programme. It looks at the application of normative measures on private institutions that have been used to operating in a loosely controlled environment with little accountability.

## **L'accréditation des hôpitaux au Liban : un véritable défi**

**RÉSUMÉ** Au Liban, la qualité des soins hospitaliers a connu depuis mai 2000 un changement de paradigme. En effet, à l'attachement traditionnel aux structures et équipements physiques a succédé une vision pluridimensionnelle plus large qui met l'accent sur les processus gestionnaires et les indicateurs de performance et de résultats. En l'absence d'une représentation active des consommateurs, l'élan du changement a été insufflé par le ministère de la Santé publique qui a soutenu la mise en place d'un programme d'accréditation des établissements hospitaliers. Cet article décrit et analyse l'expérience du Liban dans l'introduction de ce programme. Les auteurs examinent l'application de mesures normatives aux établissements privés qui opéraient auparavant dans un environnement caractérisé par l'absence de contrôle strict et le plus grand flou en matière de responsabilité.

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## Introduction

Advances in technology are putting health systems under constant pressure. Ensuring equitable access to modern and quality-assured medical services remains the most arduous challenge in view of the scarcity of resources.

Developed countries have a growing experience in pursuing accreditation as a tool to improve quality, whereas developing countries are still striving to introduce this concept and adapt it to their particular situations [1]. Some basic principles for a health services accreditation system have been founded at the international level. First, it is voluntary; second, standards are clearly defined; third, compliance is assessed by periodic external review by health professionals; and fourth, the outcome of the review denotes compliance (yes/no, rating scale) [2]. In addition, accreditation is awarded for a time-limited period, and the whole process is generally independent of the financing system. Besides its basic purpose of assessing hospitals' compliance with standards, a hospital accreditation programme may play an educative, consultative and informative role, and provides a platform for continued dialogue among various stakeholders [3].

## Health care delivery in Lebanon

In Lebanon, private hospitals are traditionally owned by physicians, charitable and religious organizations, and universities. The business community has now become involved by taking shareholdings in existing hospitals or investing in new ones. This development in hospital ownership has led to further growth of the hospital sector in an unregulated manner, which has worsened the oversupply of services and thus induced a greater demand and use of these services.

The situation is further complicated by an oversupply of physicians who have significantly different backgrounds because of the many different countries of training. In the absence of nationally adopted clinical protocols, this has led to differences in medical treatment provided, and this is compounded by the lack of transparent policies and procedures at the administrative, financial and clinical levels. The functioning of private hospitals is determined largely by a supply-driven market situation, with the Ministry of Public Health (MOPH) having limited capability to control either the proliferation of medical technology or its proper use.

The financing role of the MOPH in covering the uninsured (almost half of the population) through contracting with private hospitals without any objective selection criteria has had a negative impact on both the cost and quality of hospital care.

Lebanese entrepreneurs have always enjoyed the freedom to transact business in a deregulated environment with limited government control. The provision of hospital services is seen as a private enterprise activity, and profit is pursued without enough concern for the quality of the services provided or client satisfaction. Contracting with the MOPH and other financing agencies is vital for hospitals and they use all means to secure such contracts, including social and political pressure.

Hospital accreditation is considered one of the mechanisms that could reorient private providers' behaviour in a climate of market failure aggravated by political interference in health financing. Even though private hospitals and professional associations are resourceful and capable of driving the accreditation process, thus following the example of their peers in other developed countries, they have been reluctant to take this step despite its potential benefits. Therefore, the MOPH took the initiative

to instigate the accreditation process as part of its normative and regulatory role in supporting, financing and supervising the whole process.

The MOPH has thus become part of an international trend of the last 5 years for governments to intervene increasingly in funding, or even managing directly, accreditation programmes in order to establish an additional tool for regulation and public accountability [2].

