Report

Accreditation: the Argentine experience in the Latin American region

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The development of the Latin American hospital accreditation programmes had a heterogeneous evolution similar to that of the region itself, despite the existence of previous assessment tools facilitated by the Pan-American Health Organization (PAHO).

As interest in quality of care spread globally – supported by the universal dissemination of computer and communication technologies – in Latin America the process took the form of a ‘multifocal’ phenomenon: expanding spontaneously in an unorganized and unplanned fashion. It should be pointed out, however, that like the international culture encouraged by the Internet, the trend towards quality in health care is expanding horizontally, and not as a simple ‘top-down’ regional or national initiative.

The influences on the region were also diverse. First, there was the significant impetus given by PAHO to promote the preparation of a suitable assessment tool designed for the Latin American Region, which would act as a recommendation to start accreditation programmes in all countries. To this end, many regional and subregional meetings were held to exchange experiences and reach a consensus. Unfortunately, only a few countries followed this trend.

Secondly, the international expansion of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the USA, creator of the original accreditation method, had an impact on the region. Initially, JCAHO started its activities in both American and Canadian hospitals [1], but later, Canada split off and created its own accrediting body: the Canadian Council of Health Services Accreditation (CCHSA). JCAHO continued only domestic assessments within the region until the early 1990s.

After an internal revision of its methodology, focused mainly on results under the ‘Agenda for Change’ [2], JCAHO tried to extend its experience and advice to other countries, and especially to the Latin American region. For these tasks, JCAHO relied on a subsidiary body: the Joint Commission International. Today, CCHSA also performs consulting activities outside Canada.

Another influence on the region came from industry through the International Standards Organization system. This universal model of quality standards for processes focused on production or service and now penetrated and subdued health care organizations [3], though with few echoes in this region.

Lastly, there was the influence of the regional commercial agreements, Treaty of the North Atlantic Free Trade Area (NAFTA) in North America and the Common Market of the Southern Cone (MERCOSUR, in Spanish) in South America. Although not focused specifically on health services, these agreements will have a significant impact on the development of local trends in each signatory country.

Some Latin American initiatives

The regional process encouraged by PAHO began in 1990, after it signed an agreement on technical co-operation with the Latin American Federation of Hospitals (LAFH). Their aims were to develop quality improvement programmes for the countries of the region and an Argentine team was entrusted with the task of studying the issues and writing an accreditation manual, suitable for the Latin American reality.

This duty was performed successfully by a group of medical audit experts counselled by different scientific societies. In May 1991, in Washington DC, the draft paper was analysed by 22 countries and approved after some formal changes. The final version was translated into four languages, published by PAHO [4] and a recommendation made for its application within the region.

In December of that same year, a working plan was devised to promote the implementation of accreditation programmes through subregional meetings of health sector leaders. It is important to highlight the fact that PAHO is an intergovernmental body. Consequently, the working plan and agreement with LAFH implied an opening to local associations and non-governmental organizations. As a very important share of the health sector is in the hands of Social...
Security and private initiatives, all efforts were focused on attracting the interest of these health care decision-makers. From 1992 to 1995, there were four subregional meetings: (i) the English-speaking Caribbean countries; (ii) the Andean countries; (iii) the Spanish-speaking countries of Central America, Mexico and the Caribbean; and (iv) the Southern Cone. Finally, in October 1995, in a final Latin American regional conference, it became clear that not all countries were able to develop their own programmes by adapting tools previously approved by consensus, because other key stakeholders wanted a stake in programme development too.

Some countries such as Bolivia, Peru, Cuba, Guatemala and the Dominican Republic adopted a modified version of the PAHO-manual. Venezuela and Trinidad & Tobago [5] instead adopted models based on the JCAHO manual. The Ministry of Health of Bolivia enforced the programme only for public hospitals [6], whereas the Chilean Ministry of Health developed a continuous improvement programme for public hospitals, methodologically based on the JCAHO model [7].

