International Journal for Quality in Health Care Advance Access published February 13, 2013

Profiling health-care accreditation organizations: an international survey

CHARLES D. SHAW[1], JEFFREY BRAITHWAITE[1], MAX MOLDOVAN[1], WENDY NICKLIN[2], ILEANA GRGIC[2], TRIONA FORTUNE[3] AND STUART WHITTAKER[4]

[1]Centre for Clinical Governance Research, Faculty of Medicine, University of New South Wales, 2052 Sydney, New South Wales, Australia, [2]Accreditation Canada, 1150 Cyrville Road, K1J 7S9 Ottawa, Ontario, Canada, [3]The International Society for Quality in Health Care, Joyce House, 8-11 Lombard Street East, Dublin 2, Ireland and [4]The Council for Health Service Accreditation of Southern Africa, PO Box 676, Howard Place, 7450 Cape Town, South Africa

Address reprint requests to: Charles Shaw, 1 St Nicholas, Houghton, BN189LW Arundel, UK. Tel: +44-1-79-88-31-884; E-mail: cdshaw@btinternet.com

Accepted for publication 12 January 2013

Abstract

Objective. To describe global patterns among health-care accreditation organizations (AOs) and to identify determinants of sustainability and opportunities for improvement.

Design. Web-based questionnaire survey.

Participants. Organizations offering accreditation services nationally or internationally to health-care provider institutions or networks at primary, secondary or tertiary level in 2010.

Main Outcome Measure(s). External relationships, scope and activity public information.

Results. Forty-four AOs submitted data, compared with 33 in a survey 10 years earlier. Of the 30 AOs that reported survey activity in 2000 and 2010, 16 are still active and stable or growing. New and old programmes are increasingly linked to public funding and regulation.

Conclusions. While the number of health-care AOs continues to grow, many fail to thrive. Successful organizations tend to complement mechanisms of regulation, health-care funding or governmental commitment to quality and health-care improvement that offer a supportive environment. Principal challenges include unstable business (e.g. limited market, low uptake) and unstable politics. Many organizations make only limited information available to patients and the public about standards, procedures or results.

Keywords: institutional regulation, certification, accreditation, health-care standards, public information, cross-border care

Introduction

Health-care accreditation is often adopted, in widely differing settings, as a mechanism for service improvement or as a vehicle for health reform. There is limited evidence of the impact of accreditation [1–5], although in developing countries there are indications that facilities with initial low levels of standards adherence significantly improve their levels of compliance as a result of participating in accreditation programmes supported by quality improvement interventions [6]. Comparative descriptions of accreditation organizations (AOs) are scarce. Several surveys have tracked AOs in Europe since 2000 [7–9], but there has been no comparable global picture because WHO commissioned the International Society for Quality in Health Care (ISQua) to review accreditation activity in 1999 [10].

This survey, initiated in 2009 and executed in 2010, aimed to describe global patterns and characteristics of health-care AOs, identify factors that are associated with development and sustainability and raise issues for consideration by accreditation agencies, regulators and funding agencies to which they may relate nationally. It brings our knowledge of global developments up to date. More broadly, the survey aimed to identify opportunities for sharing knowledge, experience and collaboration between AOs in service design and delivery, and with the international and bilateral aid organizations that invest widely in new programmes.

Methods

Project structure and governance

A reference group (see contributors) nominated by ISQua's International Accreditation Program (IAP) approved the project proposal in 2009. It was coordinated by the first author. Primary data collection was managed by Accreditation

Canada; the resulting database was transferred to the University of New South Wales (UNSW), Australia for validation and analysis in November 2010.

Inclusion and exclusion criteria

The organizations included offered external assessment against published standards, formally recognized institutional compliance with those standards (accreditation) and were available nation wide (or internationally) to health-care provider institutions or networks at primary, secondary or tertiary level. Excluded organizations were those limited to sub-national regions or provinces; restricted to individual clinical specialties, departments, programmes or functions; or primarily with a focus on training or continuing education.

Questionnaire design

The questionnaire was modified from previous European surveys and adapted to capture the range of programmes provided by the larger national and international organizations. It consisted of 165 unique questions requiring text, categorical or numeric answers relating to policy and governance, development, funding, training and facilitation, report management, scope of services and activities in hospital and primary care.

Recruitment and data management

Test e-mails were sent in December 2009 by Accreditation Canada to 61 organizations identified from previous surveys, IAP records and personal contacts. These messages asked contacts to verify e-mail addresses for communication, confirm access to Internet and to name the director to whom formal invitations should be issued to participate in the survey. Responses were invited in January 2010 to an address that generated a password and gave instructions on accessing the website to complete the questionnaire in English. After repeated individual reminders, initial data collection closed in July 2010.

