

# AGED CARE STANDARDS AND ACCREDITATION AGENCY LTD

## CARING FOR OLDER AUSTRALIANS

### SUBMISSION BY AGED CARE STANDARDS AND ACREDITATION AGENCY

#### LTD

#### **Introduction**

Aged Care Standards and Accreditation Agency Ltd (Accreditation Agency) welcomes the opportunity to comment on the Issues Paper, *Caring for Older Australians*.

Our response is based on our knowledge and understanding of like arrangements in Australia and in other countries and over ten years experience of the aged care accreditation scheme in Australia as the company appointed as the accreditation body under the *Aged Care Act 1997*. It is also based on a body of knowledge built through feedback surveys from approved providers and their staff, thousands of visits to nursing homes in the ten year period, over 100,000 interviews with residents and their relatives in the two years to 30 June 2010, the background knowledge of our registered aged care quality assessor workforce (many of which currently work in or have prior experience in the delivery of services to the aged) and research into other systems of accreditation (with the increasing number in care arrangements variously known as residential aged care, social care or long term care auspiced by government).

This response is limited to those areas that are directly related to the accreditation arrangements and processes. In making this response Accreditation Agency recognises that the Department of Health and Ageing has initiated the review of the accreditation arrangements and accreditation standards.

Aged Care Standards and Accreditation Agency Ltd is not a regulatory body. In essence the role of Accreditation Agency as the accreditation body is to assess performance against predetermined standards and report those assessments to the Department of Health and Ageing (the regulator).

The following paragraphs address some of the issues that we believe are relevant to the Productivity Commission's deliberations in the area of quality and regulation.

#### **What is accreditation?**

Accreditation is defined a number of different ways in the literature. The International Society for Quality in Health Care (ISQua) describes accreditation as 'a public recognition of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards' (ISQua 2004, p. 8).

The Joint Commission on Accreditation of Health Care Organisations (JAHCO), a large United States based not-for-profit organisation formed in 1951, describes accreditation as a process in which an entity, separate and distinct from the health

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care organisation assesses the health care organisation to determine if it meets a set of standards requirements designed to improve quality of care (JAHCO 2010).

Accreditation is an internationally recognised evaluation process that is used in many countries to assess the quality of care and services provided in a range of areas such as health care, long term residential aged care, disability services, and non-health related sectors such as child care. It has been rapidly adopted by health and aged care services worldwide as part of a safety and quality framework.

The model of organisations related to but arm's length from government undertaking long term care accreditation assessment, follow up monitoring and public reporting is not unique to Australian residential care. It is well established in countries such as England, United States of America (15,800 homes funded by Medicaid and inspected by state authorities), Republic of Ireland, Scotland and Wales. Countries such as Hong Kong, Korea, Japan, India, Netherlands, Denmark, France and Spain are well down this path in development. There are also some variations on the theme to be seen in Canada, Germany and New Zealand.

Contemporary accreditation programs have both compliance and quality elements that work in a complementary way to promote quality and safety. Accreditation programs focus on continuous quality improvement strategies. They usually consist of a process that involves self-assessment, review or assessment of performance against predetermined standards by an external independent body, and monitoring of ongoing performance against the standards by the accreditation body.

Accreditation is not a one-off event that occurs every 3 years, or whatever the particular period of accreditation for a specified program may be. Once accredited a service or organisation is expected to maintain a level of performance that continues to comply with the accreditation standards and it is expected to undertake continuous improvement.

A program that continues to assess and monitor the performance of an organisation against the standards during the period of accreditation supports the delivery of quality care and supports quality improvement. It is not commonly recognised by members of the Australian residential aged care sector that the identification of non-compliance with the standards is part of a monitoring program that supports quality improvement.

The benefits of accreditation have been identified by a number of commentators. These benefits include:

- improves risk management and risk reduction (JACHO 2010)
- improves an organisation's performance (JACHO 2010)
- strengthens community confidence in the quality and safety of care, treatment and services (JACHO 2010)
- provides a framework that assists organisations to create and implement systems and processes which improve operational effectiveness (LTCQ 2002)

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- stimulates sustainable quality improvement (Mays 2004)

The accreditation system for residential aged care in Australia consists of many of the characteristics that commentators attribute to an effective accreditation system. These include: a framework that provides incentives and disincentives; mandatory participation; evaluation conducted by an external accreditation body; open and transparent accreditation standards and processes; public reporting of accreditation reports; unannounced visits to monitor continuing compliance with accreditation standards; and encouragement of continuous quality improvement (Shaw 2001; Scrivens 1997).

