

SCHOOL OF PUBLIC HEALTH, COLLEGE OF HEALTH SCIENCES,
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NHIS ACCREDITATION PATTERN
AMONG PRIVATE HEALTH SERVICE PROVIDERS IN GHANA



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DECLARATION

I hereby declare that apart from specific references which have duly been acknowledged, this research is my own work put together.

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DEDICATION

To my husband Dr Leslie Lamptey and children Jordan and Jasmine. Also to Dr E. G Amoako and Mrs Alberta Amoako, my parents for all the support when it mattered the most.



ACKNOWLEDGEMENT

I thank God Almighty for the grace and strength He gave me.

To the management and staff of the National Health Insurance Authority, I say thank you for allowing me to use your data on accreditation.

To the Department of Health Policy Planning and Management, I thank you all for your administrative and technical support during my studies.

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ABSTRACT

Unsuccessful attempts at securing NHIS accreditation do not prevent a facility from providing services to the general public. Knowledge on how well these facilities perform during the accreditation process is therefore needed to inform policy on improving quality of healthcare delivery. The study was a cross sectional quantitative review of NHIS accreditation data on all private health care providers who applied to the NHIA for accreditation from July 2009 to July 2012, with the purpose of describing the pattern exhibited by Private Health Service Providers in the NHIS accreditation process. The accreditation data was extracted from the NHIS database and analysed using Microsoft Excel. One thousand two hundred and fifty-two (1,252) PHSPs passed accreditation out of the 1,593 applications received, with a 78.5% success rate. Pharmacies were the most accredited PHSPs, having 22% of total accredited PHSPs. This result is explained by the fact that Pharmacies and Chemical shops are mostly privately owned and are the first point of call for most sick Ghanaians. The success rate across the Regions, levels and batches was generally above 60% and there was no clear pattern to performance across the Regions and levels of care. The Region, level or batch with the most applications had the most failure and vice versa. Fourteen 14 (11%) of the reapplications were for upgrades, meaning only 109 (32%) of the 341 failed facilities re-applied.

In conclusion the NHIS accreditation process has a high success rate, most accredited PHSPs are Pharmacy and Chemical shop levels and the conferment of provisional accreditation may be the reason for the low levels of re-application among the failed facilities.

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LIST OF ACRONYMS

ANDEM.....	Agence Nationale pour le developpement De l'Evaluation Medicale)
AHRQ.....	Agency for Healthcare Research and Quality.
DMHIS.....	District Mutual Health Insurance Scheme
GNP.....	Gross National Product
HIFA.....	Health Institutions and Facilities Act
JACHO.....	Joint Commission on Accreditation of Health Organisations
LI.....	Legislative Instrument
LMIC.....	Low and Middle Income Countries
NGO.....	Non-Governmental Organisation
NHIA.....	National Health Insurance Authority
NHIS.....	National Health Insurance Scheme
NHIF.....	National Health Insurance Fund
OECD.....	Organisation of Economic Cooperation

and Development

PDA.....	Personal Digital Assistant
PHSP.....	Private Health service Providers
WHO.....	World Health Organisation

DEFINITION OF TERMS

Accreditation.....	A system of assessing the performance a healthcare provider,
Batch.....	Major nationwide accreditation survey
Downgrade.....	Accredited to provide service at a level lower than previously applied for.
Failure.....	Inability to score at least 50% in accreditation process.
Level of care.....	Categories of health services provided
Module.....	Unit for assessment in accreditation
Private healthcare provider.....	A privately owned facility that provides medical, dental, maternity and diagnostic services to the general public.
Provisional accreditation.....	Accredited to provide service for six months whiles making provision to improve in areas where a facility performed poorly.
Quality of care.....	Adherence to set standards of healthcare

provision.

Reaccreditation.....

Facility on provisional accreditation

reapplying for accreditation.

Upgrade.....

Accredited to provide a higher level of care.

CHAPTER ONE

INTRODUCTION

1.1 Background

This was a cross sectional quantitative review of NHIS accreditation data on all private health care providers who applied to the NHIA for accreditation from July 2009 to July 2012.

Increase in privatisation of health care provision has become a central element of health sector reform in many countries. For this reason, the roles of private facilities in the health sector in Ghana and Africa in general cannot be over emphasised. In Ghana, 37% of hospital admissions (Accra excluded) are provided by missions (Marek et al 2005). Similar phenomenon is seen in other low and middle income countries (LMIC), evident by the fact that India has 80% of its 390,000 qualified allopathic doctors working in the private sector which provides one third of inpatient and two thirds of outpatient services (Sauerborn, 2001).0.

Currently, concerns with accountability in health systems reflect in several factors, first is dissatisfaction with health system performance in both industrialized and developing/transitioning countries. This discontent has been focused on costs, quality assurance, service availability/access, equitable distribution of services, abuses of power, financial mismanagement and corruption, and lack of responsiveness (Brinkerhoff, 2004). Experience with quality improvement demonstrates its potential positive influence on both management and clinical outcomes in low income settings (Groene et al, 2008).

A potential method of fostering sustained facility-level improvements and larger system-level change is the establishment of an accreditation process for health facilities. Although accreditation programmes take a variety of forms, accreditation is typically a formal process of assessing the degree to which health facilities meet predetermined standards pertaining to quality and availability of services (Cleveland et al, 2011).

As stated by Ensor and Weinzierl, regulation is traditionally seen as the use of bureaucratic and administrative controls by government to correct market failure (Ensor & Weinzierl, 2007). Yet traditional methods such as licensing and certification frequently fail to control behaviour because of the limited resources available to government in low- and middle-income countries, and because of the powerful countervailing incentives that encourage deviant behaviour to continue, resulting in the provision substandard quality of care (Ensor & Weinzierl, 2007). It is increasingly being realised, therefore, that goals of policy can sometimes be achieved more efficiently by involving other actors in the regulatory mechanism (Ensor & Weinzierl, 2007)

In America, state-by-state reports on quality by the Agency for Healthcare Research and Quality (AHRQ), along with the state scorecard on health system performance constitute a rich database to inform state and national health policy and stimulate further research and analysis of the determinants of and interrelationships among quality, health outcomes, access, cost, and equity dimensions of performance (AHRQ 2006; Cantor et al. 2007).

In Ghana, the NHIS began in 2005 with a regime of provisional accreditation which was characterised by minimal criteria with no inspection of facilities, a formal accreditation system was however developed in 2008 and implemented from 2009. Accreditation is a legal requirement for NHIS in Ghana, and the National Health Insurance Authority (NHIA) has the mandate to do this (Tweneboah, 2011). There is however very little information on the performance of both public and private service providers in the process, information such as the trend of outcomes as well as factors associated with success and failure in the accreditation process is not available.

The fact that unsuccessful attempts or poor performance in accreditation does not prevent a service provider from attending to the general public is a good reason for a descriptive study on facility performance to be undertaken, to better inform state and national health policy, especially with the establishment of the Health Facilities Regulatory Agency and to stimulate further research and analysis of the determinants and interrelationships among quality, health outcomes, access, cost, and equity of healthcare.

1.2 Problem statement

Patients receive poor quality of care when they visit health service providers which do not adhere to set standards of health care delivery. The quality of health service delivery can be improved by thoroughly assessing facilities before they commence operations and by periodic monitoring to ensure standards are continuously adhered to, the NHIA seeks to achieve this through its accreditation process to ensure NHIS subscribers are only

served by service providers which provide a certain level of quality healthcare. However the general performance pattern of both private and public providers in this exercise has not been thoroughly analysed and documented and facilities continue to provide service to the general public even when they perform poorly in the NHIA accreditation process.

The unavailability of information on the performance pattern of service providers means facilities which perform poorly in key areas or fail accreditation entirely, due to non-adherence to set standards will continue to provide service to the general public. This is because the respective regulators of these facilities are often constrained and are poorly equipped to assess quality and adherence to set standards.

This problem needs to be solved in order to improve the quality of health service delivery in Ghana, by thoroughly assessing facilities before they commence operations and by periodic monitoring to ensure standards are continuously adhered to.