Excel tables detailing individual responses from all 44 responding organizations were circulated in September 2010 for verification before summary presentation at the ISQua conference in Paris 2010. The database was then transferred from Accreditation Canada to UNSW for further validation and gap analysis; revised responses were circulated again in April 2011. The data were cleaned and validated, and problems resolved. More detailed results were presented at the ISQua conference in Hong Kong in September 2011 following which the final tables were provided to every participating organization.

Results

Response rate

Of the 61 organizations initially approached to take part in the survey, 44 responded (Appendix Table A1). No data were received from eight organizations that had existed in 2000; with the exception of Indonesia and Brazil CBA that continue to operate, these organizations are now assumed to be inactive or have changed their role.

Growth and development of AOs

New AOs. Starting with the Joint Commission in 1951, followed soon by the Canadian Council on Hospital Accreditation, most early AOs were independent of government. Governmental accreditation [managed within a ministry of health (MoH) or a government agency] grew rapidly from the mid-1990s. By 2010, the 44 AOs were divided roughly equally among government, independent and mixed models (typically, independent but with formal representation on the governing body) (Fig. 1).

Development of existing organizations. Of the 33 organizations that were identified in 2000 and were eligible for inclusion in the 2010 survey, 16 were well established (based on accreditation survey activity) 10 years later (Table 1); 14 were inactive, or reported little or no growth.

The environment of accreditation

Socioeconomic and political climate. The 44 AOs responding in 2010 operate in 38 different countries with diverse socioeconomic and political settings. In terms of economic prosperity, the purchasing power parity adjusted gross domestic product per capita ranges from as low as US$2200 in Kyrgyzstan to US$46 860 in the USA [11]. The population sizes range from over 1.20 billion in India to 2.8 million in Mongolia (August 2011). The political settings differ by country, largely influenced by historical legacy and contemporary legislative and structural arrangements.

Legislation for accreditation. Two-thirds of AOs (29 out of 44) were formally authorised by national legislation, official decree, or both. Where health care is devolved to provincial or state governments, legislation may exist at sub-national level (e.g. Canada, Argentina). Apart from USA Joint Commission International (USA JCI), AOs reporting no legislative basis included: Australia, Czech Republic, Denmark, England, Germany, India, Japan, Jordan, Malaysia, South Africa, Spain and the Netherlands.

Government strategy for accreditation. Government strategies tend to be associated with legislation; 36 AOs reported supportive government policies at national or regional level. Nine of these national policies were specific to health-care accreditation. Over a third (16 AOs) reported a national strategy for quality and safety. No supportive policy was reported from Brazil, Czech Republic, England, Germany and Jordan.

Incentives for participation. Although 'quality improvement' was the most frequently stated motivator (cited by 36AOs, 81.8%), this was accelerated by commercial carrots (marketing 50%, preferential funding 40.9% medical tourism 27.3%) and regulatory sticks (government policy 52.3%, legislation 34.1% and reduced inspection 11.4%). AOs that may ease the burden of statutory inspection on health-care

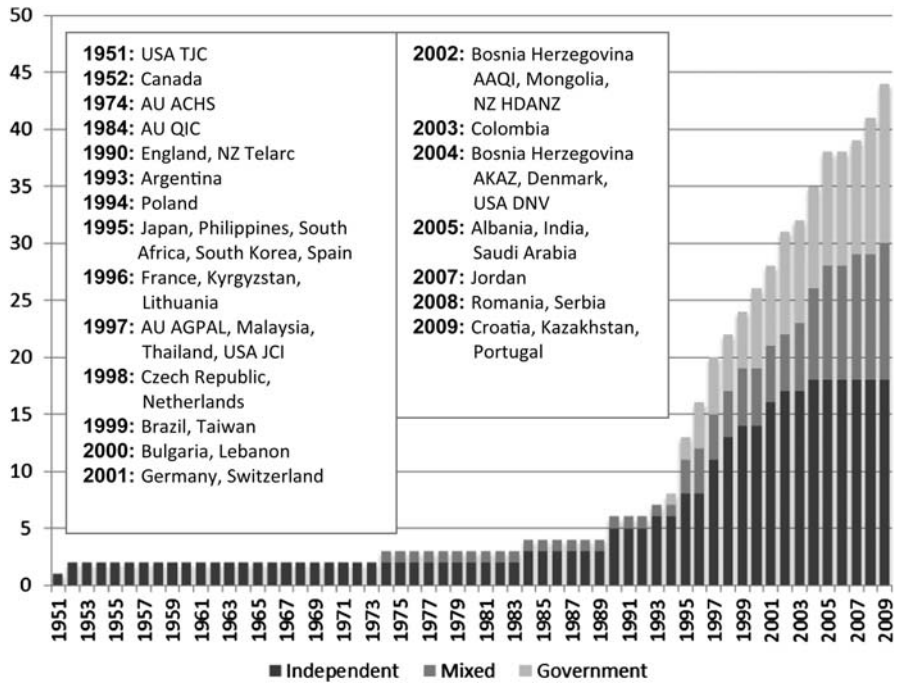

Figure 1 Global growth of AOs 1951–2009.

