Accreditation of hospitals in Lebanon: is it a worthy investment?

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Abstract

Objective. This study explores the views of Lebanese hospitals on the worthiness of accreditation vis-à-vis its associated expenses in addition to examining the type and source of financial investments incurred during the accreditation process.

Design. Observational cross-sectional design.

Participants. All private short-stay hospitals registered with the Syndicate of Private Hospitals in Lebanon (110 hospitals).

Main Outcome Measure. Hospital’s views on the worthiness of accreditation in lieu of its associated expenses. Other measures explored included areas of expenditure increase and sources of expenses coverage for accreditation.

Results. Three-fifths of responding hospitals (63% response rate) considered accreditation as a worthy investment. Favorable views on accreditation were mostly related to its effect on enhanced quality and safety culture. Unfavorable views regarding the worthiness of accreditation investment were justified by absence of link with enhanced tariffs from payers (25.7%). All hospitals incurred increased expenses due to accreditation. Areas of highest increase included training of staff (95.7%), consultants’ costs (80.0%) and infrastructure maintenance (77.1%). Most of the hospitals covered expenses through internal absorption (52%) or bank loans (45.7%).

Conclusions. The financial burden of accreditation on hospitals has to be factored in the decision of its adoption at a national level, especially in developing countries.

Keywords: accreditation, expenditure, financial investment, private hospitals, financial coverage

Introduction

Accreditation has evolved into a cornerstone in today’s health-care systems; where, currently, the number of health-care accreditation programs are estimated at more than 70 (including national accreditation systems) spreading beyond North America to Europe and many developing countries, with the number doubling every few years [1, 2]. The review of literature on the effectiveness of health-care accreditation reveals a complex picture, with mixed views and inconclusive findings. Researchers, nonetheless, agree on the fact that the preparations for accreditation give hospitals a valuable opportunity to reflect on the treatment of patients and on its operational modalities [3, 4] as well as an effective strategy that aids in the introduction of organizational change [5]. However, many have criticized the financial burden it imposes on hospitals, especially in developing countries [6, 7]. Such a concern is merited as hospitals need to make resources available for a prolonged process, commencing from the initial plans by the hospital to carry out a survey on accreditation all through the accreditation process [8]. Those costs are mainly classified into two major categories. The first includes fees paid to the accrediting body, arrangement for surveys and implementing survey recommendations. The second are referred to as ‘standards costs’ that are expenses spent by hospitals to comply with the applicable standards [9]. That is why some have highlighted the need to monitor and assess the financial return or worthiness of engaging in accreditation [1]. Such a question is linked to others on how hospitals financially cope with the accreditation expenses and where are those expenses concentrated.

Lebanese context

Lebanon is a middle-income country of an estimated 4.2 million inhabitants located in the Eastern Mediterranean Region (EMR). The country witnessed a civil war between the years 1975 and 92 that had a huge toll on the country,
including a major negative impact on the health-care sector. The limited governance capacity of the state, as a consequence of the civil war and the complex political system of the country, has led to the poor regulation of the private sector and civil society groups. Accordingly, the private sector’s involvement in the provision of health care has witnessed a rapid expansion. The number of private hospitals has increased by 60% during the war [10] and this is mainly due to unrestricted financing by the Ministry of Public Health (MoPH). The WHO World Health Statistics report published in 2010 shows that the number of hospital beds in Lebanon sums up to 34 per 10,000 population scoring among the highest indicators in the EMR (average number of beds is 12 per 10,000 population) [11]. Furthermore, the total health care expenditure in Lebanon summed up to around 2.8 billion US dollars in 2010 accounting to 7% of the national gross domestic product [12, 13]. To tackle the aforementioned issues, the Lebanese government—through the MoPH—initiated a series of reforms in the sector in an effort to combat the increasing health costs and to decrease the inefficiency in the health-care system. Although the reform process succeeded in improving certain figures in the system, it was not able to address all the pressing problems.

In 2000, the MoPH took the initiative to introduce a national hospital accreditation scheme as a systematic means for ensuring quality of care [14]. The new accreditation system introduced a paradigm shift from the traditional focus on physical structure resembled by the old alpha-star classification of hospitals to a broader multidimensional approach with more emphasis on clinical and managerial processes and performance. The introduction of the new hospital accreditation scheme helped nourish an environment of continuous quality improvement by developing an external evaluation system with particular emphasis on safety, indicators and data reporting, as well as infection control mechanisms and patient advocacy. To serve as an incentive-based regulation, the MoPH linked the results of the initial accreditation cycles to the reimbursement system for hospitals that have contractual agreements with the Ministry [14].