1.3 Conceptual framework

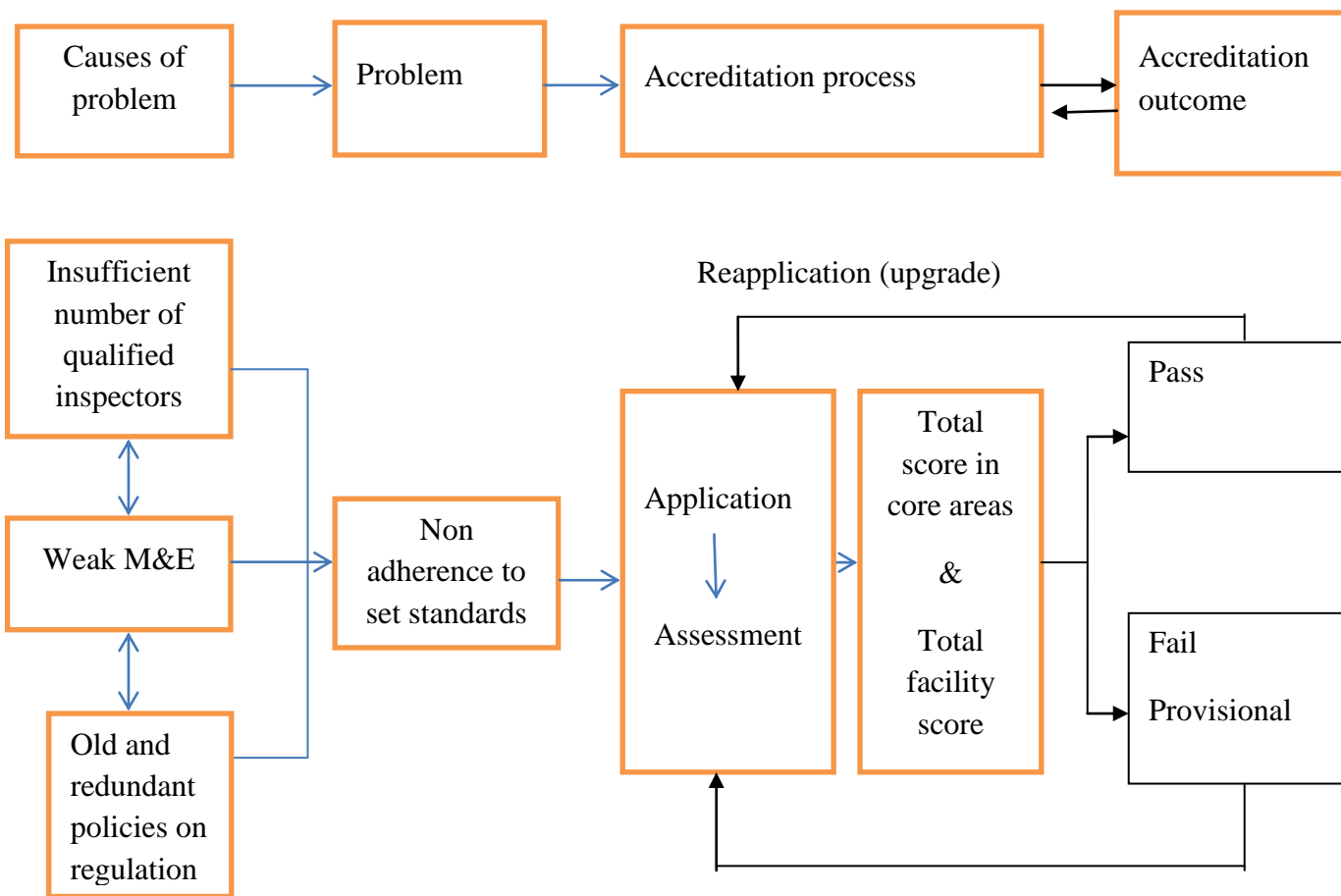
Non-adherence to set standards in the provision of health care is a major problem in Ghana as it is in many industrialised and developing countries; this is primarily due to constraints faced by government-run regulatory bodies (Brinkerhoff, 2004). Such constraints include weak monitoring and evaluation system, insufficient numbers of qualified inspectors and old and redundant policies. It is in recognition of this problem that the Health Institutions and Facilities Act (HIFA) was passed, this new law seeks to empower the institutions which were previously regulating the activities of only private facilities and maternity homes to regulate public facilities as well, to ensure uniformity.

The degree of non-adherence to set standards of medical practice is reflected by the fact that not all applications for NHIS accreditation are successful, albeit their existence as functional health service providers.

As part of NHIA's regulation, all prospective service providers under the NHIS will have to undergo an accreditation process (Act 650) or credentialing (as stipulated by the new Act 685) to ensure that the basic standards are adhered to ensure quality service to subscribers. When an application is made and the appropriate fee paid, the applicant is given a manual with which they are to prepare for inspection and scoring. During the inspection, scoring is done based on the various accreditation standards (modules) and according to facility type and level of service provision. Scoring is done with the assistance of a personal digital assistant (PDA) in which the scoring system has been programmed.

Facilities which already have NHIS accreditation may reapply for an upgrade to provide higher services, those who failed but were given provisional accreditation will also have to reapply to be reassessed. Accreditation when conferred has a viability period of five years, after which the facility must reapply. Figure 1 is a diagrammatic representation of the conceptual framework. Further evidence has been provided in section 2.1.3.

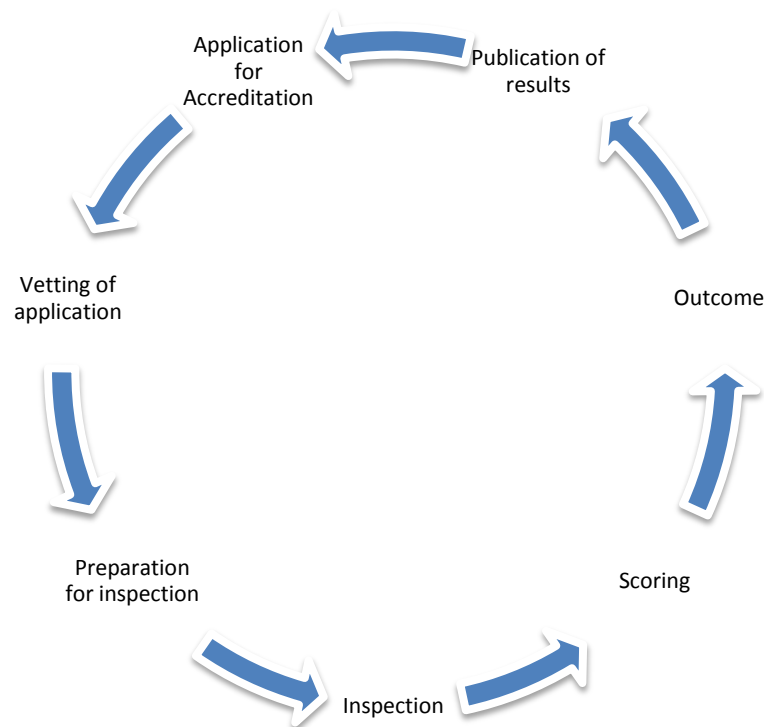
Figure 1: Conceptual framework of health facility accreditation



1.4 NHIS accreditation process

Figure 2 is a diagrammatic representation of the NHIS accreditation process, the process begins with an application from a facility interested in providing services under the NHIS; a completed application form is submitted along with relevant documents and applicable fees.

Figure 2: NHIS accreditation cycle



Applications are vetted by accreditation officers to ensure that forms are appropriately filled and basic criteria are met. The officers look out for a certificate of business registration, a certificate from appropriate regulatory body and proof of qualification and certification of members of staff.

Applicant facilities then go through a preparation process of for inspection: applicants use the manual they receive upon application to make necessary preparation for inspection.

Inspection and scoring of facilities using the following modules: range of service, staffing, environment and infrastructure, basic equipment, organisation and management, safety and quality management, out-patient care, in-patient care, maternity care, specialised care, diagnostic services and pharmaceutical services. The requirements under the various modules is dependent on the type of facility (hospital/clinic, pharmacy/chemical shop, maternity home) and the level of service provision (primary, secondary or tertiary).

Scoring is done according to the following criteria: Score 3 if all criteria are met, Score 2 if half or more are met but not all ($\geq 1/2$), Score 1 if less than half are met (but not zero), Score 0 if no criterion is met and Score "N/A" if the standard is not applicable. Core areas for assessment are: Range of services, Staffing levels relevant to services, Organisation and management, Safety and quality management and Care delivery.

Unit / module scores are added up and the cumulative scores in all the modules determine the facility score on which the outcome is based, a facility is accredited if the facility score is 50% and above. Provisional accreditation is given when facility score is less than 50% but scores 50% and above in core areas put together. Accreditation is denied when a facility scores below 50% overall and/or in core areas put together. Facilities which are already accredited to provide service at a lower level may reapply for accreditation for a higher level, these facilities are assessed on modules based on the desired high level and

when successful an upgraded accreditation is given (NHIA Accreditation Manual and Tool, 2009). The interpretation of the assessment score is shown in table 1 below.

Table 1: NHIS accreditation score interpretations

Grade	Total facility score
A+	90% - 100%
A	80% - 89%
B	70% - 79%
C	60% - 69%
D	50% - 59%
E = fail	Facility score < 50% and / total in core areas < 50%
Provisional	Facility score < 50% but total in core areas 50% or above

1.5 Justification

The ability of facilities to go through successful NHIA accreditation translates into provision of quality healthcare resulting in improved outcome of disease episodes. Proportions of the various outcomes of NHIS accreditation give an idea of the level of adherence to standards in private health facilities, as the present mode of regulating these facilities is constrained. Literature on the performance of service providers, especially private providers in any accreditation process in Ghana is limited; research must therefore be conducted on the pattern of NHIA accreditation outcomes and factors associated with

the various accreditation outcomes. The NHIA requires this information as a baseline on future policies on accreditation to ensure equitable distribution of quality health care in accordance with WHO recommendations.

1.6 Objectives

1.6.1 General Objective

The general objective of the study is to describe the pattern of the NHIS accreditation among Private Healthcare Providers in Ghana.

1.6.2 Specific Objectives

The specific objectives are:

- I. To determine the pattern of Private Health Service Provider accreditation under NHIS.
- II. To determine the pattern of failure among Private Health Service Providers.
- III. To determine the pattern of reapplication among Private Health Service Providers with provisional accreditation (reaccreditation)
- IV. To determine the pattern of reapplication among Private Health Service Providers who have accreditation to provide service at a lower level(upgrading)
- V. To determine the factors associated with accreditation and failed accreditation among Private Service Providers

CHAPTER TWO

2.1 literature review

2.1.1 Role of private sector

The increasing privatization of health care provision has been a central element of health sector reform in many countries. The roles of private facilities in the health sector in Ghana and Africa in general cannot be over emphasized. In Ghana, 37% of hospital admissions (Accra excluded) are provided by missions (Marek et al, 2005).

The public sector finances less than half of total health expenditures, the rest is being financed from out-of-pocket, which goes primarily to buying services from the private sector (Marek et al, 2005).