Table 1 Accreditation activity of 33 organizations 1999–2009

Status	Organisations	*n*
Inactive	Ireland, Lithuania, Portugal, Slovak Republic, UK (HAP), Zambia	6
Little or slow growth	Argentina, Bosnia (AAQI, AKAZ), Finland, NZ Telarc, Spain, Switzerland, UK (HQS, now CHKS)	8
Activity stable, growing	Australia (ACHS, AGPAL, QIC), Canada, Czech Republic, France, Germany, Japan, Malaysia, Mongolia, the Netherlands, Poland, South Africa, South Korea, Taiwan, Thailand	16
No accreditation survey data 2009	Brazil CBA, Colombia, Indonesia	3

providers include Brazil (IQG), Kazakhstan, New Zealand (HDANZ), the Netherlands and USA (The Joint Commission).

Relationship with certification. Two-thirds of AOs have no relationship with a 'national accreditation body' [NAB within the International Organisation for Standardisation (ISO) system). Four health-care AOs reported a formal relationship: two (Colombia and India) are owned and operated by the NAB itself. The CHKS in the England is accredited by the UK Accreditation Service as competent to certify health-care providers under ISO 9001. Switzerland's programme is close to the ISO model. Albania, Canada, Philippines and South Korea (and JCI) responded as 'not applicable'.

The management of accreditation

Governance and stakeholder representation. Clinicians, largely doctors, continue to be the dominant presence on governing bodies of AOs. Only South Korea includes representation of indemnity insurers; just under one half of governing bodies include health-care regulators and hospital owners; less than one-third include health-care insurers and patients and families (Table 2).

Customer base. Of the 44 respondents, all except 2 served both the public and private sectors; 34 provided services to hospitals and 20 to primary health care (PHC). More than 40.9% (18) of the AOs that provide accreditation services to hospitals also provide for PHC; five provide for PHC, but not hospitals. Other programmes included nursing homes, screening and diagnostic services, preventive health and traditional medicine.

International operations. Most AOs (25 out of 43) offered no services across borders, but others provided accreditation surveys to HCOs (12) or technical assistance to develop a national programme (9). International accreditation of health-care organizations (HCOs) was dominated by USA JCI, Australia's ACHS and Accreditation Canada (Table 3), but several other AOs support other countries that are linked by proximity, culture or language.

Table 2 What stakeholders are represented on the governing body?

Stakeholders	Number of AOs	Percentage of AOs
Indemnity insurers	1	2.3
Patients, families	12	27.3
Other industrial associations	12	27.3
Health-care insurers	13	29.5
Hospital owners	19	43.2
Regulators	19	43.2
Academic/training institutions	20	45.5
Clinical professionals	32	72.7

Table 3 International hospital accreditation

Organization	Hospitals accredited
Australia ACHS	25 in India, Dubai, Bahrain and Hong Kong
Canada	19 in Anguilla, Bermuda, Brazil, Italy, Kuwait, Saudi Arabia
Germany	7 in Austria
JCI	253 in 36 countries
USA DNV	4 in Brazil, India
USA TJC	US Military Hospitals in Germany, South Korea, Japan, Italy, Spain, England, Iceland
South Africa	1 in Botswana

Involvement of AOs. Most AOs developed their own standards for accreditation (34 out of 38 hospital, 20 out of 22 PHC) either directly or in partnership with external experts. Most (30 out of 44) provided coaching and facilitation to assist HCOs to meet accreditation standards. For others, help was provided by a private company or non-government organization (NGO), or by the MoH or public institute.

Most (32 out of 44) make final award decisions through an internal assessment panel and 6 out of 44 through an external panel. Where accreditation gives access to public funding, the final decision may be made by the MoH.

Activity levels. Four of the 5 AOs reporting fewer than 10 full hospital surveys in 2009 were established at least 10 years ago; 7 reported 275 or more surveys in 2009 (Australia ACHS, Accreditation Canada, Brazil, Japan, France, Philippines, and USA Joint Commission) (Figs 2 and 3)

Impact of services

Saturation. Although several AOs were unable to identify how many hospitals were eligible for their accreditation programme, 27 reported the proportion of participating hospitals. Fig. 4 indicates the proportion of hospitals participating in accreditation programmes, rather than the proportion that meet accreditation standards. The highest uptake was among governmental regulatory programmes, many of which described all participating HCOs as accredited even before the programme was active. Non-governmental programmes have taken much longer to achieve the saturation levels of USA TJC (86.9%), Australia ACHS (67.9%) and NZ Telarc (66.7%). In Europe, some relatively new voluntary AOs are nearing or exceeding 20% coverage, notably Czech Republic, Germany and the Netherlands (the latter exceeded 50%)—and continuing to grow.