In Australia aged care accreditation is conducted by an external body, residential aged care homes are required to be accredited to receive Australian government subsidies, unannounced visits are undertaken to monitor continuing compliance with standards, reports on assessments of aged care homes' performance are available to the public, and there is a strong focus on continuous improvement in the standards.

While the accreditation related processes invariably involve a relationship principally between the accrediting body and the approved provider, public accreditation schemes exist for the benefit of consumers of services provided by the facility. The system is expected to be transparent and accountable in its processes and open to public scrutiny. There are a number of stakeholders with an interest in the assessment and its outcomes. These include relatives of residents, prospective residents, staff, management and owners of aged care facilities, government and the taxpayer generally who seek reassurance that public money allocated to providers, directly or as subsidies is achieving the required level of care.

### **International accreditation schemes**

Accreditation is not peculiar to Australia or to residential aged care. The origins of accreditation can be traced from its beginnings in the United States in the first half of the twentieth century to its adoption in Canada and Australia in the 1950s and 1960s (Scrivens 2002). It has subsequently been embraced by many countries as a means to focus health care organisations on improvement of performance and to promote safety and quality of care. There are currently many other countries embarking on the development of organisations and programs that offer accreditation.

In the United States the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) began accrediting hospitals in 1951 and now accredits over 17, 000 health care organisations and programs. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Other examples of the many accreditation systems around the world are provided by Belgium, France and Scotland (Scrivens 2002). A recent survey of European countries revealed hospital accreditation programs in 15 countries and the development of programs in two others (The Belgium Health Care Knowledge Centre 2008).

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In Australia, a variety of organisations are involved in accreditation within the healthcare sector. The Australian Council on Healthcare Standards (ACHS) provides an accreditation system for a range of health care facilities. Other accrediting bodies include the Quality Improvement Council (QIC) and Australian General Practice Pty Ltd (AGPAL). In addition to these healthcare related systems there are accreditation schemes for other sectors such as community care services and child care services.

The assessment and monitoring of the performance of services offering care and services to elderly people is not unique to Australia. JCAHO has been accrediting organisations offering long term aged care in the United States since 1966 (JCAHO 2010).

In England health and adult social care services, including residential care for the elderly, are assessed and continuously monitored against essential standards by the Care Quality Commission (CQC). In Scotland the role of the CQC is fulfilled by the Scottish Commission for the Regulation of Social Care ([www.carecommission.com](http://www.carecommission.com)) and in Wales by the Care Standards Inspectorate for Wales ([www.cssiw.org.uk](http://www.cssiw.org.uk)). In Northern Ireland the role is fulfilled by the Regulation and Quality Improvement Authority ([www.rqia.org.uk](http://www.rqia.org.uk)).

In New Zealand long term care facilities for the elderly (rest homes) are evaluated and monitored against predetermined standards by an a third party auditing agency designated by the Ministry of Health, and in Ireland the Health Information and Quality Authority (HIQA) is responsible for regularly inspecting residential care services for older people and assessing performance against national standards.

Although the accreditation systems may use different terms to describe their roles and processes they all assess the performance of long term care facilities against predetermined standards and guidelines, they all involve assessment by a third party, they are all mandatory and all involve continuous monitoring of performance.

### **Residential Aged Care Accreditation in Australia**

The processes for managing the accreditation arrangement recognises that accreditation is one part of a broad safety and quality framework directed at safeguarding the quality of care and quality of life of residents and promoting quality improvement in the sector.

Within the sector and community there is often confusion and sometimes misinformation concerning the objectives of accreditation schemes and particularly in relation to the residential aged care accreditation arrangements.