In most African countries, the private sector plays a more significant role than government, especially when compared to OECD countries, where public financing provides the majority of resources (Marek et al., 2005). As reported by Tountas et al, in Greece private health expenditure has gone up, reaching 3.9% of the country's GNP (i.e.43% of the total expenditure in health) in 2000. The number of private hospitals and hospital beds has however decreased (i.e. hospitals decreased from 468 in 1990 to 218 in 2000 and private beds decreased from 25,075 in 1980 to 15,806 in 2000). The number of private doctors and private diagnostic centres has significantly increased as well and this situation has been attributed to the provision of inadequate and low quality public health services (Tountas et al, 2005). Apart from key public health services such as immunization, family planning and treatment for tuberculosis and HIV/AIDS (which are often not provided) private health facilities provide almost all the services provide at

public health facilities. This increased role for the private sector was seen as a means to improve health service provision through improved efficiency and quality (Marek, et al, 2005)

2.1.2 Quality of care

Quality of care has been defined by the WHO as the level of attainment of health systems' intrinsic goals for health improvement and responsiveness to legitimate expectations of the population (WHO 2000). Another very influential definition of quality of care is that proposed by the Institute Of Medicine (IOM) in the United States and which has been adopted by a range of organizations including the United States Department of Health and Human Services, the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance, as well as regulatory bodies such as the Health Care Financing Administration (Edinger 2000).

Donabedian indicated that quality of healthcare can be assessed by evaluating its structure, process and outcomes. Structure (or input) is the attributes of the settings in which care occurs and the resources needed for health care. This would include material resources (facilities, capital, equipment, drugs, etc.), intellectual resources (medical knowledge, information systems) and human resources (health care professionals). Process denotes the use of resources in terms of what is done in giving and receiving care. This can be classified into patient-related processes (intervention rates, referral rates, etc.) and organizational aspects (supply with drugs, management of waiting lists, payment of health care staff, collection of funds, etc.). Outcomes describe the effects of

health care on the health status of patients and populations and comprise final outcomes such as mortality, morbidity, disability or quality of life, as well as intermediate outcomes, for instance, blood pressure, body weight, personal well-being, functional ability, coping ability, improved knowledge and others (Donabedian, 1988)

2.1.3 Regulation in the health sector

There are currently some concerns with accountability in health systems, and this reflects on several factors including the dissatisfaction with health system performance in both industrialized and developing/transitioning countries. Discontent has focused on costs, quality assurance, service availability/access, equitable distribution of services, abuses of power, financial mismanagement and corruption, and lack of responsiveness (Brinkerhoff, 2004).

Health ministries, insurance agencies, public and private providers, legislatures, finance ministries, regulatory agencies and service facility boards are all connected to each other in networks of control, oversight, cooperation and reporting and regulation is often seen as a potential response to address the many problems which arise in the private production, financing and delivery of health services as well as having a crucial and balancing role in the push towards privatization (Kumaranayake, 1997).

Although basic regulatory legislations exist in most developing countries, the degree to which regulations are enforced and effective is low, giving rise to lots of problems, especially in the private sector. Problems associated with private sector activity in the health sector include: poor physical infrastructure and a shortage of qualified staff; low

standards of care; poor equipment or inappropriate technology; misuse of public resources within the private sector (e.g. public supplies and time of professional staff diverted to the private sector) and medical malpractice and negligence. (Kumaranayake, 1997).

Licensure, accreditation, and certification are different systems of quality assurance, with which health service providers can be regulated. These systems have different purposes and different capabilities and selecting the right system or combination of systems requires careful analysis of user needs and expectations and purpose (Rooney & Van Ostenberg, 1999).

Licensing is a statutory mechanism by which a governmental authority grants permission to an individual practitioner to engage in an occupation or to a healthcare organization to operate and deliver services. Licensing allows governments to ensure basic public health and safety by controlling the entry of healthcare providers and facilities into the healthcare market and by establishing standards of conduct for maintaining that status (Zeribi & Marquez, 2005).

Accreditation is a formal process by which a recognized body, usually a non-governmental organization (NGO), assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site

evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation (Rooney & Van Ostenberg, 1999)

Certification is a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Although the terms accreditation and certification are often used interchangeably, accreditation usually applies only to organizations, while certification may apply to individuals, as well as to organizations. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure. When applied to an organization, or part of an organization, such as the laboratory, certification usually implies that the organization has additional services, technology, or capacity beyond those found in similar organizations (Rooney & Van Ostenberg, 1999).

African countries have been urged by the World Health Organisation (WHO) for so long to establish national quality improvement programmes as part of health sector reforms (WHO, 2003; Cleveland et al, 2011). Experience with quality improvement demonstrates its potential positive influence on both management and clinical outcomes in low income settings (Groene et al, 2008). Furthermore, accreditation programmes may increase equity across health systems by fostering incremental improvements in quality (Montagu, 2003). Nevertheless, most quality improvement efforts described in the literature focus on

changes in an individual health facility or in a set of facilities rather than system-wide reform (WHO, 2003).

(Braithwaite, Healy and Dwan, 2005), proposed a framework for analysing regulation that is based on the concept of responsive regulation, “which maintains that regulators are more likely to succeed by using mechanisms that are responsive to the context, conduct, and culture of those being regulated”. Escalating sanctions can be invoked “that is, soft words before hard words and carrots before sticks”.

2.1.4 Accreditation and health insurance

Many countries are attempting to efficiently manage excess capacity in their health system and rein in total cost. The hope is that this can be done without deterioration in the availability and quality of health care services. New methods of payment for services are being designed to introduce efficiencies into the provision of health care services and thus reduce cost. For instance, centralized systems that previously paid all costs for facilities’ operation and services delivery to the population are implementing payment controls through the introduction of payment linked to diagnosis, employer-supported insurance, and private insurance (Rooney & Van Ostenberg, 1999) as well as social insurance systems.

The National Health Insurance Scheme (NHIS) in Ghana was established by the National Health Insurance Act, 2003 (Act 650) and National Health Insurance Regulations, 2004 (L.I. 1809) with the view to improving financial access of Ghanaians, especially the poor

and the vulnerable, to quality basic health care services and to limit out-of-pocket payments at the point of service delivery (Bennett, Creese, & Monasch, 1998).

Act 650 and LI 1809 permitted the commissioning of the National Health Insurance Authority (NHIA) “to secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents.” The NHIA licenses and regulates district-level mutual health insurance schemes (DMHISs) as well as other schemes (Blanchet et al, 2012)

Enrolment and membership in a DMHIS is mandatory for all residents of Ghana except those working with the Ghana Armed Forces, the Ghana Police Service or those who have proof of holding a health insurance policy. Persons eligible for enrolment and membership are expected to pay a contribution of GHC 7.2 per year (equivalent to US\$ 7.74 at time of passage of Act). A period of six months may lapse between payment of membership and issuance of membership cards for accessing service (Seddoh et al, 2011).

The Scheme provides for persons to be exempted from paying membership fees. These are: Contributors to the national Social Security and National Insurance Trust (SSNIT) or drawing pension benefits on SSNIT, persons under the age of 18 with at least one parent paying membership fees or covered by the exemption clause, persons above the age of 70 years and persons classified as indigents according to the criteria set by the Act 650 and LI1809 (Seddoh et al, 2011).

The legislative instrument defines a benefit and an exclusion package for which a member of the Scheme may have access. Any service provider wishing to provide services to members of the Scheme have to apply to the NHIA for accreditation and licensing to provide a specified set of services from the benefit package according to their assessed competency (Seddoh et al, 2011). NHIA accreditation begun in 2005 with a regime of provisional accreditation which was characterised by minimal criteria with no inspection of facilities, a formal accreditation system was however developed in 2008 and implemented from 2009. About 2,647 facilities had been given accreditation out of the 2915 inspected in the first three batches of accreditation (Tweneboa, 2011).

Health care providers in America are accredited by private institutions, and this serves a crucial quality assurance function in the American health care system. Since the start of widespread third-party payment for health care services, third-party payers have used private accreditation to thereby identify which health care institutions are qualified to provide services for payment to their beneficiaries. Private accreditation serves to alleviate the need for third party payers to make independent assessments of the quality of their providers' facilities and services (Kinney, 1994).

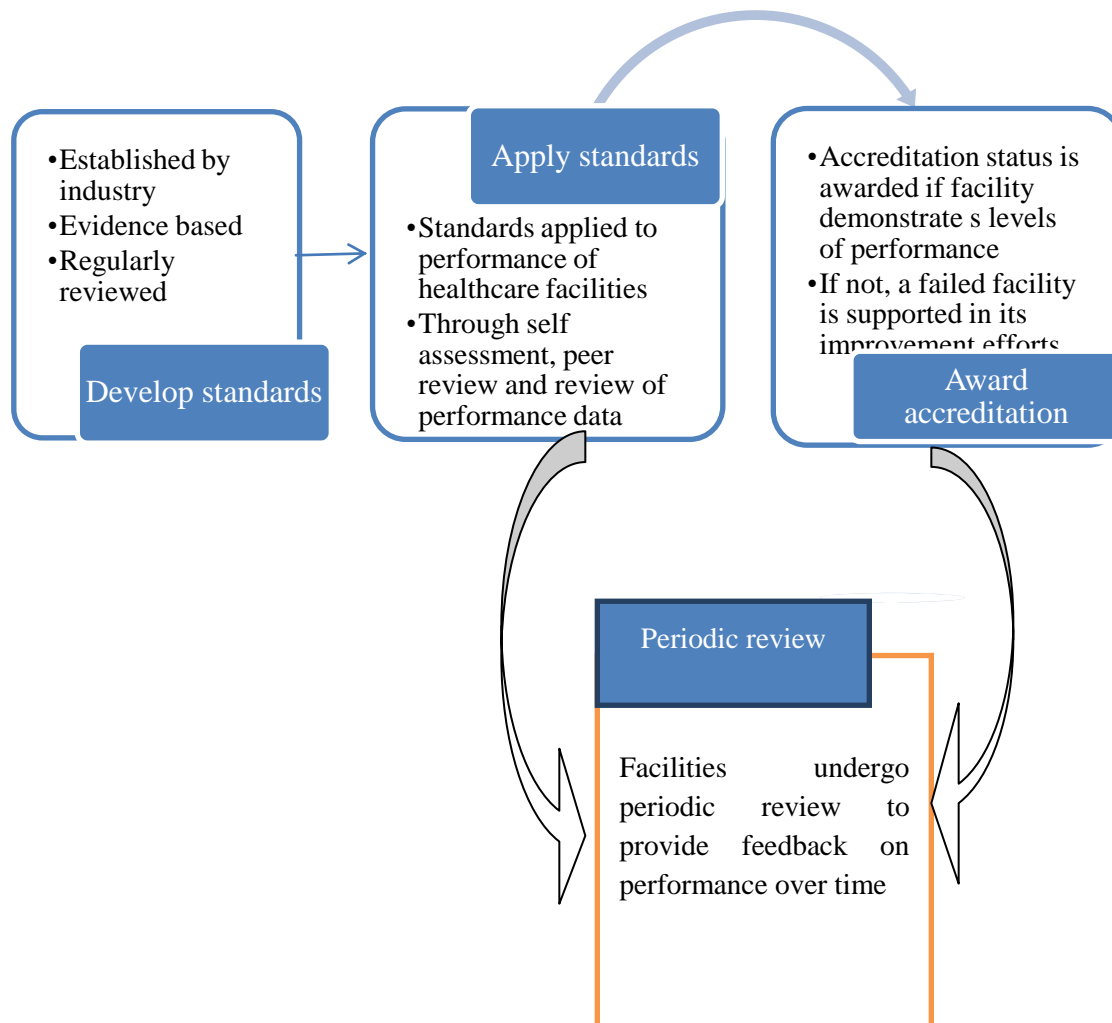
As the Medicare and Medicaid programs came on-line in 1965, the federal government and states became third-party payers and they used private accreditation to identify qualified hospitals, the federal government and states used private accreditation as evidence of compliance with Medicare conditions of participation and state licensure laws, respectively. This resulted in effective delegation of government's regulatory