### **Accreditation legislative framework and historical background**

The introduction of an accreditation system in Lebanon has been possible on the basis of the 1962 legislation [4] amended in 1983 [5], which set the legal framework for the MOPH to regulate the Lebanese hospital sector. Article 7 of the amendment decree specifically states, “the MOPH has the right to evaluate, classify and accredit hospitals according to their status, field of specialty and range of services provided”. The law sets a Committee for Evaluation Classification and Accreditation of Hospitals chaired by the Director-General of Health and including high-level representatives of the MOPH, the Syndicate of Private Hospitals, the Order of Physicians, the Army Medical Scheme, the National Social Security Fund, and the University Medical Centres. This law stipulates that the Committee can seek the assistance of external expertise and that accreditation results should be tied to contractual agreements with hospitals. Thus, although accreditation is not compulsory, it can be considered as a prerequisite for a hospital to be eligible for contracting with the MOPH and other public purchasers.

The original classification system for hospitals based on the 1983 decree was an

alpha–star system. The alpha rating reflected the level of medical services: the greater the quantity and complexity of clinical services offered, the better the alpha rating classification. The star classification reflected the level of hotel services provided by the hospital. In the alpha system, any hospital failing to fit in classes A, B, C or D came into class E. Consequently, no hospital was declared unclassified or failed. It is worth mentioning that the tariffs of medical services were set by the MOPH according to the hospital class. This system provided a strong financial incentive for hospitals to invest in sophisticated equipment and to venture into high-tech services without rational planning.

In 1999, the MOPH took a strategic decision to introduce a new accreditation system based on international references. This was possible under the prevailing legislation and it started by the formation of a new committee representing all stakeholders. The committee was able to develop a modern accreditation programme by adopting standards set by an international consultancy firm and made official by ministerial decrees [6,7]. The committee was also entitled to validate the accreditation results presented by the consultants and to decide on the accreditation awards. The multi-representative nature of the committee allowed for the involvement of the major stakeholders and full collaboration of hospitals with the survey teams.

### **The new accreditation system**

The introduction of a hospital accreditation system aimed at creating incentives for continuous quality improvement by developing an external evaluation system based on the scientific process. Particular emphasis was put on patient and staff safety, reporting

data of morbidity, mortality, utilization and workload, as well as infection control mechanisms and patient advocacy. The final evaluation would lead to the formulation of explicit recommendations and quality action plans [8].

The implementation of the accreditation system in Lebanon was divided into 4 phases: developing and testing standards and procedures, conducting the first national survey, conducting a follow-up audit through a second survey, and revising standards and conducting a third national survey.

### **Developing and testing standards and procedures**

#### *Developing standards*

In May 2000, and following an international bidding process, an Australian consultancy team was contracted to set accreditation standards and develop guideline manuals for hospitals in Lebanon. The Health Sector Rehabilitation Project, financed by the World Bank, supported and supervised the project.

A two-tiered system of standards was developed: basic standards to compensate for the lack of basic requirements for licensing in legislation, and accreditation standards, based on the principles of total quality management. The basic standards were viewed as minimum standards to provide a safe environment of health care delivery for patients and staff, with special emphasis on infrastructure, waste disposal, electrical and biomedical equipment and fire safety among others. The accreditation standards were designed to test the ability of hospitals to provide quality care to patients, and to set up information systems assisting management in the planning and provision of services [8].

In developing these standards, an extensive search of the published literature

on accreditation in health care took place to learn from the international experience, particularly in the United States of America (USA), Canada, Australia, Ireland, New Zealand, France and the United Kingdom. At the same time the situation in Lebanon was assessed with regard to its adaptability to international accreditation concepts, and the ability of the Lebanese hospitals to comply with the new system.

In setting standards, the MOPH sought consensus among different stakeholders. The consultants produced guideline manuals to further explain the standards and provide hospitals with an additional tool to help them understand the process. Standards and guidelines were developed in English with an Arabic translation.