The objectives of the accreditation scheme for aged care residents in Australia should be to:

- promote quality of care and quality of life for residents
- contribute to the protection of the health, safety and well being of residents
- promote quality improvement

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The objectives of accreditation assessment activity should be to:

- measure performance against the Accreditation Standards
- ensure the accreditation body has an accurate view of the status of individual homes and the industry relative to the standards
- identify and act on divergence from the standards in a timely manner
- ensure non compliance is identified early and remedied within a reasonable timeframe
- minimise the prospects of non-compliance through timely assessment activity
- promote continuing improvement in quality of care and life for residents

### **Risk and the management of risk**

The accreditation scheme as part of the broader safety and quality program in itself will not prevent misadventure or mistake. Accreditation can be described as a (risk mitigation) strategy designed to reduce the risk of misadventure.

The effectiveness of accreditation as a risk mitigation strategy is directly linked to the way in which the accrediting body identifies and acts upon the potential for non compliance with the standards. The underlying premise is that the Standards are 'fit for purpose' and will contribute to quality outcomes for service users.

In the United States, JCAHO has been conducting on-site accreditation surveys for a number of services, including long term aged care, on an unannounced basis since 1996. Unannounced visits by State authorities are a feature of the third party assessment of nursing homes receiving Medicaid funding.

More recently unannounced visits, know as unannounced surveillance audits, have been introduced partway through a service providers period of certification (accreditation) in New Zealand. These visits, introduced following public concern about the standard of care in rest homes, were designed to provide the Ministry of Health with assurance the provider is continuing to meet relevant standards (Ministry of Health 2010).

In Ireland visits are a mixture of announced and unannounced and they may take place by day, evening, at night and on weekends (HIQA).

Although sometimes criticised unannounced visits have a number of benefits. They help organisations to focus on providing safe, high quality care at all times; affirm the expectation of continuous compliance with the standards; enhance the credibility of the accreditation process by ensuring that an organisation's performance is observed under normal circumstances; address public concerns that the accreditation body receives an accurate reflection of the quality and safety of care; and provide an assurance the provider is continuing to meet relevant standards (Ministry of Health 2010; JCAHO 2010).

In conducting the visit program, Accreditation Agency uses a risk management approach based on the information available to it as the accreditation body. The first level of this risk management approach involves site visits, in the form of announced support contacts and unannounced support contacts, designed to

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assess a home's performance against the standards. In doing so, such site visits ascertain whether a home's performance has changed since earlier visits. Site visits are part of the strategy that serves to identify those providers that are the industry's poorest performers (as described in the Commissions draft report).

The second level of the risk management based approach is to review the information Accreditation Agency has obtained about the home including the performance of the home prior to the visit and determine which areas of its activities will be the focus of the visit.

An accreditation scheme that has a targeted visit program based on a combination of assessed risk (based on information including that provided by the approved provider) coupled with random visits, will give better assurance that the accreditation body has an accurate view of the status of the home.

In any year, around 10% of homes will have identified non compliance. Given the nature of the industry it is impossible to estimate the level of non compliance that occurs and is identified through the homes internal systems and corrected before an unannounced visit. It is arguable that the Accreditation Agency visit schedule promotes the timely correction of problems.

There is no empirical evidence as to what extent the possibility of an unannounced visit contributes to promoting compliance with the standards. Anecdotally, approved providers and their staff report there is a deterrent effect.

Accreditation Agency recognises that an unannounced visit disrupts the home's management during the time of the visit. The feedback statistics, however, suggest the level of disruption is not as extensive as some commentators have suggested. In fact, Accreditation Agency's feedback program reveals that in 2008/09, when asked to comment on the question "Please rate the performance of the team in terms of allowing care staff to continue their duties during the visit", more than 97% responded 'excellent' or 'very good'. Subsequent reports have been similar. There were over 4,000 forms returned in the reported period.

To provide some context it is relevant to report that under the current arrangements most homes receive one unannounced visit each year and the duration is variable based on the purpose of the visit. Most two team member visits are concluded in a day. It would be extremely rare for an unannounced visit to extend beyond two days.

Accreditation Agency's experience in the accreditation process since its introduction in the late 1990s has enabled it to identify the common indicators of risk for approved providers. The identification of these risk indicators, and communication of these to approved providers, is part of the value of the accreditation scheme.