Public information. Most AOs made information publicly accessible on an open website: about accreditation standards 33 (75.0%), assessment procedures 29 (65.9%), scoring rules 24 (54.5%) and criteria for awards 19 (43.2%). Six (13.6%) did not publish accreditation results of named HCOs. Most gave public information in various degrees of detail: status only 14 (31.8%), status and date certificate expired 13 (29.5%), summary report 6 (13.6%) and full report 4 (9.1%). A proportion of AOs do not name HCOs that have been denied accreditation, or had it removed.

Some two-thirds (28) of accreditation websites were in their local language (including English), 14 (31.8%) were in local language and a second language (usually English). The USA JCI website is in English, Spanish, Italian, Brazilian Portuguese, Simplified Chinese and Arabic.

International standardization

A minority of AOs reported that their current hospital standards include and refer specifically to external guidance such as from WHO 17 (38.6%) or the ISQua principles for standards 16 (36.4%). Five PHC organizations (11.4%) had been accredited by ISQua and 15 hospital AOs (34.1%).

Discussion

Until this study, the only data we had were over 10 years old; now, we have an updated profile of international developments in accreditation. From this survey, and the survey of 2000, it is evident that new AOs continue to appear, averaging two per year since 2000, but only half of them are likely to be thriving 10 years later. Of the 14 AOs that have ceased or were least developed since 2000, 6 were started with government support (until policy changed) and 6 were independent but unable to engage the potential market. Both new and old programmes are increasingly linked to health-care funding, or to an escalating governmental focus on quality health care, or to health system regulation or all three, although some of the older accrediting bodies continue to rely on generating income from the services they deliver. The analysis that follows aims to characterize the use of accreditation as a vehicle for organizational development on the one

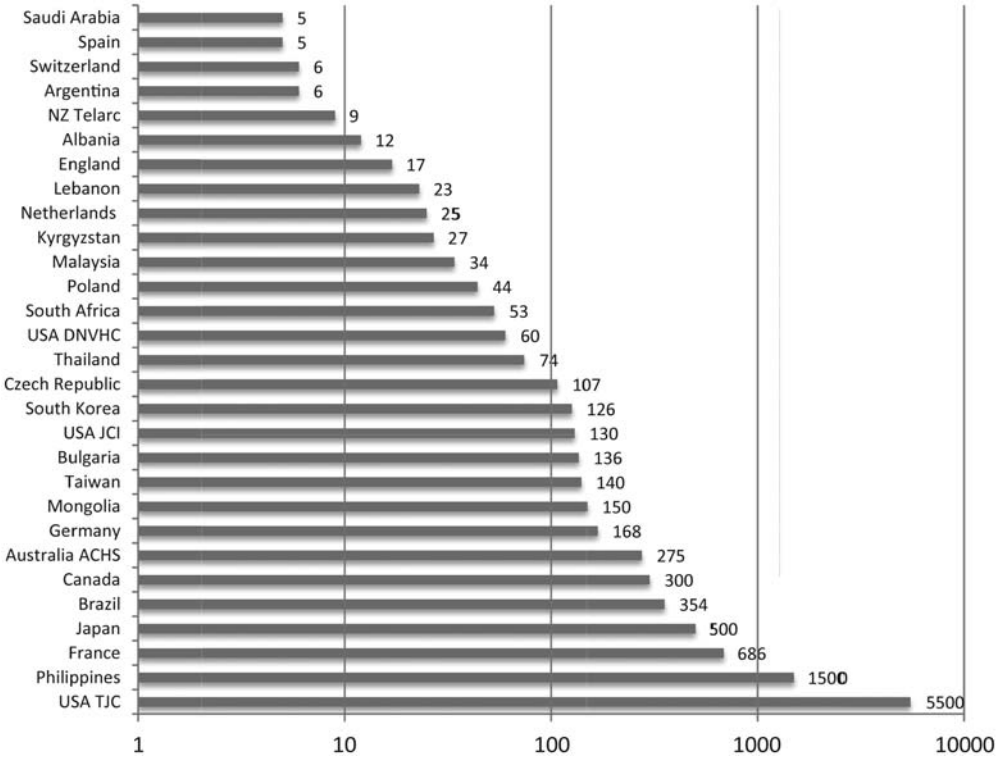

Figure 2 Full on-site visits 2009 (hospital)—log scale.

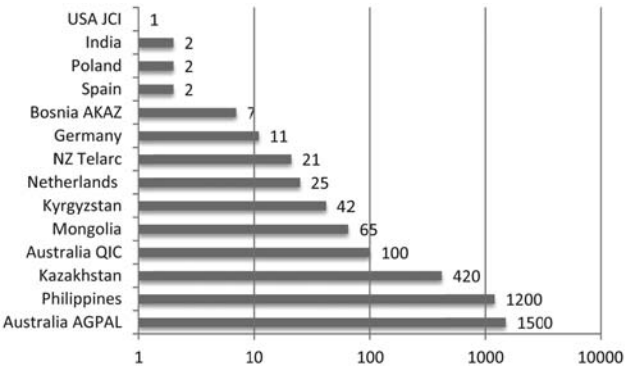

Figure 3 Full on-site visits 2009 (PHC)—log scale.

hand and as a vehicle for health system regulation on the other, to identify opportunities for sustainable (co)existence.