#### *Pilot testing*

Six hospitals participated in the pilot-testing phase. Their selection took into account geographical distribution, size, profit and non-profit mix and public/private status. Each surveyed hospital was requested to identify a staff member from every department to attend an information session about the accreditation process and standards at the beginning of every visit. One of the consultants, in collaboration with the departmental representative, determined whether the department met each standard.

At the end of the pilot survey, surveyors presented a short verbal summary of the results of the survey to hospital senior managers and staff. Each hospital representative was asked to evaluate the process and standards, using a short 10-point questionnaire.

#### *Survey procedures and scoring*

Conducting the accreditation survey required a multidisciplinary team. Using a standardized survey toolkit, each team member used his/her expert judgement to ask questions and to examine whatever was

considered necessary to achieve a fair and reasonable assessment of the hospital. The survey was carried out in a professional manner respecting confidentiality.

Suggestions made by the survey team were presented in an educative, non-threatening way. During, and at the end of the survey visit, those conducting the survey met to discuss findings and to determine the major points to be stressed. A positive approach was sought in a feedback session, in order to encourage and praise any work that had achieved good outcomes.

Learning was considered as an integral part of the accreditation process. This was done through a lengthy auditing visit, as well as through a full report with a detailed assessment. For each department, the report highlighted strengths and opportunities for improvement with reference to the corresponding standards. Copies of each of these reports were provided to the MOPH. The report included a scoring system designed as follows:

- For basic standards: yes (1 point), no (0 points), not applicable (not scored)
- For accreditation standards: yes (1 point), needs improvement (0.5 point), no (0 points), not applicable (not scored).

Each department was scored separately for the basic and accreditation standards, and an overall percentage score for the hospital was also recorded [9]. The MOPH defined the passing mark as a combined score (all departments) of 80% for the basic and 60% for accreditation standard.

### **First national survey**

The consultancy team started the first national hospital survey on 18 September 2001 and finished it on 1 July 2002. The total number of eligible hospitals was estimated at 178. During the survey, a number of hospitals were declared closed for major

renovations or declined to participate. Thus 128 hospitals throughout Lebanon were included and each was audited by one of the two teams of surveyors. The consultants spent 2–3 days in each hospital depending on the size of the hospital.

Hospitals were advised ahead of the survey date and were provided with a proposed schedule for the duration of the visit. Each hospital was given the opportunity to attend a seminar a month before the beginning of the survey on the aims and objectives of the accreditation, and was provided with copies of standards and guidelines, which had been prepared and made official a year before the survey. Upon arriving to the hospital, the team leader presented a brief overview of the project, and members of the team introduced themselves and gave a brief outline of their professional expertise.

As the survey progressed, some hospitals hired private consultants to assist them in complying with the standards, such as writing policies and procedures. At the end of the first survey, 47 hospitals out of 128 surveyed (37%) were awarded accreditation. Accreditation was given for 3 years and these hospitals were followed up in the third survey.

As expected, small hospitals with 100 beds and fewer, which accounted for the majority of hospitals in Lebanon, were generally operating below standard. Hospitals with a 101- to 200-bed capacity achieved a somewhat better average score than larger hospitals with more than 200 beds (Figure 1) [10].

The ownership type had an impact on how well the hospital management was able to meet requirements, as shown in Figure 2. It is worth mentioning that only 2 autonomous public hospitals were included in the survey and both achieved a relatively good score.

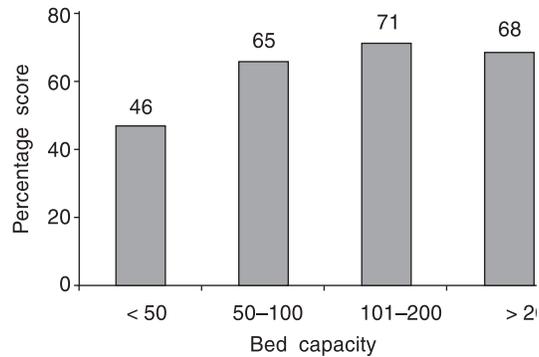


Figure 1 Score average by hospital bed capacity

### Follow-up audit through a second survey

The follow-up audit started in October 2002 and ended in June 2003. It included the upper half of hospitals that did not meet the 60% and 80% requirement in the first survey, as well as new hospitals that were not included in the first survey. It also gave the MOPH the opportunity to further review and validate the standards. A total of 45 hospitals were surveyed, including 4 of the 6 hospitals included in the pilot survey (the