The ability to identify potential risks early and mitigate them has obvious benefits for the approved provider and the home, and most importantly benefits for the residents. Announced and unannounced visits are therefore important elements of an effective risk management framework.

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The introduction of a system whereby approved providers report key data to the Accreditation Agency has the potential to reshape the current visit-centric processes that are set out in the regulations. Such reporting could include corporate information and clinical and lifestyle indicators that would inform Accreditation Agency's case management. It is understood that most approved providers already collect such information for their own purposes.

There is a common failure of members of the aged care sector in Australia to recognise the value adding properties of the accreditation processes such as unannounced visits. There is limited research in relation to the question as to whether facilities 'drop back' in performance after an announced audit. However, the Accreditation Agency does identify some homes that are found to have non compliance with the standards in a reasonably short period of time following an announced visit. The research that has been conducted in the acute care sector concluded that hospitals do 'regress' in terms of compliance with the Standards (Greenfield, Pawsey & Braithwaite 2009).

Unannounced visits to aged care homes in Australia are therefore part of the risk management framework. They enable homes to confirm achievements and identify gaps for improvements and give better assurance that the accreditation body has an accurate view of the performance of the home against the standards.

### **Cost of accreditation**

Accreditation is often portrayed as an onerous process that makes unreasonable demands on the resources of approved providers and staff of homes. Although the real cost of accreditation has not been established through reliable research there is a concern expressed by approved providers that the accreditation process requires considerable investment of resources.

However, much of the cost some approved providers attribute to accreditation are costs associated with conducting their business using quality management systems. For example, it has been reported that accreditation requires a provider to have a complaints management system and that this is therefore a cost of accreditation. The Accreditation Agency's perspective is that such a system is fundamental to the conduct of a residential aged care facility and is a cost of supporting the delivery of services. Similar comments have been reported concerning care plans and other documentation that is critical to the management of services to residents.

The common claim that the accreditation scheme requires homes to produce documentation exclusively for the purpose of accreditation is a misconception. With the exception of the current three year application for a further period of accreditation the documentation required is part of what one would normally produce to provide safe quality services and care.

Another consideration in examining the claims of cost (alone) is to consider that there are many voluntary accreditation schemes in health around the world (including Australia) and the participation rates (despite the fees) are very high.

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The Accreditation Agency is aware that there is a growing industry of consultants who work with (some) approved providers to develop quality systems or undertake mock audits. This has a cost. The Accreditation Agency's perspective is that developing systems and having roles such as quality managers is a cost associated with the delivery of quality care and services, not accreditation.

Further, in relation to residential aged care there is a fee charged for accreditation. The calculation of the fee is set out in Section 2.6 of the Accreditation Grant Principles 1999. This is clearly a cost of accreditation.

Homes with more than 20 allocated beds are charged an accreditation fee. The Department of Health and Ageing fully subsidises the accreditation fees for homes with less than 20 allocated beds. All other homes pay a fee depending on their number of allocated beds.

A schedule of fees for applications for accreditation on or after 1 July 2010 are available at: <http://www.accreditation.org.au/accreditation/accreditationfees/>

In addition to the application fee there is a cost associated with completing the three year application (self-assessment form) and maintaining good care and services. However, self-assessment is a common component of most accreditation systems across many sectors and industries world wide and it has many benefits for organisations. Most organisations, including aged care homes, routinely evaluate and monitor their own performance because of these benefits. They include enabling homes to identify what they are doing well, how well they are doing it, and what they could be doing better. In other words, as part of normal effective management strategies self-assessment enables homes to identify their strengths and opportunities for improvement, and provides the basis for planning. Often members of the aged care sector fail to recognise the value adding properties of the self-assessment.

The presence of assessors on site does require input from members of the management team and care staff. However, the time required on site to assess performance of the home against the accreditation standards is not as intrusive, nor as costly, as some approved providers would suggest. Accreditation site audits, conducted every three years for homes compliant with the standards, is usually two to three days. The duration of unannounced and announced visits is on average one day on site.