Health system environment

Government, policy and legislation. Although two-thirds of AOs are supported by enabling legislation, many independent programmes thrive without it. Five AOs are struggling or inactive, despite being supported by a published government strategy. If enabling legislation is not essential, and national strategies often change with ministers and governments, AOs must choose reliable partners for survival.

In countries where accreditation is adopted as a tool of regulation, it is generally authorized by legislation that prescribes (often prematurely restrictive) details of how a government agency should function. This top-down model may incorporate some elements of traditional accreditation, such as self-assessment and peer review, but it favours static control rather than dynamic development. In the USA, the inspector general of health services contrasted the 'collegial' approach of accreditation (to educate and elevate) with the regulatory approach of inspection (to investigate and enforce) [12]. Many countries are now trying to strike a balance between the two approaches, or even to combine them in a single agency. The survey data show that many AOs exhibit features of both approaches, occupying the middle ground between two extremes (Table 4).

Purpose of accreditation

Although the survey did not ask AOs explicitly to describe their purpose, most of them packaged facilitation and training together with compliance assessment, and the leading reason for HCOs to participate was stated by three quarters of respondents as 'quality improvement'. The government agenda commonly focuses more on protection of public money and public health—that is increasingly interpreted as a priority for reducing variation in practice to increase efficiency, and for patient safety, consistent with WHO global initiatives [13]. Some federal ministries (such as in Australia [14] and South Africa [15]) are writing their own standards for safety or quality assurance looking for efficient approaches to external compliance assessment that may include or exclude well-established accreditation programmes.

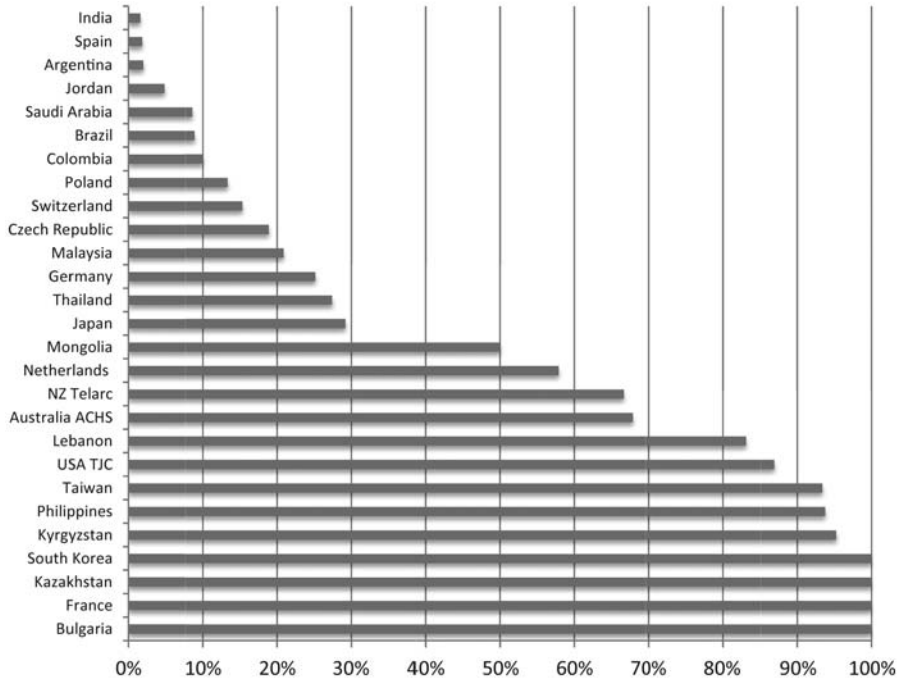

Figure 4 Percentage of uptake of accreditation by eligible hospitals.

Table 4 Comparing developmental and regulatory external assessment

	Developmental	Regulatory
Purpose	Dynamic, organizational improvement	Static, control
Terminology	Accreditation, certification	Licensing, registration
Governance	NGO, stakeholders	National, regional government agency
Primary customers	Health-care providers	Government
Secondary customers	Patients, professions, health-care insurers	Population, politicians, public finance
Incentives for HCOs to participate	Ethical, commercial	Legal, mandatory
Uptake	Voluntary self-selection to available programmes	All institutions in all sectors
Standards	Defined by NGO, optimal achievable	Defined by regulation, minimal acceptable
Funding	Self-financing	State
Cross-border mobility	Limited by language, culture	Limited by political borders

Terminology

State-controlled accreditation programmes for health-care institutions are often run by the same agencies as for licensing of institutions and of professionals and are usually mandatory. This contrasts with the traditional AOs that offer voluntary external assessment of institutions independent of regulation or licensing of individuals. Between the two poles, some mandatory programmes certify compliance with national standards for safety; these standards are more demanding than traditional licensing, but less demanding than traditional accreditation.