responsibilities for assuring that health care institutions meet the requisite quality standards for participation in their respective programs (Kinney, 1994).

2.1.5 Accreditation in practice

Figure 3 shows a generic accreditation model which forms the backbone of most accreditation systems. Internationally, accreditation is designed to improve organizations through the development of new standards or upgrading existing standards through research or expert advice, and by defining criteria and performance indicators and applying these standards, criteria and indicators to organizational processes and outcomes. Most accreditation systems assess and rate the performance of organizations and services by evaluating their progress and appraising their compliance with standards, usually through self-assessment surveys, data review and structured visits by surveyors. Peer surveyors are usually used for these surveys. The core concerns addressed by the processes of accreditation are whether organizations satisfy pre-designated standards, are regularly examined and continuously improved, and the extent to which customer satisfaction is met or enhanced (Braithwaite et al, 2011).

Figure 3: Generic accreditation model (Braithwaite et al, 2011).



There is a wide range of national and international organizations addressing issues of quality of care and these have influenced the development of regional, national and international quality of care strategies across Europe. Among the most influential are the United States-based JCAHO and the IOM, as well as the International Society for Quality in Health Care (ISQua). At European level, influential bodies include the European

Society for Quality in Healthcare (ESQH), the Council of Europe and the World Health Organization (WHO) Regional Office for Europe (WHO, 2008).

Assessment and reporting of health-care quality has become increasingly important and more widespread, this trend has resulted in the proliferation of quality indicators to measure performance and outcomes. Indicators are used to monitor the quality of care in a single institution or across the health-care system, to promote quality improvement activities, to make comparisons over time between institutions (benchmarking), or to assist consumers to choose health-care providers (Copnell et al, 2009).

Accreditation of hospitals began in the USA as a mechanism to ensure an appropriate environment in which clinicians could practise effectively. It was adopted in Canada and Australia, where it conformed to the early design of standards to control the hospital environment. In the past decade, these accreditation systems have changed in response to the decline in the role of the hospital in health care delivery; the demands of governments and the public for greater information about quality of health care. They have also responded to pressure for greater knowledge of clinical effectiveness by introducing indicators of clinical performance. Within the past 10 years, accreditation has been adopted in a number of other countries where governments have extended their role into assuring the quality of health care. Accreditation, originally perceived as a vehicle to enable organizational development, is increasingly an agent of government regulation (Scrivens, 1995).

Germany's accreditation system began with systematic quality assurance programmes addressing selected topics in the mid-1970s at regional levels (Birkner 1998; Ollenschlager, Marshall & Qureshi 2004). At national level, professional self-regulation, with monitoring of technical safety and hygiene, was, until the end of the 1980s, regarded as sufficient to ensure quality of health care (Busse & Riesberg 2004). Then in the mid-1990s, "quality in health care" became a priority topic both in professional self-administration and health policy at state level – focussing on the use of quality management programmes, clinical guidelines, and quality indicators (Helou, Schwartz & Ollenschlager 2002).

Egypt's accreditation system has a total of 716 standards in 3 categories: (69) critical standards, (322) core standards and (325) non-core standards. To become accredited, a hospital must meet all the critical standards and reach a cumulative score of 85% on the core standards. The noncore standards constitute a more ambitious target that hospitals are encouraged to work toward; current accreditation requires hospitals to reach a cumulative score of 40% on the non-core standards (Partners for Health Reform plus, 2005).

According to a report by William Newbrander (Newbrander,1999) the voluntary & Private Hospitals Registration Unit in Tanzania is responsible for licensing of all health facilities that are not public, however a facility will have to go through an accreditation process in order to qualify to provide services under the National Health Insurance Fund (NHIF).

The provider is required to:

1. have sufficient and adequate resources: human (health personnel), equipment, and Facilities (state of the buildings);
2. have formal quality assurance and utilization review process;
3. accept the NHIF payment mechanism;
4. adopt the referral protocols and accept the planned sharing of expensive health resources;
5. have rights for patients;
6. have information systems and provide available and necessary data with NHIF.

The accreditation process by the NHIF may take one of four forms, the NHIF can:

- (1) Rely on other government units inspection results to determine accreditation status
- (2) Do the inspections itself
- (3) Contract out for the inspections
- (4) Seek to form a separate autonomous non-government unit that would accredit all Health facilities in the country, public and private.

In Canada, the agency responsible for accreditation is a private not-for-profit organisation made up of a consortium of professionals and the process is not compulsory except in Quebec. Standards for assessments are based on leadership and partnership, human resources, environment and information management. Accreditation reports are not made available to the general public (Touati & Pomey, 2009).

Quality and safety policies in France were implemented through the intermediary of an independent agency, the Agence Nationale pour le développement de l'Évaluation Médicale (ANDEM), which later became the Agence Nationale d'accréditation et d'évaluation en santé (ANAES) and finally the Haute Autorité de Santé (HAS). Legislation created by the ANAES in 1996 made accreditation compulsory and specified certain standards to apply to parts of the process (Touati & Pomey, 2009).

In both Canada and France, accreditation is a rigorous peer review process comprised of self-assessment against a given set of standards, an on-site survey, the issuance of a report that sometimes includes recommendations and follow-up on those recommendations. In both countries, standards are applied on a national basis, allowing teams and organizations to benchmark and share best practices. The process occurs over a 3-year cycle in Canada and a 4-year cycle in France (Touati & Pomey, 2009).

2.1.6 Experiences with accreditation

Braithwaite et al indicated that accreditation results predicted leadership behaviours and cultural characteristics of healthcare organisations but not organisational climate or consumer participation and there is a positive trend between accreditation and clinical performance (Braithwaite et al., 2010)

From an assessment of the first 100 accreditation results from France, out of the 100 accredited hospitals, there were 40 public, 43 private and 17 mixed ownership. Nine (9) facilities were accredited without recommendations for improvement, 47 with recommendations for improvement, 40 with reservations, and 4 with major reservations. All facilities received requests for improvement. According to the study, the size of the

hospital correlates with number and degree of seriousness of the, hence the bigger the hospital, the more numerous and more serious the decisions (Daucourt & Michel, 2003).

CHAPTER THREE

Methods

3.1 Type of study

This was a descriptive quantitative cross sectional study using secondary data on NHIS accreditation from July 2009 to July 2012, covering 7 accreditation surveys.

3.2 Study area

This study involved data on Ghana's NHIS. As of July 2012, the NHIA had 3434 accredited health service providers, of which 1252 belonged to the private sector.

3.3 Variables

Accreditation outcome (accredited, provisional accreditation or failed accreditation) is the dependent variable. The independent variables are the total facility score and the total score in core areas.

3.4 Study population

Study population was all health service providers who had applied for NHIS accreditation in the NHIA database.

3.5 Sampling

Sample frame was private healthcare providers who applied for NHIS accreditation from July 2009 to July 2012. All private providers who have applied for NHIS accreditation from its inception to July 2012 were purposively selected for the study. A sample size of 1593 PHSP was used.

3.6 Data collection

Data was extracted from the NHIA accreditation data base which contains information on location, ownership, level of care, facility characteristics and accreditation scores and accreditation status of all facilities that have ever applied for NHIS accreditation with the aid of a data extraction checklist, and transported into Microsoft Excel.

3.7 Quality control

For quality control, the completeness of the data was assessed and facilities whose data was incomplete contacted or visited to obtain missing information. Data was extracted by the researcher to ensure the right information was what got analysed.

3.8 Data processing

Microsoft Excel was used to extract relevant aspects of the transported accreditation data on PHSP.

3.9 Data analysis

The analysis focused on determination of the pattern of PHSP accreditation under the NHIS, pattern of failure among PHSPs, pattern of reaccreditation among PHSPs with provisional accreditation, pattern of upgrading among PHSPs and factors associated with accreditation success and failure.