remaining 2 were being rehabilitated) and 8 new ones. Of these, 39 hospitals (87%) passed the accreditation.

Results were given to each hospital separately and were not made available to the public. Some hospitals, however, published their results in the newspapers for marketing purposes. This has prompted the MOPH to change the new accreditation system into a system of awards, with no scores attached, to avoid any future misinterpretation or perverse use of results in the media.

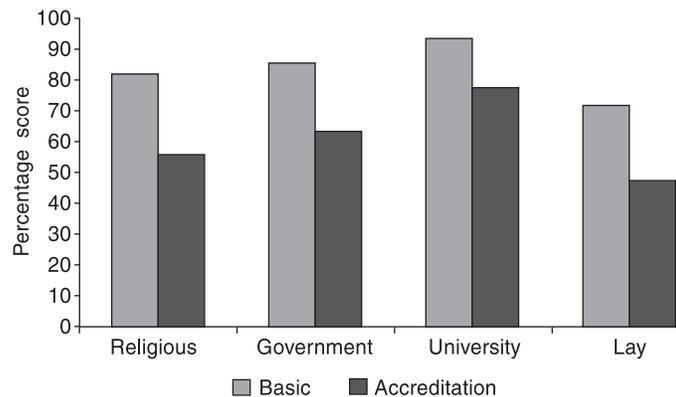


Figure 2 Basic and accreditation scores by type of ownership

### Revision of standards and the third national survey

The original standards and concomitant scoring system emphasized the existence of documentation (mostly of policies and procedures) but did not require thorough assessment of its content, and proper implementation was not evaluated for all written policies and procedures nor was the measurement of expected outcomes. It became imperative, therefore, for the revised standards to be written in such a way that hospitals are required to provide evidence that policies and procedures are appropriate and are actually put into practice to improve quality. Standards have been written in a more direct manner specifically to avoid any misinterpretation [11]. In addition, specific standards have been produced for 5 additional specialty areas: chemotherapy, renal dialysis, psychiatry, cardiac catheterization and intensive care units.

For the third national survey (2004–05), the revised standards were scored differently, some remaining with unitary scoring and others with variable weights allocated. Weight allocations took into account areas of concern identified in the previous surveys, such as documentation, infection control, clinical nursing, blood bank, biomedical services, staffing, laundry, paediatric services and central sterilizing department. These areas were highly weighted in order to encourage urgently needed reforms. In addition, “not applicable” ratings for unavailable services no longer existed because it put advanced hospitals at a disadvantage during the first 2 surveys. The removal of the “non-applicable” rating allowed a more consistent scoring method across all hospitals because it prevented hospitals from concealing departments on the day of the survey, thus helping their total score, as had happened on several occasions during the first 2 surveys. Moreover, the intention to

tie accreditation with payment implied that results should reflect not only the quality, but also the complexity of services provided by the hospital.

For the third survey, accreditation was awarded differentially in 4 bands depending on the hospital score. Every department had a different passing score depending on the band in which the hospital belonged. Once a hospital was assigned to a certain band, the score became of no importance in differentiating hospitals within the same band and results were declared as follows:

- Accreditation—awarded for 3 years in the band corresponding to the hospital’s score, if the hospital did not fail more than 3 departments in its band.
- Accreditation—awarded for 18 months, if the hospital failed more than 3 departments in its band.
- Partial accreditation—awarded for 12 months, if the hospital score fell no more than 2% below the band passing score, and did not fail more than 3 departments.
- Fail—accreditation not awarded, if the hospital’s global aggregate score did not reach the threshold of the lowest band.