Governance

Representation on the governing body reflects the values, mission, stakeholders and relationships of an AO. Developmental programmes traditionally were dominated by clinical professions (largely doctors); regulatory ones often had a steering group of officials rather than a representative governing body. In the middle ground, many long-established and some newer AOs include a range of partners to reflect not only their primary customers but also the necessity of partnerships to align with other quality organizations and initiatives and economic and regulatory drivers that sustain the participation of HCOs in the accreditation programme.

Primary and secondary customers

Developmental programmes depend for survival on meeting the needs of customers and being able to demonstrate the value of continuing participation. Regulatory programmes

have a captive market, assured funding and are accountable to government; they have less need to demonstrate value. In the middle ground, organizations trade off some independence in return for a degree of assured business mediated by health-care insurers or regulators.

Incentives and markets for accreditation

Sustainable AOs have adapted their programmes, products and services to prevailing incentives and the markets that they generate. Broadly, these fall into four categories:

- Ethical: the original drivers of accreditation, quality improvement and organizational development remain the leading reasons cited for accreditation and specifically the voluntary participation approach. These may be linked to professional development, the recognition of clinical training and public esteem.
- Commercial: access to public funding, health insurance benefits and advantage in a competitive market.
- Regulatory: nearly all the long-established AOs now offer a degree of regulation by proxy, for example as third party assessor of compliance with regulation on behalf of national, state or provincial government, or by reducing the burden of inspection by statutory authorities.
- International: medical tourism generates a market for accreditation (and for ISO certification) of health-care providers across borders; new national and regional accreditation programmes may buy technical assistance from established organizations, often funded by international and bilateral donors.

Uptake

Some variations in survey workload and in market saturation may be artificial but, in general, growth in activity and participation of the majority of health-care providers suggest sustainable organizations. Regulatory systems have the advantage of high uptake, but have to cover all sectors of the health system, whether or not they are commercially viable; voluntary systems need a secure income stream to cover operations and development and growth to reduce unit costs. This is difficult in countries that have a small national population, where accreditation is based at regional level or where there is competition (with other AOs, ISO certification or regulatory bodies). Governmental or internationally funded programmes are established in Bosnia (two programmes share a population of 3.8 million), Albania (3.2 million), Mongolia (2.8 million) and Lebanon (4.3 million).

Accreditation across borders

NGO programmes can extend their market by working across regional or national political borders. This option is not available to many governmental programmes. Whether the aim of cross-border acitivity is to increase commercial viability, enable patient mobility or promote equality of organizational standards, external assessment organizations must demonstrate consistency and compatibility with other agencies in terms of methods and the provision of public information.

Public information

Research shows that published data on health-care providers are used less by the public than by government and other health-care organizations. This may reflect the practical difficulties of presenting data consistently (even within countries) as well as a need to educate the public on the value of external assessment programmes. Although patients and the population are assumed to be the ultimate beneficiaries of external assessment programmes, accessible information is limited and inconsistent; the language of accreditation is not public friendly, and there is no agreed minimum data set or mechanism for exchange of information on compliance with organizational standards.

Limitations of this study

Applying the inclusion and exclusion criteria meant omitting several external assessment programmes with relevant experience, such as those that were:

- Specialty based: e.g. Aged Care Accreditation, Australia.
- Region based: e.g. Shanghai municipality (larger population than many countries), Italian regions, Spanish provincial governments.
- Not called 'accreditation': e.g. Mexican certification program for 850 hospitals, UK Care Quality Commission, Quality Improvement Scotland.

Further exploration of common themes should explicitly include alternative systems such as certification and regulation. These often share principles and major challenges even if they do not share the same terminology.

Invitations to participate were limited to known organizations and personal contacts. More information on new (or recently deceased) programmes might have been found by searching databases of international aid to sponsor health reform projects.

Some concepts were misunderstood by respondents (e.g. counting 'surveyor-days') or confused (e.g. government policy inferred from legislation); interpretation of results should recognize differences in culture and language. Balancing this, raw data from the 44 organizations were circulated twice to all participants for verification and presented graphically at two ISQua conferences.

Conclusions

The world is moving from 'soft' to 'hard' quality improvement. AOs are increasingly interacting with governments, regulators and health insurers for long-term sustainability. The challenge to traditional accreditation is to adapt longitudinally to the political and economic environment to sustain services

that benefit health-care administrators, providers and their patients. The challenge to regulators is to find ways of sharing the cost and burden of the oversight of the health system with NGOs and to demonstrate that regulatory interventions serve their purpose.