To date, the MoPH has implemented accreditation through three national surveys. The First National Survey (Survey I) spanned 128 hospitals between September 2001 and July 2002. Small-sized hospitals were, on average, operating below standards when compared with medium-sized hospitals and large-sized hospitals [14]. In the Second Survey (Survey II), launched in 2004, accreditation standards and scoring mechanisms were reviewed and slightly amended. Among the 142 surveyed hospitals, only 85 met the requirements: large-sized hospitals had higher ratings than medium-sized hospitals, whereas small-sized hospitals had the lowest rating [14]. The third cycle of national hospital accreditation was initiated in 2011. In this cycle, hospitals were expected to be more familiar with accreditation requirements and processes. Furthermore, in this cycle, the MoPH opted to unlink the financial incentive to the results of the accreditation in an effort to enforce the transparency of the process. As such, it would be timely to assess the financial burden hospitals incur as a result of accreditation and their perspective of its added value and worthiness to the institution, given their anticipated engagement in a new cycle.

The impact of the introduction of a national accreditation system has been assessed in few studies in Lebanon. These reported a positive impact on the quality of care offered to patients in small and medium sized hospitals compared to large hospitals as indicated by clinicians [15]. Accreditation’s impact on the Lebanese health-care system went beyond the initial objective of improving the quality of care provided by hospitals (whether private or public) to enforce the MoPH’s role/influence in regulating the activities of hospitals [16]. According to the MoPH, accreditation in Lebanon ensured quality improvement, compensated for the diminished role of consumers/patients in the Lebanese health-care system and shifted the emphasis away from infrastructural aspects toward provision of health care [17].

### Study objective

In light of the limited evidence on the worthiness of accreditation from a financial investment stand point, this study aims to explore the views of Lebanese hospitals’ directors on the worthiness of accreditation vis-à-vis its associated expenses in addition to examining the categories of increased expenses, as well as sources of funds for the expenses incurred during the accreditation process.

### Methods

#### Study design and data sources

The study employed an observational cross-sectional design. The study population comprised all private general short-stay hospitals registered with the Syndicate of Private Hospitals in Lebanon (110 hospitals). Data sources included: (i) publicly accessible list of hospitals generated by the Syndicate that included hospital characteristics and contact information, (ii) MoPHs accreditation classification of hospitals (based on the 2005–06 cycle) and (iii) survey completed by hospital administrators regarding accreditation expenses. The survey instrument comprised three questions. The first asked the administrator whether the hospital incurred increases in expenditures related to the accreditation process. The survey was also used to assess the mechanisms which hospitals follow to cover the increased expenses, if any, and identify whether accreditation is financially worth the investment. Hospitals were also asked in an open-ended question to elaborate on their opinion regarding the accreditation as a worthy investment (the survey was administered during the period between July and August 2011). The study was approved by the American University of Beirut Institutional Review Board.

#### Study measures

The dependent measure included the hospital director’s views on the worthiness of accreditation vis-à-vis its associated expenses to the institution itself. Independent variables...
included hospital characteristics [size and accreditation status during the previous cycle (2005–06)]. The hospital size expressed as number of beds was categorized as small (0–49), medium (50–99) and large (100+). The accreditation status was divided into class A, B, C and D based on the MoPH’s classification. Classification of hospitals into the different classes was dependent on the hospital performance in the accreditation review process, specifically translated into scores. Top-scoring hospitals were classified as A based on cut-off levels. Class A hospitals tended to be the large teaching hospitals with D hospitals mostly the smaller rural ones.

Another set of independent variables included areas of expenditure increase. In addition, mechanisms of financial coverage in relation to the accreditation process were explored: increasing patient bill, internal absorption, bank loans and donations.

**Data analysis**

The data was entered and analyzed using Statistical Package for Social Sciences 19. Univariate analysis was conducted that included frequency tables on hospital characteristics, views on worthiness of accreditation given the expenses, expense categories and sources of financial coverage. Given the nature of the data, responses to closed-ended questions were entered as numeric data with ‘0’ representing negative responses and ‘1’ representing the positive ones (answered as yes). Bivariate analysis included comparison of means using Pearson Chi-square, Fisher’s exact and Bonferroni tests that were used to examine the dependent variables across the hospital size and accreditation status. Statistical associations were revealed through cross tables.

In addition to analyzing the quantitative data, a qualitative data analysis was conducted based on open-ended question elaborating the different opinions of hospital administrations regarding the worth of the accreditation investment. The thematic analysis grouped points of views into common favorable and unfavorable themes.

**Results**

Out of the eligible 110 hospitals approached, 70 hospitals responded (63%). Small hospitals (<50 beds) constituted 28.6% of responding hospitals, medium hospitals (50–99 beds) were 45.7% and large hospitals (100+ beds) were 25.7% (Table 1). Responding hospitals classified in the previous accreditation cycle (2005–06) as class A (by the accreditation system) constituted 18.6%, class B hospitals were 7.1%, class C were 32.9% and class D comprised 20%, with the rest not being accredited (did not apply for accreditation, new hospitals or failed accreditation).