The third round of hospital survey launched in October 2004 included 144 hospitals, 85 (58.6%) of which were awarded accreditation [12] (Table 1).

### Lebanese particularities and challenges

#### Quality management

The old classification system focused on physical structure and equipment with no consideration to staff competencies [Jencks SF. Unpublished consultation, 1999]. Tariffs set according to the hospital class provided financial incentives for purchasing

**Table 1 Comparison of the third accreditation survey results with the old classification system**

Hospital class/ band	Old classification system		Third accreditation survey	
	No.	%	No.	%
A	32	25.4	15	10.4
B	34	27.0	8	5.6
C	24	19.0	36	25.0
D	19	15.1	26	18.1
E	17	13.5	—	—
Failed	0	0	59	41.0
Total	126	100.0	144	100.0

sophisticated equipment often without conducting feasibility studies or developing business plans. This led to an increase in the use of new technology and hence an increase in the overall hospitalization cost.

The old classification system promoted the belief that unless a hospital provided “the full options”—that is a complete range of the latest sophisticated medical technology—then it was not considered to be a good hospital. Little attention was paid to whether market opportunities warranted a wide range of equipment or indeed whether the hospital could afford the necessary qualified staff to operate such equipment safely and efficiently.

In addition to the perverse incentives generated by this system, it induced opportunistic behaviour by hospitals; some made exceptional, on-the-spot effort specifically for the survey visit in order to obtain a higher classification [13]. The audit tool and procedures of the system were unable to uncover such inconsistent adherence to a continuous quality improvement plan.

Provision of good quality medical services has been based on the assumption that this required impressive equipment and leading physicians because health care

managers lacked the knowledge and tools for objective measurement and evaluation of quality [3]. However, some hospitals were working towards achieving ISO certification, which was a good exercise that provided building blocks for a quality management system, but did not provide enough experience for a system of health care quality.

In the original standards (set by the consultants after deliberation with all stakeholders), emphasis was put on organizational aspects and staff qualification and skills. Written policies and procedures deemed necessary for all areas of work, and more specific information, were required. Data collection on utilization and workload was introduced to assist with planning.

The revised standards aimed at ensuring that: the written policies and procedures were properly applied and led to measurable outcomes, collected data were analysed to monitor management functions as well as clinical care, and information was used to improve quality. New concepts were also introduced such as performance appraisals and competency testing for all staff to encourage the creation of a new culture in hospital management and quality assurance [11].

The evolution from the rating system of the first 2 surveys into a system of awards was intended to avoid misconceptions and to discourage opportunistic marketing [14]. Most of the revised standards require long-term implementation, and compliance necessitates continuous quality improvement efforts. On the other hand, the audit methodology allows, to a large extent, for the detection of emerging performance. However, the accreditation programme still needs further development in order to direct the system towards promoting deep-rooted quality practice.

The transition from the old classification to the last version of standards was smooth and progressive. No legislation had to be amended and requirements were planned to be incremental and feasible for most hospitals. Nevertheless, complying with the last version of standards necessitated a high level of commitment. The majority of hospitals responded to the challenge and made an exceptional effort, including some of those that failed but are expected to receive the accreditation award in the next survey, provided they do not lose their resolve to make the necessary effort.

Some hospitals, however, misconstrued the whole concept by comparing their scores to the scores of other hospitals, taking the outcome personally, and by focusing on the financial consequences. It is of prime importance for MOPH officials to reorient the debate and focus only on quality improvement, which is the main purpose of the whole exercise. Payment issues should be addressed separately so as not to jeopardize the accreditation programme, and it should be well understood that the only useful comparison for a hospital is with itself, and assessment of its own progress over time.

Over the next few years, it is expected that the standards will be continually refined so that they become measures of an

integrated organizational system. It would be unrealistic, and in fact detrimental to the success of the accreditation process, to have aimed for too high a standard at the instigation of the accreditation process [9].