Estimation of pattern of successful accreditation per batch was done by dividing the total number of accredited PHSP per batch by the total number of applications from PHSP then multiplied by 100. This was done by batch, Region and level of care for all 7 batches of accreditation to determine the pattern of PHSP accreditation in Ghana.

Estimation of pattern of failure per batch was done by dividing the total number of failed PHSP per batch by the total number of applications from PHSPs then multiplied by 100. This was done by batch, Region and level of care for all 7 batches of accreditation to determine the pattern of PHSP failure in the accreditation process in Ghana.

Estimation of pattern of successful reaccreditation per batch was done by dividing the number of accredited PHSPs with provisional accreditation per batch by the number of PHSPs with provisional accreditation who apply for reaccreditation to determine the pattern of reaccreditation among PHSPs.

Estimation of pattern of successful upgrade per batch was done by dividing the total number of successful upgrade per batch by the total number of upgrade applications per batch to determine the pattern of upgrading among PHSP.

Estimation of factors associated with successful and failed accreditation was done by determining the frequency of occurrence of factors common to accredited facilities and factors common to failed facilities was used to determine factors that were associated with accreditation and failure. Microsoft Excel was used for analysis of the data.

3.10 Study limitations

The data was also not uniform across all the batches, especially information on reapplication deductions therefore had to be made on which facility was reapplying for reaccreditation and which ones were pure reapplications making it a potential source of error. Data only captures total facility scores and scores in “core areas”, leaving out scores in the other modules.

CHAPTER FOUR

Results

4.1 Pattern of PHSP accreditation

4.1.1 Application pattern of Regions

The NHIS accreditation process begins with the submission of a completed application form and the appropriate fees and documentation. There have been a total of 1593 applications from PHSPs for the first seven batches (major nationwide surveys) of accreditation which occurred between July 2009 and July 2012. Table 2 is a summary of accreditation applications among the Regions.

TABLE 2: Distribution of total applications among the Regions

Region	Batch1 n (%)	Batch2 n(%)	Batch3 n(%)	Batch4 n(%)	Batch5 n(%)	Batch6 n(%)	Batch7 n(%)	overall total n(%)
Ashanti	133(30.2)	126(29.5)	61(17.3)	39(30.23)	32(19.6)	6(26.1)	9 (15.2)	406(25.5)
BrongAhafo	55(12.5)	25(5.8)	66(18.7)	16(12.40)	15(9.2)	4(17.4)	6 (10.2)	187(11.7)
Central	52(11.8)	10(2.3)	13(3.7)	8(6.20)	14(8.6)	2(8.7)	6(10.2)	105(6.6)
Eastern	41(9.2)	32(7.5)	9(2.6)	0(0.00)	8(4.9)	2(8.7)	4(6.8)	96(6.0)
Greater Accra	60(13.6)	92(21.5)	105(29.8)	25(19.38)	51(31.3)	6(26.1)	13(22.0)	352(22.1)
Northern	18(4.1)	54(12.6)	24(6.8)	5(3.88)	16(9.8)	0(0.0)	5(8.5)	122(7.6)
Upper East	34(7.7)	7(1.6)	4(1.1)	6(4.65)	3(1.8)	0(0.0)	0(0.0)	54(3.4)
Upper West	1(0.2)	12(2.8)	5(1.4)	4(3.10)	4(2.4)	0(0.0)	1(1.7)	27(1.7)
Volta	18(4.1)	18(4.2)	19(5.4)	3(2.33)	1(0.6)	0(0.0)	1(1.7)	60(3.8)
Western	28(6.4)	51(11.9)	46(13.1)	23(17.83)	19(11.7)	3(13.0)	14(23.7)	184(11.5)
Batch total	440(100.0)	427(100.0)	352(100.0)	129(100.0)	163(100.0)	23(100.0)	59(100.0)	1593(100.0)
% of grand total	27.6	26.8	22.1	8.1	10.2	1.4	3.7	

In batch 1 of accreditation there were 440 applications, out of which applications from the Ashanti Region formed about 30%. Applications from Brong Ahafo, Central and Greater Accra Regions combined to form almost 40% of the total applications for the first batch. The remaining 30% of applications was divided amongst the Eastern, Northern, Upper West, Upper East, Volta and Western Regions. Batch 2 applications were 427 in total and were dominated by the Ashanti Region with about 30% applicants; the next largest applications came from the Greater Accra Region with about 22%. The least number of applications was from the Upper East Region, making up just over 1.6% of the applications.

The Greater Accra Region had the most application for accreditation in the third batch of accreditation survey, contributing almost 30% of the total applications (352) for the batch; this was followed by the Ashanti and BrongAhafo Regions with 17% and 18% respectively. The Upper East Region had the least contribution with a little over 1%. The fourth batch with a total application of 129 followed a similar trend as the first two batches, with the Ashanti and Greater Accra Regions having the most applications at 30% and 19% respectively. Applications from the Western Region came close with 18% and the Region with the least number of applications was the Volta Region with 2%. With 31% of the total applications (163), Greater Accra Region had the most number of applications for the fifth batch of accreditation survey, followed by the Ashanti Region with 20%, the Volta Region had the least number of applications (1%).

The sixth batch had the least number of applications (23), with the Greater Accra and the Ashanti Regions having the most applications at 26% each. There were no applications from the Northern, Upper East, Upper West and Volta Regions for this batch of

accreditation survey. Batch seven had 57 applications, the Western Region putting in about 24% of the applications, the Greater Accra Region had the next highest number of applications with 22%. There was no application from the Upper East Region and the Upper West and Volta Regions had the least number of applications, about 2% each.

4.1.2 Application pattern by levels of care

For the purposes of this study, Diagnostic Centres, Eye Clinics, Dental Clinics and Physiotherapy Centres are lumped together as “Other” in terms of level of care. Table 3 is a summary of the application pattern by the various care levels.

Table 3: Distribution of applications by batch and level of care

Batch	Chemical shop n(%)	Clinic n(%)	Scan centre n(%)	Pharmacy n(%)	Maternity home n(%)	Primary Hospital n(%)	Laboratory n(%)	Other n(%)	Grand Total n(%)
1	55(12.5)	82(18.6)	17(3.9)	80(18.2)	131(29.7)	47(10.7)	28(6.4)	0(0.0)	440
2	73(17.4)	91(21.7)	5(1.2)	99(23.6)	57(13.6)	55(13.1)	22(5.2)	18(4.3)	420
3	69(19.6)	86(24.4)	10(2.8)	78(22.2)	36(10.2)	35(9.9)	23(6.5)	15(4.3)	352
4	30(22.1)	38(28.0)	3(2.2)	25(18.4)	10(7.3)	16(11.7)	7(5.2)	7(5.2)	136
5	31(19.0)	41(25.2)	11(6.8)	27(16.6)	12(7.4)	13(7.9)	17(10.4)	11(6.8)	163
6	3(13.0)	3(13.0)	2(8.7)	4(17.4)	4(17.4)	3(13.0)	3(13.0)	1(4.4)	23
7	5(8.5)	15(25.4)	1(1.7)	15(25.4)	4(6.8)	5(8.5)	5(8.5)	9(15.3)	59
Level total	266	356	49	328	254	174	105	61	1593
% of grand total	16.7	22.3	3.1	20.6	16.0	11.0	6.6	3.8	100.0

Out of the 1593 total applications for accreditation, 356 applications, constituted about 22%, were from clinics, 21% from the pharmacies and 17% from the chemical shops. Scan Centres contributed 0.3% of the applications. For the first batch of accreditation, 30% of the applications came from the maternity homes, 19% from the clinics and 18% from the pharmacies. There were no applications from Physiotherapy Centres, Diagnostic Centres, Dental and Eye Clinics for batch 1 of the accreditation survey.

There were 420 applications in batch 2, 24% of these came from pharmacies, applications from clinics constituted 19%. Diagnostic Centres, Physiotherapy Centres, Dental and Eye Clinics combined to contribute 4% of the applications in the second batch. Of the 352 applications received for the third batch of accreditation, 24% came from Clinics, 22% from Pharmacies and 19% from Chemical shops. A total of 15 applications came from Diagnostic centres, Physiotherapy Centres, Dental and Eye clinics which constituted 4% of the batch total. Clinics contributed about 28% of the 136 applications for the fourth batch of accreditation survey; this was followed by 22% from Chemical shops and 19% from pharmacies. There were 3 applications from Scan Centres, making them the level with the least number of applications in the fourth batch.

Applications from Clinics constituted about 25% of the fifth batch applications, Chemical shops were the level with the second highest number of applications constituting about 19% of the applications, Scan Centres and the Other levels of care combined to contribute about 13% of the applications. Applications from Pharmacies and Maternity homes were the highest in the sixth batch of accreditation survey; they combined to contribute about 35% of the total applications for that batch. Chemical shops, Clinics, Primary Hospital and Laboratories had the same number of applications, contributing about 53% of the

total. With a total of 30 applications (15 each), Clinics and Pharmacies combined to constitute about 51% of the applications for the seventh batch survey and there was 1 application from a Scan Centre.

4.2 Accreditation performance

After a facility has applied for accreditation, it is inspected and scores given for the various aspects, the outcome could either be a pass or a fail. Of the 1,593 applications from PHSPs, there have been 1,252 passes (79%) and 341 failures (21%).