Given the amount of effort and money invested worldwide in accreditation and regulation, and the common pursuit of valid standards and reliable measurement, there are economic and technical reasons to share research and experience more actively in the international community. The evidence for regulatory impact on quality is sparse [15] and this survey did not identify nascent AOs. Many health reform programmes, especially in lower and middle-income countries with international funding, include the introduction or strengthening of institutional/organizational accreditation or licensing. Systematic evaluation of these interventions could provide valuable insight into what determines sustainability and help to design interventions to match the local environment.

Many HCOs post survey reports on their own websites. Information regarding the procedures and results of assessments as posted on accreditation websites is often limited within programmes and incompatible between organizations. Agencies and AOs could promote public awareness and participation in health-care assessment, especially across borders, by adapting and publishing a common data set to describe the status of participating institutions.

Contributors

Adaptation of European survey tool: Jerod Loeb (Joint Commission) and Karen Timmons (JCI).

Communications and technical support for the web-based data capture: Su Huynh and Evan Mundy (Accreditation Canada, Ottawa).

ISQua reference group: Brian Johnston (ACHS, Australia), Hélène Beaard (Netherlands), May Abu Hamdia (Jordan) , BK Rana (India) and Paul vanOstenberg (JCI).

Additional information: Nurdaulet Sharenov (Kazakhstan), Johan Pauwels (Belgium), Hugo E. Arce (Argentina), Eric de Roodenbeke (International Hospital Federation), Daróczy Zita (Hungary) and Abdullah Alkhenizan (Saudi Arabia).

Presentation graphics: Betina van der Merwe (COHSASA, South Africa, and Danielle Marks (UNSW, Australia).

Funding

This research was supported by the partners who provided their expertise. No formal funding was allocated.

References

1. Greenfield D, Braithwaite J. Health sector accreditation research: a systematic review. *Int J Qual Health Care* 2008;**20**:172–83.
2. Greenfield D, Braithwaite J. Developing the evidence base for accreditation of healthcare organisations: a call for transparency and innovation. *Qual Saf Health Care* 2009;**18**:162–3.
3. MATRIX Knowledge Group. *Literature Review on the Impact of Hospital Accreditation*. Paris: Haute Autorité de Santé, 2010.
4. Nicklin W, Dickson S. *The Value and Impact of Accreditation in Health Care: A Review of the Literature*. Canada: Accreditation Canada, 2009.
5. Øvretveit J, Gustafson D. Using research to inform quality programmes. *Br Med J* 2003;**326**:759–61.
6. Salmon JW, Heavens J, Lombard C *et al*. Operations research results. In: *The Impact of Accreditation on the Quality of Hospital Care: KwaZulu-Natal Province, Republic of South Africa*. Bethesda: U.S. Agency for International Development (USAID) by the Quality Assurance Project, University Research, 2003, pp. 1–56.
7. de Walcque C, Seuntjens B, Vermeyen K, Peeters G, Vinck I. *Comparative Study of Hospital Accreditation Programs in Europe KCE Health Services Research*. Brussels: Belgian Health Care Knowledge Centre, 2008.
8. Shaw C, Kutryba B, Braithwaite J, Bedlicki M, Warunek A. Sustainable healthcare accreditation: messages from Europe in 2009. *Int J Qual Saf Health Care* 2010;**22**:341–50.
9. Shaw CD. Accreditation in European healthcare. *Jt Comm J Qual Patient Saf* 2006;**32**:266–75.
10. Shaw C, Amess M, Hittinger R, Johnson K, Pryce D, Wildridge V. (Eds) *Quality and Accreditation in Health Services: A Global Review*. Geneva: WHO, 2003.
11. World Economic Outlook Database-September 2011, International Monetary Fund http://www.imf.org/external/pubs/ft/weo/2011/02/weodata/index.aspx.
12. Brown JG. *The External Review of Hospital Quality: A Call for Greater Accountability*. Boston: Department of Health and Human Services, 1999.
13. WHO Patient Safety. Geneva: http://www.who.int/patientsafety/about/en/index.html.
14. Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Health Service (NSQHS) Standards*. Sydney: Australian Commission on Safety and Quality in Health Care, 2011.
15. National Department of Health. *National Core Standards for Health Establishments in South Africa*. Tshwane: National Department of Health, 2011.

