Today more than two thirds of the 1.1 billion Indian population seek the private sector for their health needs. This is surprising as India is a middle income developing country with approximately 30% of people still living below the poverty line. Public sector health services have received the attention of policy makers and regulators but have received meager financial support from a government that spends less than 2% of GDP on health care. In this situation government institutions are stretched to the limit to maintain a clean environment and deliver effective healthcare that today is heavily dependent on expensive technology for its functioning. The result is the transfer of sections of the population to an unregulated private sector. It is here that hospital accreditation (from a national or international agency) can help. By laying down standards for all aspects of institutional care together with a roadmap for achieving the same, patients will slowly develop confidence that healthcare they receive conforms to certain accepted norms (see Box 1).

Accreditation as a concept had its early beginnings in USA a century ago. In 1910 Dr. Earnest Codman introduced the ‘end result system’ which tasked hospitals to track every patient treated by then to determine if treatment had been effective. In 1919 the American College of Surgeons set up the Hospital Standardization Programme, which met with an overwhelming response from the medical profession. After three decades a larger organization was founded in 1953 named the Joint Commission on Accreditation of Hospitals, which in 1987 became the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Institutions accredited by JCAHO were recognized by Medicare as suitable for treatment of their patients. In 2007 JCAHO again changed its name to the Joint Commission and the Joint Commission International (JCI). The latter functions in several countries worldwide as a reputed accreditation body (see Box 2).

In India the movement for voluntary accreditation started hesitantly in the 1930s with attempts to include nursing homes as well as hospitals under one umbrella. In 1952 the National Institute for Health and Family Welfare laid down standards for equipping hospitals of 50 beds or more. Today the scenario shows an accelerated demand for quality healthcare (see Box 3). Reasons for this relate to an increased awareness of patients rights highlighted by the media, consumer courts, and the Internet. Healthcare costs are spiraling and people want value for their money. Health insurance companies are now in the arena and will likely provide only limited fixed reimbursement to patients for designated diseases and surgeries. Finally the lure of medical tourism motivates hospitals to improve their facilities as potential patients will surely limit their search solely to accredited institutions.

The National Accreditation Board for Hospitals and Healthcare Organisations (NABH) is a branch of Quality Council of India set up with the cooperation of Ministry of Health and Family Welfare. The first set of NABH standards for hospital accreditation were released in 2005 keeping “the Indian ethos and working environment in mind”. The focus was on quality and safety, - not only patient safety but also that of the hospital employee and hospital environment. NABH suggests the best way to implement standards is to create an in-house core committee made up of representatives from hospital administrative departments together with representatives from nursing and medical faculties. This committee through its interaction with various hospital departments is responsible for creating the quality manual as well as all departmental manuals. Additionally it is tasked to oversee the initial implementation of standards and the subsequent monitoring of the same. Safety measures are incorporated into the standards but should things go wrong a mechanism is provided whereby incidents

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**Box 1**

**The Domains of Quality**

Adapted from the Royal College of Physicians (London) – 2010

- **Patient experience**
  - The patient is the focus. ‘Quality healthcare’ will not mean the same for every patient.

- **Effectiveness**
  - Healthcare should deploy beneficial interventions at the right time.

- **Efficiency**
  - Make the best of limited resources. Avoid waste - material and abstract (e.g. time).

- **Timeliness**
  - Avoid potentially harmful delays. Deploy interventions to prevent illness.

- **Safety**
  - Risk cannot be reduced to zero but minimize harm.

- **Equity**
  - Strive for a level playing field.

- **Sustainability**
  - Sustainability should be viewed as an essential characteristic of healthcare.

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**Box 2**

**Patient Safety Goals – Checklist**

(Adapted from the Joint Commission – 2009)

The Goals focus on key problems in healthcare safety

- Identify patient correctly
- Improve staff communication
- Administer medicines safety
- Prevent hospital acquired infections
- Prevent errors in surgery
- Check patient medicines
- Prevent patients from falling
- Help patients to be involved in their care
are reported, systems investigated, and corrective measures taken to prevent future mishaps. Quality is enhanced by staff education, audits, and tracking of established quality indicators derived from all areas of the hospital on a monthly basis. Hospital committees tackle quality and safety issues of special importance such as infection control, safe medication, blood transfusion, fire and disaster preparedness, and radiation safety. NABH advocates a culture of continuous quality improvement. Accreditation is a journey and not a destination, a laudable concept but one which can be taxing for busy staff with multiple competing priorities. Experience shows that the nursing staff, technicians and support staff are the most responsive to the constant goadings of the core committee whilst the medical faculty is slow to embrace change.

In 2011 NABH proudly announced that 100 hospitals out of 600 applicants had successfully completed the accreditation process and that some of these were government institutions. There is no doubt that accreditation more than any other single factor has started to move Indian hospitals out of the doldrums to join others on the international stage. But we end with a note of caution. Accreditation is a wonderful tool for the betterment of an institution but it is in no way a guarantee for successful patient outcomes. The Institute of Medicine document ‘to err is human’ (see Box 3) which has had such a profound effect internationally on the patient safety movement was written in 1999 at a time when all major hospitals in the United States had been accredited for several years.

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Box 3
Healthcare Shortcomings in Quality (USA)
The Institute of Medicine (IOM) in its 1999 document ‘To err is human’ (Ref 1) highlighted important deficiencies in quality healthcare. The IOM is an organization independent of the US Government
- Between 44,000 and 98,000 Americans die from medical errors annually
- Medication-related errors for hospitalized patient cost roughly $2 billion annually.
- Around 18,000 Americans die each year from heart attacks because they do not receive preventive medications, although they were eligible for them.
- Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents
- More than 50 percent of patients with diabetes, hypertension, tobacco addiction, hyperlipidemia, congestive heart failure, asthma, depression and chronic atrial fibrillation are currently managed inadequately.