Feedback from the homes also suggests that the site visits are not as onerous as some claim them to be. All homes are requested to complete an anonymous feedback questionnaire at the completion of all types of visits. The feedback in response to the question about the impact of the visit on staff time and their ability to continue their work has been very positive and suggests that assessors do not make unreasonable demands on the time of staff when on site. Responses to the question 'staff were able to continue work' in 2008/2009 showed satisfaction rates of 96.38% (unannounced visits) and 98.34% (announced). In 2009/10 the satisfaction rate was 98.34% (unannounced) and 95.30% (announced). This is sourced from over 4,000 feedback forms each year.



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The primary purpose of accreditation processes is to assess compliance with the accreditation standards to ensure residents are safe and receive adequate care and services. It is therefore appropriate for approved providers to be expected to provide sufficient time and resources to demonstrate their compliance with Accreditation Standards that aim to protect the health, safety and well being of residents in aged care homes.

### **Choice of accrediting body**

A decreasing number of providers have said that it would be more appropriate for approved providers to be able to select their accrediting body rather than the current arrangement of a single accreditation body appointed by government. Generally, no reasons have been advanced to support this position. The Accreditation Agency notes the argument previously put by the (Productivity Commission) Regulation Taskforce that competition amongst accreditation providers could reduce the cost of accreditation. Market forces do have the potential to force accreditation fees paid by approved providers down. However, further debate on the effect of costs (in the broader context) and benefits is deserving of some rigor in the debate. In terms of accreditation fees paid by approved providers, the context is that the maximum accreditation fee is \$15,191 and this is paid once every 3 years by those homes which have over 100 beds. The vast majority of homes pay a lesser fee and in fact homes with less than 21 beds have their fee fully subsidised by the government.

Some groups such as Catholic Health Australia (CHA) do not support the proposition of having multiple accrediting bodies. CHA said: "Allowing a number of accredited certifying organisations to compete to provide accreditation of an approved service and have responsibility to the Government for compliance would result in even less consistency of assessments and decisions. CHA considers that neither consumers nor the community would accept this approach" (Senate Report)

Some sections of the industry have previously argued that there is 'inconsistency' within the current accrediting body albeit little evidence or explanation to support the view is brought forward. A single accrediting body optimises the prospects of consistency in decision making, enhances public confidence in the scheme, and removes the opportunity for providers to shop around for their accreditor.

Accreditation Agency agrees with the Senate Community Affairs Reference Committee which stated "The Committee does not support the suggestion proposed by several providers of allowing a range of agencies to provide accreditation services. It believes that such an approach has the potential to lead to greater inconsistency in assessment outcomes by involving a greater number of organisations in providing accreditation services. The Committee also considers that it may encourage providers to 'shop around' for a 'soft' auditor....."

The Auditor General of New Zealand in a recent review of the arrangements in New Zealand titled 'Effectiveness of arrangements to check the standard of services provided to rest homes' opined that there were risks in the New Zealand's scheme.

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They can be paraphrased as;

- Conflict of interest that could compromise the integrity of audits The risk that homes might select the cheapest or most lenient audit organisation
- Commercial pressure might compromise the auditors independence
- Multiple auditing organisations might interpret the standards differently
- Auditors might have inadequate skills and expertise

It is Accreditation Agency's view that some of these risks might be manageable by an attentive authorising body. However all but the last point present significant challenges and substantial risk with little evidence of any material benefit to residents (for whose benefit accreditation in residential aged care exists) or approved providers.

Accreditation Agency believes that a single accreditation body appointed by government is appropriate. It should be the policy position of government that any such accreditation body should have formal accreditation as an accrediting body for its management systems and assessor training and management program from an internationally recognised organisation in the health/aged care sphere such as ISQua (Paterson et al 2005). Given the importance attached to the role of the accreditation body it is essential that the accreditation body is also subject to scrutiny by the Parliament and the Australian National Audit Office.

### **Resident engagement**

The level of resident engagement in the accreditation process is currently limited to confidential interviews conducted with residents and their representatives during visits by assessors from Accreditation Agency. In the two years to 30 June 2010 the assessors conducted over 100,000 interviews. Whilst conducting such interviews forms part of the assessors training and is a structured process the current arrangements limit the engagement to the times at which the assessors are visiting the homes.

Accreditation Agency has recently commenced dialogue with consumer groups to discuss how gathering information about resident experience can be ongoing. We will also be considering the concept of consumers (users of the services) as members of assessment teams.

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