Appendix

Table A1. Responding organizations

Country	Name of AO	Acronym
Albania	Qendra kombetare e Cilesise, Sigurise dhe Akreditimit te Institucioneve Shendetesore (H 2005)	NCQSA-HI
Argentina[a]	Instituto Técnico para la Acreditación de Establecimientos en Salud (H 1993)	ITAES
Australia[a]	Quality Improvement Council (PHC 1984)	QIC
Australia[a]	Australian Council on Healthcare Standards (H 1974)	ACHS
Australia[a]	Quality in Practice/Australian General Practice Accreditation Limited (PHC 1997)	QIP/ AGPAL
Bosnia[a]	Agencija za unapredjenje kvaliteta zdravstvene zastite Republike Srpske (PHC 2002)	AAQI
Bosnia[a]	Agencija za kvalitet i akreditaciju u zdravstvu u Federaciji BiH (H, PHC 2004)	AKAZ
Brazil	IQG—Health Services Accreditation (H 1999, PHC 2008) TA to Chile, Argentina, Peru, Mexico	IQG
Bulgaria	Akreditatsionen Savet v MZ (H 2000)	AC
Canada[a]	Accreditation Canada (H 1952, PHC 2010)	NA
Colombia[a]	Icontec (H 2003)	Icontec
Croatia	Agencija za kvalitetu i akreditaciju u zdravstvu (H 2009)	
Czech Republic[a]	Spojená akreditační komise, o.p.s. (H 1998, PHC 2009)	SAK
Denmark	Institut for Kvalitet og Akkreditering i Sundhedsvæsenet (H 2004) TA to Norway	IKAS
England[a]	CHKS Accreditation Unit (H 1990, King's Fund) TA to Portugal, Italy, Denmark, South Africa, Ireland, Cyprus, Germany	CHKS
France[a]	Haute Autorité de Santé (H 1996)	HAS
Germany[a]	Kooperation für Transparenz und Qualität im Gesundheitswesen (H 2001, PHC 2004) TA to Austria, Lithuania	KTQ
India	National Accreditation Board for Hospitals and Healthcare Providers (H 2005, PHC 2008)	NABH
Japan[a]	Japan Council for Quality Health Care (H 1995)	JCQHC
Jordan	Health Care Accreditation Council (H 2007, PHC 2009)	HCAC
Kazakhstan	Институт развития здравоохранения Healthcare Development Institute MoH (H 2009)	
Kyrgyzstan[a]	Medical Accreditation Commission, Kyrgyz Republic (H 1996, PHC 1998) TA to Tajikistan, Kazakhstan	MAC
Lebanon	National Committee for Hospital Accreditation (H 2000)	CNAH
Lithuania[a]	Valstybine akreditavimo sveikatos prieziuros veiklai tarnyba (H 1996)	VASPVT
Malaysia[a]	Malaysian Society for Quality in Health (H 1997)	MSQH
Mongolia[a]	Magadlan itgemjleliin kheltes Health Accreditation Division (H 2002, PHC 2003)	HAD
Netherlands[a]	Nederlands Instituut voor Accreditatie in de Zorg (H 1998, PHC 1998) TA to Belgium (Flanders), Aruba, Suriname, Netherlands Antilles	NIAZ
New Zealand	Health and Disability Auditing New Zealand Ltd (H2002)	HDANZ
New Zealand[a]	Telarc Quality Health (H 1990)	Telarc
Philippines	Philippine Health Insurance Corporation (H 1995, PHC 2000)	
Poland[a]	Centrum Monitorowania Jakosci w Ochronie Zdrowia (H, PHC 2004) TA to Albania, Kyrgyzstan	NCQA
Portugal	Departamento da Qualidade na Saúde/Direcção-Geral da Saúde/Ministério da Saúde (H 2009)	
Romania	Comisia Națională de Acreditare a Spitalelor (H 2008)	CoNAS
Saudi Arabia	المجلس المركزي لإعتماد المنشآت الصحية Central Board For Accreditation of Healthcare Institutions (H 2005, PHC 2010)	CBAHI
Serbia	Agencija za akreditaciju zdravstvenih ustanova Srbije (H 2008)	AZUS
South Africa[a]	The Council for Health Service Accreditation of Southern Africa (H 1995, PHC 1998) TA to Botswana, Lesotho, Nigeria, Rwanda, Swaziland, Zambia	COHSASA
South Korea[a]	한국보건산업진흥원 Korea Health Industry Development Institute (H 1995)	KHIDI

(*continued*)

Table A1. Continued

Country	Name of AO	Acronym
Spain[a]	Fundacion para el Desarrollo de la Atencion Sanitaria (H 1995, PHC 2007)	FADA
Switzerland[a]	Stiftung sanaCERT Suisse (H 2001)	sanaCERT
Taiwan[a]	Taiwan Joint Commission on Hospital Accreditation (H 1999)	TJCHA
Thailand[a]	Insitute of Medical Certificate (ITD) Healthcare Accreditation Institute (H 1997)	HAI
USA	Joint Commission International (H 1997, PHC 2008)	JCI
USA	DNV Healthcare (H 2004)	DNV
USA	The Joint Commission (H 1951)	TJC

H, Year in which hospital programme was started; PHC, year in which primary health-care programme was started.
TA, technical assistance provided to other countries.
[a]Organization submitted data to survey in 2000.