4.2.1 Accreditation passes

Table 4 is a summary of accreditation passes among the 10 Regions

Table 4: Distribution of passes among the Regions

Region	Batch1 n(%)	Batch2 n(%)	Batch3 n(%)	Batch4 n(%)	Batch5 n(%)	Batch6 n(%)	Batch7 n(%)	overall total n(%)
Ashanti	72(24.4)	111(30.5)	45(16.6)	35(28.9)	9(6.5)	6(27.3)	8(15.4)	286(22.8)
BrongAhafo	15(503)	13(3.6)	53(19.6)	15(12.4)	14(10.1)	4(18.2)	6(11.5)	120(9.6)
Central	38(13.4)	8(2.2)	10(3.7)	8(6.6)	13(9.3)	0(0.0)	5(9.6)	82(6.5)
Eastern	36(12.7)	24(6.6)	9(3.3)	7(5.8)	12(8.6)	2(9.1)	4(7.7)	94(7.5)
Greater Accra	43(15.2)	82(22.5)	64(23.6)	21(17.4)	49(35.2)	6(27.3)	11(21.1)	276(22.0)
Northern	18(6.4)	52(14.3)	23(8.5)	3(2.5)	13(9.35)	1(4.5)	5(9.6)	115(9.2)
Upper East	30(10.6)	4(1.1)	2(0.7)	3(2.5)	4(2.9)	0(0.0)	0(0.0)	43(3.4)
Upper West	1(0.3)	10(2.7)	5(1.8)	4(3.3)	3(2.1)	1(4.5)	1(1.9)	25(2.0)
Volta	7(2.5)	13(3.6)	18(6.6)	2(1.6)	1(0.7)	0(0.0)	1(1.9)	42(3.3)
Western	23(8.1)	47(12.9)	42(15.5)	23(19.0)	21(15.1)	2(9.1)	11(21.1)	169(13.5)
Batch total	283(100.0)	364(100.0)	271(100.0)	121(100.0)	139(100.0)	22(100.00)	52(100.0)	1252(100.0)
% of grand total	22.6	29.1	21.6	9.6	11.1	1.8	4.2	

Most of the passes were from the second batch (364), making up 23% of the total passes. The least number of passes was from the sixth batch (22), constituting about 2% of the total passes. Ashanti Region had 23% of the overall passes across the seven batches; the Greater Accra Region followed closely with 22%. The remaining 55% was shared among the remaining eight Regions with the Upper west Region having the least, 2%. Ashanti Region had the most passes in batch one with 25%, followed by Greater Accra, Central and Eastern Regions with 15%, 13% and 13% respectively. The Upper West Region with 1 pass had the least in this batch. Ashanti Region also had the highest number of passes in the second batch, coming up with 31% of the total passes, the Greater Accra Region acquired 23% of the total batch passes, the Upper East Region had the least number passes, 1% of the total batch passes.

The Region with the highest percentage of passes in the third batch of accreditation was the Greater Accra Region, which had 24% of the total batch passes, followed by Brong Ahafo Region with 20%. The Ashanti and Western Regions had 17% and 16% respectively. Upper East Region with 5 passes (2%) had the least in this batch. Out of the 121 passes in the fourth batch, the Ashanti Region had the most passes with 29%, Western Region was next with 19% and Volta Region had the least number of passes with about 2.5%. The fifth batch of accreditation had a total of 139 passes with the most of them coming from the Greater Accra Region (35%). Volta Region had the least number of passes, obtaining about 1% of the total passes for that batch. With 22 passes, the sixth batch had the least number of passes out of the 7 batches of accreditation. The Ashanti and Greater Accra Regions had 6 passes each to form 54% of the passes, the Northern and Upper west Regions had 1 pass each and there were no applications from

the Central and Upper East Regions. Greater Accra and Western Regions had the most passes in the seventh batch of accreditation with 21% each. The Ashanti Region had 15% to become the next highest. Upper West and Volta Regions had the least number of passes, 2% each and there were no applications from the Upper East Region.

4.2.2 Accreditation failures

Out of the total 341 failed attempts at accreditation, most failures (30%) came from the Ashanti Region. Greater Accra Region had 22% followed by the Brong Ahafo with 21%. Failures from the Upper West Region constituted about 2% of the total failures, making it the Region with the least number of failures. Batch 1 of accreditation had the most failures, a total of 155 failures which forms 45% of the total failures. Batch 3 is the next highest with 80 failures, forming 24% of the failures and with 1 failure batch 6 had the least among the 7 batches. Table 5 is a summary of failure distribution.

Table 5: Distribution of failures among the Regions

Region	Batch1 n(%)	Batch2 n(%)	Batch3 n(%)	Batch4 n(%)	Batch5 n(%)	Batch6 n(%)	Batch7 n(%)	overall total n(%)
Ashanti	61(39.3)	15(24.1)	16(20.0)	4(26.7)	4(18.2)	0(0.0)	1(16.7)	101(29.6)
Brong Ahafo	40(25.8)	12(19.3)	10(12.5)	1(6.7)	8(36.4)	0(0.0)	0(0.0)	71(20.8)
Central	14(9.0)	2(3.2)	3(3.7)	0(0.0)	1(4.5)	0(0.0)	0(0.0)	20(5.9)
Eastern	5(3.2)	8(12.9)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	13(3.81)
Greater Accra	16(10.3)	10(16.1)	41(51.2)	4(26.7)	2(9.1)	0(0.0)	2(33.3)	75(22.0)
Northern	0(0.0)	2(3.2)	1(1.2)	2(13.3)	3(13.6)	0(0.0)	0(0.0)	8(2.3)
Upper East	4(2.6)	3(4.8)	2(2.5)	3(20.0)	1(4.5)	0(0.0)	0(0.0)	13(3.8)
Upper West	0(0.0)	2(3.2)	2(2.5)	0(0.0)	0(0.0)	0(0.0)	1(16.7)	5(1.5)
Volta	11(7.1)	5(8.1)	2(2.5)	1(6.7)	0(0.0)	0(0.0)	0(0.0)	19(5.6)
Western	4(2.6)	3(4.8)	3(3.7)	0(0.0)	3(13.6)	1(100.0)	2(33.3)	16(4.7)
Batch total	155(100.0)	62(100.0)	80(100.0)	15(100.0)	22(100.0)	1(100.0)	6(100.0)	341(100.0)
% of grand total	45.5	18.2	23.5	4.4	6.5	0.3	1.8	100.0

In batch 1, Ashanti Region had 61 failures, which makes up 39% of the batch failures. Brong Ahafo's 40 failures constitute 26% of the batch failures, making it the second Region with most failures. The Upper East and Western Regions had the least failures in first batch each contributing about 3% to the total batch failures. Batch 2 had a total of 62 failures, 15(24%) from the Ashanti Region, 12 (19%) from Brong Ahafo and 10 (16%) from Greater Accra Region. Northern and Upper West Regions had 2 failures each. The Greater Accra region had the most failures in the third batch of accreditation, obtaining 51% of the total batch failures. Upper East, Upper West and Volta Regions had the least numbers, obtaining 3% each. There was no failure from the Eastern Region.

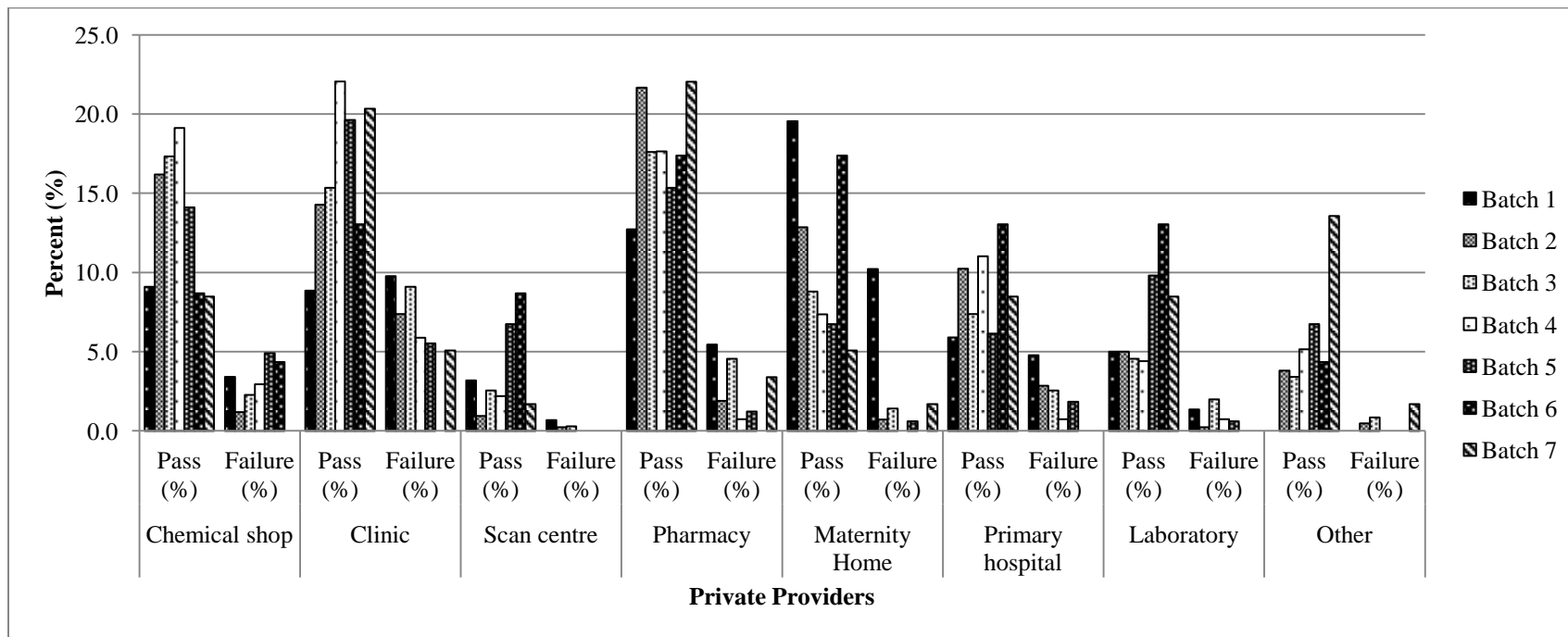
The fourth batch of accreditation had a total of 15 failures, most of which came from the Ashanti and Greater Accra Regions with 4 failures each. There were no failures from the

Central, Eastern, Upper West and Eastern Regions. The fifth batch had 22 failures, 8 (36%) coming from the Brong Ahafo Region, the Ashanti Region had 18%, while the Northern and Western Regions had 14% each. There were no failures from the Eastern, Upper West and Volta Regions, and there was only 1 failure in the sixth batch of accreditation, and it came from the Western Region. Out of the 6 failures in the seventh batch, Western and Greater Accra Regions had 2 each forming a total of 66%. There were no failures from the Brong Ahafo, Central, Eastern, Northern and Upper East Regions.