Table 1: Views on accreditation expenses of participating hospitals by hospital size and accreditation status

<table>
<thead>
<tr>
<th>Category of increased expenses (%)^b</th>
<th>Total</th>
<th>Hospital size (beds)</th>
<th>Accreditation status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Small (&lt;50)</td>
<td>Medium (50–99)</td>
</tr>
<tr>
<td>Infrastructure maintenance</td>
<td>77</td>
<td>95*</td>
<td>66</td>
</tr>
<tr>
<td>Buying new equipment</td>
<td>76</td>
<td>83*</td>
<td>78</td>
</tr>
<tr>
<td>Upgrading available property</td>
<td>74</td>
<td>80</td>
<td>78</td>
</tr>
<tr>
<td>Recruitment/orientation of new staff</td>
<td>59</td>
<td>80*</td>
<td>50</td>
</tr>
<tr>
<td>Training of current staff</td>
<td>96</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Salary adjustments</td>
<td>13</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Benefits granted to staff</td>
<td>59</td>
<td>60</td>
<td>53</td>
</tr>
<tr>
<td>Housekeeping services</td>
<td>60</td>
<td>70</td>
<td>63</td>
</tr>
<tr>
<td>Laundry services</td>
<td>64</td>
<td>70</td>
<td>69</td>
</tr>
<tr>
<td>Dietary services</td>
<td>63</td>
<td>75*</td>
<td>69</td>
</tr>
<tr>
<td>Administrative services</td>
<td>67</td>
<td>80</td>
<td>66</td>
</tr>
<tr>
<td>Consultant costs</td>
<td>80</td>
<td>95*</td>
<td>72</td>
</tr>
</tbody>
</table>

Source of funds for accreditation expenses (%)^b

<table>
<thead>
<tr>
<th>Source of funds for accreditation expenses (%)</th>
<th>Total</th>
<th>Hospital size (beds)</th>
<th>Accreditation status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage by internal absorption</td>
<td>53</td>
<td>45</td>
<td>56</td>
</tr>
<tr>
<td>Coverage by bank loans</td>
<td>46</td>
<td>40</td>
<td>47</td>
</tr>
<tr>
<td>Coverage by shareholder/owner contribution</td>
<td>17</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Coverage by donation</td>
<td>9</td>
<td>20*</td>
<td>6</td>
</tr>
</tbody>
</table>

^aNumbers were rounded.

^bCategories are not mutually exclusive.

*P < 0.05.

#P < 0.1.
Approximately three-fifths (64.3%) of responding hospitals considered accreditation as a worthy investment with all of them indicating incurring increased expenses due to accreditation. The areas where these increases were the highest included training of current staff (95.7% of hospitals had increases in that area), followed by accreditation consultants’ costs (80.0%), infrastructure maintenance (77.1%), buying new equipment (75.7%) and upgrading available property (74.3%) among others. Findings also revealed that hospitals employed different sources of financial coverage for the increase in expenses associated with accreditation. Most of the hospitals covered expenses through internal absorption from operations (52%) or through bank loans (45.7%) noting that some of the hospitals had more than one mean of financial coverage.

Assessing the bivariate association between size and hospitals’ view of the worthiness of accreditation revealed no association between the two (Table 1). However, findings showed that a higher proportion of small hospitals incurred increased expenses associated with infrastructure maintenance when compared with middle and large hospitals ($P < 0.05$). The same trend was observed with recruitment and orientation of new staff ($P < 0.05$), dietary services ($P < 0.05$) and consultant costs ($P < 0.05$). Examining the association of accreditation classification with investment worthiness and sources of investment also revealed no significant association with the former. However, when compared with expenses classification, hospitals classified as D were more likely to have increased expenses invested in infrastructure maintenance compared to hospitals in other class categories ($P < 0.05$). A similar finding was observed for dietary services with hospitals in classes C and D being more likely to have increased expenses when compared with hospitals classified as A and B ($P < 0.05$). Approximately, 29% of hospitals considering accreditation as a worthy investment were those classified as C and are of medium size, followed by hospitals classified as A and are large (Fig. 1a). Examining hospitals in each classification/size category revealed that all those classified as A/Medium, B/Medium, C/Large and D/Medium considered accreditation as a worthy investment (Fig. 1b); the smallest percentage was among hospitals classified as D/Small.