Brazil is a rather complex case due to its federal structure. Here, the Ministry of Health devised an adapted version of the PAHO manual for general enforcement. The programme is being applied in the states of Rio Grande do Sul, Para, Santa Catarina, Sao Pablo and Rio de Janeiro [8], although Rio de Janeiro later signed a direct agreement with JCAHO.

Mexico, pioneer among the Latin American countries in encouraging the quality of care movement and in developing accreditation standards through the National Institute of Public Health, deserves special attention. Located in North America, it is included in NAFTA and is focused on compatibility with its regional neighbours. A prestigious consulting group is now establishing technical co-operation links with CCHSA.

Finally, Argentina – perhaps because it played a leading role in the development of the PAHO manual – follows this manual strictly, making adjustments and updating it. The manual of the Technical Institute for Accreditation of Healthcare Organization (ITAES, in Spanish) stems from the PAHO manual. Here the key stakeholders in the health sector are developing an accreditation programme without any government support.

This overview based on available information, while not exhaustive, aims to explain the multiple factors – such as the organizational characteristics of each health system, the domestic and foreign factors and the predominant political organization – involved in a country's decision regarding the development and the implementation of an accreditation programme. The USA and Canada, for instance, began their accreditation programmes together in spite of the different organizational structure of their health systems, but implemented them separately to fit their respective environments.

The Argentine experience

The Accreditation Project has followed a long and sinuous pathway in Argentina. From the late 1970s to 1990, a so-called ‘preliminary’ stage was developed. Basically, several bibliographic revisions were published and different trials of quality standards were developed. Formal tests and ‘pilot’ experiences aimed at assessing different types of services and hospitals.

In 1990, the joint PAHO and LAFH agreement provided a special incentive that promoted the accreditation method, and a draft paper was outlined, as explained previously [4]. Simultaneously, another agreement was signed by the main providers and financing associations of the Social Security System. As a result, the Joint Commission for Quality in Health Care (COMCAM, in Spanish) was organized and a draft paper developed within COMCAM’s framework. By the end of 1991, as the health authorities changed, COMCAM lost support and collapsed before starting its accreditation programme [9].

The challenge to continue the project originated from a wide group of private health care institutions. In this opportunity, their aim was not another political agreement among a few great institutions, but to cluster many individual hospitals, health providers, financial entities and various scientific societies. Consequently, in December 1993, ITAES was constituted as a non-governmental, non-profit civil organization.

To review the existing tools (the PAHO/LAFH and COMCAM manuals) ITAES relied on the most experienced experts in health care quality throughout the country. Their task was accomplished with the support of several scientific societies, i.e., surgery, pediatrics, intensive care, infectology, hospital architecture and engineering, biochemistry, radiology, haemotherapy and immunohaematology, anesthesiology and medical audit.

The accreditation standards include around 40 services and activities. They avoided detailed and troublesome descriptions (i.e. long event descriptions or extensive structure guides). They focused on selecting the most representative tracer criteria: representativity, simplicity and practicality. At present, these standards are designed for use only by general acute care hospitals [10].

The major methodological difference between the new instrument and its predecessors was the omission of different levels of satisfaction (three or four) for each standard, because this contradicted the concept that quality in health care is independent from the kind, size and complexity of the organization. On the other hand, it fed a common Argentine confusion between categorization and accreditation. As a result of their different objectives, these two evaluation modalities are complementary to each other. Whereas accreditation establishes integral quality criteria, categorization stratifies the organizations depending on their complexity or vital risk.

For the final accreditation decision, the individual weight of each standard is equivalent. All standards corresponding to the present services within the organization should be accomplished. The standards have two parts: the first is for evaluation and requires obligatory fulfillment, and the second – applicable only once the first is fulfilled – is a number of ‘suggestions for improvement’. The obligatory part is divided
into three columns: (i) the phrasing of the standard; (ii) explanations of the text; and (iii) documents and data to be provided by the organization.

When selecting the methodology and designing the evaluation instruments, the operative costs were considered versus the reliability of results. The different steps in the assessment procedure are:

- once the Requirement of Accreditation form has been received and it has been verified that the hospital satisfies the preliminary requirements, the surveyors’ visit follows;
- during the survey, the surveyors verify the requirements for the respective standards using an instrument called the operative form, which includes results and observations;
- finally, the information is processed by a computer system into an evaluation form that enables the surveyors to reach the final survey decision.