4.2.3 Performance by levels of care

Figure 3 is a summary of the performance of the various levels of care in the NHIS accreditation surveys.

Figure 4: Accreditation Performance by level of care



There were 55 applications from Chemical shops in batch 1, the number of Chemical shops that passed accreditation constituted about 9% of the overall passes for batch 1, failures from Chemical shops formed 3% of the overall batch failures. Of the 82 applications from Clinics, 39 passed and 43 failed, forming 9% and 10% of the total batch passes and failures respectively. Seventeen (17) scan centres applied in batch 1, 14 passed and 3 failed. The 14 passes formed 3% of the overall batch passes. Maternity homes had the most passes and failures in the first batch, obtaining about 20% of the overall passes and 10% of the total failures. In batch 2, Pharmacies had the most number of passes, obtaining about 22% of the total batch passes. Chemical shops had the next highest number of passes (16%) with the least number of passes coming from the scan centres (1%). Clinics had 31 failures which formed the greatest percentage of failures in the batch, 3(1%) of the second batch failures came from the maternity homes. There were 61 passes from Chemical shops and 62 from Pharmacies; both contributed about 35% of the total passes in batch 3, the level with the least number of passes was Scan centre. Passes from Pharmacies constituted 17% of the overall passes across all seven batches, 14% of the overall passes were from clinics and 14% from Chemical shops. The level with the least percentage of passes was Scan Centre with 35 of overall passes.

4.3.1 Pattern of reapplication

A failed facility, depending on location, type of service and total score in the core areas may be given a provisional accreditation to provide service while steps are taken to reapply (reaccreditation). A failed facility may reapply to provide service at a level lower than previously applied for (downgrade), in order to increase their chances of success. A facility with formal accreditation to provide service may also reapply to upgrade accreditation to provide services at a higher level (upgrade). Accreditation reapplications began from the second batch of accreditation, a total of 123 reapplications had been made, 5 of them in the second batch. The greatest number of reapplications was seen in the third batch (42). Table 6 is a summary of accreditation reapplication among the Regions.

Table 6: Distribution of reapplication by region

Region	Upgrade		Downgrade		Reaccreditation		Reapplication	
	pass	fail	pass	fail	pass	fail	pass	fail
Ashanti	5(12.2)	0(0.0)	0(0.0)	0(0.0)	13(32)	3(7.3)	16(39.0)	4(9.8)
Brong Ahafo	1(3.5)	1(3.5)	0(0.0)	0(0.0)	3(10.4)	4(13.8)	20(67.0)	0(0.0)
Central	1(16.7)	0(0.0)	0(0.0)	0(0.0)	2(33.3)	0(0.0)	3(50.0)	0(0.0)
Eastern	1(16.7)	0(0.0)	2(33.3)	0(0.0)	0(0.0)	0(0.0)	3(50.0)	0(0.0)
Greater Accra	1(33.3)	0(0.0)	2(66.7)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Northern	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(25.0)	3(75.0)	0(0.0)
Upper East	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(50.0)	1(50.0)	0(0.0)
Upper West	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Volta	0(0.0)	0(0.0)	0(0.0)	0(0.0)	1(7.7)	0(0.0)	6(46.2)	6(46.2)
Western	4(66.7)	0(0.0)	0(0.0)	0(0.0)	1(16.7)	0(0.0)	1(16.7)	0(0.0)

Ashanti Region had 41 of the 123 reapplications, 16 of these were reaccreditation (39%), 20 reapplications (32%) and 5 upgrades (12%). Twenty –nine 29 reapplications came from the Brong Ahafo Region, made up of 20 (69%) reapplications, 7 (24%) reaccreditations and 2 (7%) upgrades. The Upper East Region had the least number of reapplications, 2 in total (1 reapplication and 1 reaccreditation) and there were no reapplications from the Upper West Region,

There have been 2 applications for downgrade, 1 each from Eastern and Greater Accra Regions, both applications were successful. A total of 13 applications have been made for upgrades, 12 passed and 1 failed. Five (5) of the applications for upgrade came from the Ashanti Region and the only unsuccessful application for upgrade was from the Brong Ahafo Region.

4.3.2 Level of care pattern of reapplication

Tables 7a and 7 b are summaries of reapplication distributions among the levels of care

Table 7a: Distribution of reapplication by level of care per batch

Batch	Chemical shop		Clinic		Scan Centre		Pharmacy	
	pass	fail	pass	fail	pass	fail	pass	fail
2	0(0.0)	0(0.0)	1(20.0)	0(0.0)	0(0.0)	0(0.0)	1(20.0)	0(0.0)
3	1(2.4)	0(0.0)	13(31)	1(2.4)	0(0.0)	0(0.0)	4(9.5)	0(0.0)
4	1(3.7)	0(0.0)	12(44.4)	0(0.0)	0(0.0)	0(0.0)	2(7.4)	0(0.0)
5	1(2.7)	1(2.7)	11(29.7)	5(13.5)	0(0.0)	0(0.0)	3(8.1)	0(0.0)
6	0(0.0)	0(0.0)	1(25.0)	0(0.0)	0(0.0)	0(0.0)	1(25.0)	0(0.0)
7	1(12.5)	0(0.0)	1(12.5)	0(0.0)	0(0.0)	0(0.0)	2(25.0)	0(0.0)

Table 7b: Distribution of reapplication level of care by batch

Batch	Maternity		Prim Hospital		Laboratory		Other	
	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
2	0(0.0)	0(0.0)	2(40.0)	1(20.0)	0(0.00)	0(0.0)	0(0.0)	0(0.00)
3	12(28.6)	0(0.0)	6(14.3)	2(4.7)	2(4.76)	0(0.0)	0(0.0)	1(2.38)
4	2(7.4)	0(0.0)	9(33.33)	1(3.7)	0(0.0)	0(0.0)	0(0.0)	0(0.00)
5	3(8.1)	0(0.0)	4(10.81)	2(5.4)	4(10.8)	(0.0)	3(8.1)	0(0.00)
6	2(50.0)	0(0.0)	0(0.00)	0(0.0)	0(0.0)	0(0.)	0(0.0)	0(0.00)
7	0(0.0)	0(0.0)	3(37.5)	0(0.0)	1(12.5)	0(0.0)	0(0.0)	0(0.00)

Out of the total 123 reapplications, 5 came from Chemical shops, 4 of these reapplications were successful, and the unsuccessful reapplication was one of two reapplications in the fifth batch. Forty-five (45) of the reapplications were from Clinics, 14 (31%) in the third batch, 12 (27%) in fourth batch, 16 (35%) in the fifth batch and 1(2%) each for the second, sixth and seventh batches. There were a total of 13 reapplications from Pharmacies, all of whom were successful. Maternity Homes also had 100% success in reapplications. Out of the 30 reapplications from Primary Hospital, 6 (20%) were unsuccessful. There was however no reapplication from a Primary Hospital in the sixth and seventh batches. Seven (7) of all the reapplications from Laboratories passed, giving them a 100% reapplication success rate.

CHAPTER FIVE

Discussion

5.1 Pattern of PHSP accreditation

As depicted by the conceptual framework, the absence of strong regulatory agencies for health service providers in Ghana, especially diagnostic service providers (Laboratories and Scan centres) coupled with the NHIS's bid to ensure subscribers receive a certain level of quality healthcare resulted in the commencement of formal accreditation by the NHIA. Accreditation in health insurance is a standard practice worldwide as stipulated by Kinney, (Kinney, 1994). Since the start of widespread third-party payment for health care services (health insurance), third-party payers (insurance companies) have used private accreditation to thereby identify which health care institutions are qualified to provide services for payment to their beneficiaries. Private accreditation serves to alleviate the need for third party payers to make independent assessments of the quality of their providers' facilities and services (Kinney, 1994).

The NHIS accreditation process begins with the submission of an application, appropriate fees and documents, and such applications were made by 1593 PHSPs across the first seven batches of accreditation, organised between July 2009 and July 2012. Applications are gathered over a period and a nationwide survey or inspection of facilities is conducted, this constitutes a batch of accreditation survey. During the inspection the various aspects of applicable modules are given scores and an average found for scores for the core modules, scores for general modules and the combined scores. A facility may

either pass or fail; failed facilities and facilities who seek to upgrade their level of care may reapply. A failed facility may be given a provisional accreditation for 6 months and will have to reapply (reaccreditation).

5.1.1 Applications

There were a total of 1,593 accreditation applications from PHSPs for the first seven batches of accreditation. 1,219 (77%) of these applications were in the first 3 batches. The Ashanti Region had the most applications, 406 applications constituting 26% of the total applications, with a total of 325 applications (22%) the Greater Accra Region had the second highest number of applications, the least number of applications, 27 (2%) was from the Upper West Region.

Although accreditation is a legal requirement for NHIS service providers, participation in accreditation is often a voluntary process (Rooney & Van Ostenberg, 1999) hence begins with an application or request to be accredited. The first and second batches of accreditation were held in July and November 2009 respectively, until then there had been no formal accreditation under the NHIS and that was the first opportunity for potential service providers to fulfil the legal requirement of being accredited hence the large number of applications observed (867).