### Health system

International experience shows that a “prescriptive blueprint approach” is inappropriate for an accreditation programme. Each health system should be viewed within the social, economic, cultural and political context of the country [3]. However, despite the widespread interest in exploring the potential of accreditation for promoting quality health care in middle- and low-income countries, there is little published guidance on how this can be done [15]. The issue becomes more complicated in a pluralistic multicultural and multireligious country like Lebanon, with a poor history of normative government interventions.

In addition to the historical development of its health system, Lebanon has benefited from the experience of other countries where governments became a prime user of accreditation [16] or even had a proactive role in quality assurance with direct regulatory implications [17]. The MOPH has developed the accreditation programme as part of its efforts to strengthen its regulation capabilities and attain better value for money in terms of hospital care financing. However, accreditation was intentionally presented as an activity independent of the government and other stakeholders. The neutral international expertise was sought to foster elements of objectivity and probity among hospitals that embraced this process and collaborated with the various audit teams all through the different phases up to the announcement of the third survey results.

The reconstitution of the accreditation committee, at the beginning of the accredita-

tion process, has been a very useful platform for dialogue between the key stakeholders. This was critical for convincing private hospitals that accreditation is needed for future development to allow Lebanon to become once more a centre of excellence for medical care in the Middle East. Actually, the hospital sector is taking advantage of this system to market itself by creating a new image thus attracting clients from abroad and regaining its historical role.

The Lebanese experience has many strengths, which include: the representation of major stakeholders in the supervising committee and their active involvement in the whole process; the large consultation sought for standards development; and the stepwise approach and transition from the old classification system to a new one. The neutral, independent and considerate international expertise was also critical for success in this diversified country. However, major problems were also encountered. Some were anticipated, such as the financial impact of the third survey threatening the survival of hospitals not awarded accreditation, but others were unexpected, such as the severe reaction to the unintended publication of the results in the media.

Voluntary participation in accreditation is considered a critical element for success in developed countries as it reflects the willingness and commitment to quality improvement [18]. This is a debatable issue in Lebanon for 2 reasons. The first is cultural and related to the strong belief that the hospital image depends mostly on its physical structure, the sophistication of its equipment, and the qualifications of its physicians. The second is the weak role of the consumer, who is often uninformed or even misled, which deprives the system of an important driving force towards better quality.

On the other hand, linking hospital classification with both the contracting and the payment system, which is based on 1983 legislation, has influenced the development of the hospital sector. The issue of abolishing this link has to be tackled with the greatest caution as it necessitates a lengthy legislative amendment, and could deprive the system of a powerful leverage for reform. It is particularly risky to remove financial incentives in the absence of an inherent culture of quality improvement and where the consumer is powerless.

## Conclusion

The evolutionary path of the Lebanese accreditation experience has followed roughly the largely "top down" quality health care movement as described by Donabedian, by focusing initially on structures and processes and involving outcomes later on [19].

The development of the accreditation process came as a result of a visionary strategy by MOPH officials that facilitated the introduction of accreditation by ensuring a general consensus and acceptance of the process by all key stakeholders. In most countries, the linkage between accreditation and contracts has taken a number of years to develop [20]. Even though the MOPH was reserved about the impact of accreditation on contracting and reimbursement, enthusiasm for accreditation was boosted by the hospitals' interest in contracting with the MOPH and other public funds and getting a better payment. Indeed, this very issue lies behind an aggressive religious- and politically-mediated campaign against the programme carried out by some disadvantaged hospitals which seriously challenged the political commitment to accreditation.

Achieving accreditation does not guarantee that care is optimal. At such an early

phase of the accreditation process in Lebanon the focus has been on establishing a framework and foundation for consistent quality practice. However, the introduction of outcome indicators over the coming years will reflect more directly the quality of hospital care delivery.

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

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