The evaluation form adheres to the structure given in the manual. Standards appear in consecutive order from 1 to 40. All questions (675 items) are closed and binary (yes/no type). The unique design of the operative form is embodied in 22 ‘orderings of information’. An ‘ordering’ represents an area and/or an individual in the organization where all the information required for evaluating the criteria used in more than one standard is concentrated. The purpose of this is to complete everything in a single visit. Both instruments are linked by a common system of codes [11]. Hence, qualitative data are used to evaluate all the methodological steps, unlike the quantitative indicators, figures or percentages, as used by JCAHO [12].

Training of surveyors in the accreditation methodology requires a 16-hour intensive course. Participants do practical work in groups (up to 20). A university degree in health care or related disciplines is a prerequisite for the training. To date, over 200 surveyors have been trained. A Code of Ethics has established that the hospital is able to reject one or more of the assigned surveyors given an adequate reason. Surveyors must come from a different city or province from that in which the hospital is located. The code also comments on the confidentiality of results and field forms.

Possible evaluation results are Not Accredited, Temporary Accreditation (1 year), Full Accreditation (2 years the first time, 3 years henceforth) and Accreditation with Merit. Once the surveyors conclude the field tasks, the Decision Committee controls the reports and recommends that the Board issue a decision.

Several ITAES’ Board Members participate in conferences, academic activities and scientific events to explain the relevance of accreditation. A significant part of this effort has been dedicated to distinguishing between hospital accreditation and the evaluation of providers performed by financial institutions. ITAES states that accreditation is a voluntary, periodic and confidential method based on known standards and on objective accreditation bodies. Financial institutions on the other hand, are linked to providers by a work contract, and therefore, may be biased. The ITAES magazine which includes quality in health care articles, ITAES news and ISQua activities is another information tool.

ITAES is also developing an accreditation manual that focuses on different types of ambulatory services, i.e. imaging diagnosis, laboratory, ambulatory surgery, non-invasive methods and rehabilitation. Manuals for behavioural health care and dental care are in the developmental stages. The review of standards for the Accreditation Manual for Hospitals is under way. This review of standards is done periodically. It will incorporate the core principles stated by the ISQua in its ‘International Principles Panel’ and approved at the ISQua Accreditation Symposium held in Budapest in 1998.

**Health care networks accreditation: a new trend**

The accreditation of health care networks must be considered a quality trend for the future. Health care quality pivots on the hospital’s internal proceedings for the care of patients, as well as the protection of health and prevention of disease for the whole population through communal health care facilities. For JCAHO in the USA, it simply meant a widening of hospital methodology by starting a specific programme in this way. To accredit a health care network, the hospitals should be accredited first [13].

However, another accreditation organization emerged as a competitor, the National Committee for Quality Assurance (NCQA). NCQA developed the Health-Plan Employer Data and Information Set (HEDIS), a set of quality indicators that Health Maintenance Organizations (HMO) were to record and process. The HMOs who chose to join this project can be assessed by comparing their respective quality indicators [14].

In 1997, the Institute for Technical Cooperation in Health (INTECH; a Washington DC-based private consulting organization) selected some Argentine experts to develop an accreditation manual, suitable for the continuous quality improvement of certain health care networks which the W.K. Kellogg Foundation had supported in some Latin American cities. The Kellogg Foundation Project, called ‘A New Initiative’ (ANI), includes a strong participation of community organizations, academic institutions and basic level care facilities.

The working group designed a completely new tool using different criteria from those used in health care organizations. Their target was to improve ANI as implemented by the organizations’ leaders themselves, and not that it should be used as a means of competition among different networks. The standards designed by the group provide an ideal model of a network that can be used as a reference. Another goal was to provide programmes of disease prevention and health promotion for the patient population. The entire project was set out in two volumes: (I) Quality Conditions and (II) Manual for Surveyors.

This manual is now being applied to test and review some
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