Table 2 presents the thematic findings from assessing hospitals’ views on the utility of accreditation given the financial investment. Favorable views on accreditation were mostly related to its effect on enhanced quality and safety culture; this was expressed by almost half of the hospitals surveyed (47.1%). Another sub theme emerging was its impact on improved patient satisfaction (32.9% of hospitals). A favorable theme emerging was related to the increase in set tariffs according to admission class for accredited facilities (8.6%). On the other hand, hospitals expressing unfavorable views regarding the worthiness of investment in accreditation justified that by the discontinuation of increased tariffs that accompanied receiving accreditation in the new cycle, in addition to the lack of increase in set tariffs by private insurance (25.7%). Another theme revolved around the lack of applicability of some accreditation standards within the national context (12.9%).

**Discussion**

Accreditation has become a trademark of quality health-care systems across the world, including many developing countries that are actively engaging in accreditation processes. Based on a review of health sector accreditation research, the financial costs of accreditation are still considered an under-researched area [1]. Very few studies have assessed the financial burden of accreditation on hospitals, and those that did came with contrasting assessments [1]. This study aims to focus on that issue and its relative value, given the associated expenses with a special focus on hospitals in developing countries.

The findings revealed that more than three-fifths (64.3%) of responding hospitals considered accreditation as a worthy investment; most of whom related it to its effect on enhanced quality and safety culture. This is consistent with other studies, where health-care providers saw in accreditation an effective strategy for assuring quality [6, 18–20]. It is likely that hospitals are aware of that link and realize that patients seek a highly reputable institution that they can trust in terms of meeting their expectations; especially that customer satisfaction leads to patients returning to the same organization for care, hence more overall profitability [21, 22]. On the other hand, hospitals expressing unfavorable views regarding the worthiness of investment in accreditation justified that by the absence of a link with enhanced tariffs from public and private payers. From a global context, accreditation of health-care organizations is fueled normally by organizations themselves most of the times, or by payers seeking better performance and value for their money [23]. Linking accreditation results to payment schemes and other financial inducements is viewed by policy makers as an incentive to engage in accreditation and attain better accreditation outcomes. For instance, the steady growth of accreditation schemes in Germany and the Netherlands is associated with the linkage of third-party accreditation to purchaser–provider contracts [24]. In developing countries, the need for incentives is even higher to promote accreditation in already complex and financially challenged health-care systems. Specifically in Lebanon, at the initiation of the national accreditation program, the MoPH gave incentive to private hospitals to participate in the process through linking the results to pay tariffs. In subsequent cycles, however, this policy has been revoked, and the tariffs levels have been disassociated with the attaining accreditation that left the hospitals unsatisfied with the policy change, especially in light of the continuing incurred expenses. Another unfavorable theme emerging from hospital responses relates to the applicability of standards that are evidence-based internationally but challenging to apply in the Lebanese hospitals’ context. Hospitals also elaborated that those standards are mostly theoretical and hard to be applied on the ground and that the benchmarking is sometimes irrelevant due to different organizational and cultural structures. The Lebanese accreditation standards were derived from seven hospital accreditation systems applied in developed countries (USA, Canada,
Australia, Ireland, New Zealand, France and the UK) [14] and were reviewed and updated over the context of the three accreditation cycles in Lebanon to conform to the national context [16]. Nonetheless, it seems that some hospitals still consider some standards as non-applicable to the national context or their respective organizations.

Another set of findings is related to accreditation-associated expenses. All hospitals in the study reported incurring increased expenses associated with accreditation. The areas where the investment was highest included training of current staff, consultants’ costs, infrastructure maintenance, buying new equipment and upgrading available property. This is predictable and consistent with findings from literature. Despite the lack of studies that assess the estimated financial burden of accreditation on hospitals, one study estimated that accreditation programs may incur an additional $326,784 US Dollars per hospital per single survey process reaching to 1% of its operational budget [8]. This increase in budget is due to the fact that certain facilities accreditation requirements may necessitate the incorporation of additional staff, which is paralleled by additional space and materials needed for the new staff operations [23]. This is to be expected as the accreditation process has been presented by some as employee-dependent and a ‘labor intensive’ process [1].

The study also showed that the Lebanese hospitals are assuming different sources funding for the increased expenses incurred. Most of the hospitals covered expenses through internal absorption from operations or through bank loans.

Figure 1 Overview of hospital characteristics associated with considering accreditation as a worthy investment (a) among those considering accreditation as worthy the investment and (b) among number of hospitals in each category. *L, large sized hospitals (>100 beds); M, medium-sized hospitals (50–99 beds); S, small-sized hospitals (<50 beds)
were in the responding ones. In addition, more non-responding hospitals were in the 100+ bed category than responding hospitals. There were two main differences in this group when compared with private hospitals, most of which went through the first cycle of accreditation. Hence, their experience with associated expenses would not be as complete as a systematic review. Int J Qual Health Care 2008;20:172–83.