Level of care is determined by the prescribed range of the various healthcare services that are provided by the PHSPs; Clinics are not allowed to admit beyond 24 hours, Primary Hospitals have wider range of services and can admit beyond 24 hours, Diagnostic Centres provide more than one investigative service. Chemical shops are not necessarily

managed by Pharmacists and they are to serve only a limited category of medicines. For the purposes of this study, Diagnostic Centres, Eye Clinics, Dental Clinics and Physiotherapy centres are lumped together as “Other” in terms of level of care.

Out of the 1,593 total applications for accreditation, 356 (22%) were from Clinics (21%) from the Pharmacies and 17% from Chemical shops, Scan centres contributed 0.3% of the total applications. Majority of the applications were from Clinics, Pharmacies and Chemical shops, this is in line with common practices in Ghana where majority of privately owned healthcare facilities are in the category of Clinics, Pharmacies and Chemical shops. There are no stand-alone Pharmacies or Chemical shops in Ghana that are run by the Government, they all form part of a setup, be it a hospital, Polyclinic or a Health centre.

Ghana has no privately owned Polyclinics, the Healthcare facilities are either Clinics or Hospitals and there are a few Government owned Maternity homes such as the one in Osu. In Ghana Pharmacies and Chemical shops are usually the first point of call for the sick in the communities; this follows a similar trend as reported in Igun’s study of why residents in a Nigerian community prefer to reports their illnesses at a pharmacy (Igun, 1987). As a result of the high level of patronage, there are many Pharmacies and Chemical shops in Ghana, these are mostly private hence the reason for their large numbers in terms of private facility applications for NHIS accreditation. Private clinics are the next most popular level of healthcare service provision in Ghana; this explains why applications from Clinics were relatively high. Private Scan and Diagnostic centres are relatively new in Ghana and requires the services of trained personnel (sonographers

and laboratory scientists) who are very few nationwide, this explains the low figures in terms of number of applications from these categories or levels of care.

5.1.2 Accreditation performance

After a facility has applied for accreditation, it is inspected and scores are given for the various aspects, this is in conformity with international processes for accreditation involving the use of quality indicators to measure performance and outcomes (Copnell et al, 2009). Of the 1,593 applications from PHSPs, there have been 1,252 (79%) passes and 341 (21%) failures, with a success rate of 78.5%. The plausible reasons for such a high rate of success may either be due to the fact that the regulatory bodies for these service providers do a good job at ensuring that facilities can provide high quality service before they are given the licence to operate or the usefulness of the accreditation tools and manuals given to facilities as a guide for their preparation for accreditation survey. There was no Regional or level of care pattern to the accreditation performance, agreeing with Braithwaite et al that accreditation results are not predicted by organisational climate or consumer participation (Braithwaite et al, 2010).

5.1.2.1 Distribution of accreditation passes

The most passes came from the Ashanti Region (286) out of a total of 406 applications (70%). Greater Accra had 276 passes out of 352 applications, giving the Region a success rate of 78%, with 25 passes out of 27 applications (92.5%), the Upper west Region had the best success rate among the 10 Regions; this could be explained by the small number of applications from the Region, hence reducing the chances of failure. The success rate

of both the Ashanti and Greater Accra Regions also follow a similar trend, the success rate is lower when the number of applications is high. The generally high success rate in the accreditation process is supported by a study of the first 100 facilities assessed in France where 9% were accredited without recommendations for improvement, 47% with recommendations for improvement, 40% with reservations, and 4% with major reservations (Daucourt & Michel, 2003), giving it a success rate of 96%. The success rate in the first batch was however low (64%) and this could be attributed to two factors: firstly the fact that it was the very first accreditation survey, most of the facilities had very little knowledge of what it was about and how detailed or otherwise the survey was going to be. The second factor being the number of applications received, batch 1 had 440 applications, making it the batch with the largest number of applications and with greater chances of failures.

The sixth batch had the least number of applications and by virtue of the fact that facilities may have had the opportunity to learn from previous surveys, the performance was the best in this batch.

5.1.2.2 Distribution of accreditation failures

Out of 341 failed attempts at accreditation across the first seven batches of accreditation, Ashanti Region had the most failures with about 30% of the overall failures, this follows a trend where by the larger the number of applications the higher the failure rate. Most of the failures (45%) also came from batch 1 where the most number of applications (27.6%) came from.

Just as seen in the trend for passes, the sixth batch with the least number of applications (1.4%) had the least number of failures (0.3%) and the first batch with the most number of applications (27.6%) had the most failures (45%). This may also be attributed to the timing of the survey (being the first), hence providers were ill prepared and did not know what to expect. In the same way the sixth batch had the least number of applications and the least number of failures. There were more failures in the seventh batch (1.8%) than the sixth batch (0.3%), and this could be attributed to the number of applications, 23 for batch 6 and 59 for batch 7.

5.1.2.3 Performance by level of care

Of the 356 applications from Clinics, 230 (65%) passed, success rate for Pharmacies was 83% and that for Chemical shops was 85%. Primary Hospitals had a surprising success rate of 73%, which could be attributed to the relatively low number of applications (174) considering the fact that the requirements for a Primary Hospital are relatively intensive. The relatively high success rates observed for Pharmacies and Chemical shops could be attributed to two reasons: the large number of applications and also by virtue of the fact that requirement for Pharmacy and Chemical shops are relatively less intense compared with levels that require clinical settings.

5.1.3 Pattern of accreditation reapplication

A failed facility, depending on location, type of service and total score in the core areas may be given a provisional accreditation to provide service whiles steps are taken to reapply (reaccreditation). A failed facility may reapply to provide service at a level lower than previously applied for (downgrade), in order to increase their chances of success and

a facility with formal accreditation to provide service may also reapply to upgrade accreditation to provide services at a higher level (upgrade). Accreditation reapplications began from the second batch of accreditation and there were a total of 123 reapplications, 7.7% of the total number of applications. There were 5 (4%) reapplications in the second batch; the greatest number of reapplications came in the third batch, 42 (34%). Ashanti Region had 41 (33%) of the reapplications. Twenty - nine (24%) reapplications came from the Brong Ahafo Region and the Greater Accra Region had 3 (2.4%) of the reapplications. Whereas there have been no reapplication from the Upper West Region, the Upper East Region had the least number of reapplications, 2 in total (1 reapplication and 1 reaccrreditation).

Majority of the failures were from the Ashanti and Brong Ahafo Regions 101 (30%) and 71 (21%) respectively, this therefore explains the reason why most of the reapplications were from the Ashanti and Brong Ahafo Regions, (33%) and 24% respectively. Although Greater Accra Region had 75 (22%) of the failures, only 3 facilities (4%) reapplied, 1 for upgrade and 2 for downgrade. This could possibly be due to the fact that majority of the facilities which failed from Greater Accra were given provisional accreditation and are therefore not motivated to reapply.

Out of the total 123 reapplications, 5 (4%) came from Chemical shops, 4 of these reapplications were successful, and the unsuccessful reapplication was one of two reapplications in the fifth batch. Forty – five (37%) of the reapplications were from Clinics and a total of 13 (11%) reapplications came from Pharmacies, all of whom were successful. Maternity homes also had 100% success in reapplications and there was 30 (14%) reapplications came from Primary Hospitals, 6 (20%) were unsuccessful.

Clinics were the level with the most failures over the first seven batches of accreditation; it therefore stands to reason that majority (37%) of the reapplications were from clinics. The success rate of Clinic reapplication (86%) was an improvement over the overall success rate (64%), an indication that clinics had the potential to perform well. Although there had been a total of 5 (10%) failures from Scan centres, there were no reapplications from Scan centres and three possible explanations could be given for this phenomenon, firstly the failed facilities are no longer interested in the NHIS, secondly the facilities have been unable to meet the requirements needed for accreditation success especially in the area of qualified personnel and lastly facilities were given provisional accreditation and are not motivated to reapply.

From the study, 1,252 out of the 1,593 (79%) total applications passed, some of the 341(21%) failed facilities were given provisional accreditation to reapply. The high success rate in the accreditation process agrees with a similar study in France on the first 100 accredited facilities, where there was a 96% success rate. The most likely reason for this trend is the fact that all applicant facilities are given a manual on accreditation; this manual explains into details the applicable modules, what is expected and how the scoring is done, with the purpose of helping facilities prepare adequately for the survey or inspection.

5.2 Study limitations

The absence of data on scores in specific modules for each facility meant it was not possible to determine the factors that are associated with passes and failures. The data was also not uniform across all the batches, especially information on reapplication,

deductions therefore had to be made on which facility was reapplying for reaccreditation and which ones were pure reapplications making it a potential source of error. The absence of adequate literature on performances in accreditation processes worldwide limited the degree to which comparisons could be made.

CHAPTER SIX

6.1 Conclusions

The study sought to describe the NHIS accreditation pattern for PHSP, looking at the distribution of applications, passes, failures and reapplications among the regions and the seven batches of accreditation survey. The study revealed that the overall success rate for accreditation is high (79%) and there is no regional pattern to the performance in accreditation. Majority of the applications came from the Ashanti and Greater Accra Regions and the Upper West Region had the least number of applications. Pharmacies and Chemical shops had the most applications and the first and second batches understandably had the most number of applications. Accreditation performances have no relation to the location and level of care of facilities and facilities will have a high chance of success so long as they use the accreditation tools and manuals to prepare for the survey. The large number of applications received from Pharmacies and Chemical shops is indicative of their numbers nationwide, hence highlighting the preference of Pharmacies and Chemical shops as the first point of call to seek healthcare services. Furthermore future research on factors that influence NHIA accreditation outcomes should be undertaken.

6.2 Recommendations

The study makes the following recommendations:

1. That the NHIA continues with the accreditation process to help improve quality of healthcare delivery in Ghana:
2. That the NHIA follows up on all facilities with provisional accreditation.
3. That NHIA conducts post accreditation surveys to ensure the continuous provision of good quality healthcare.
4. That the Ghana Health Service should continue with her peer review mechanism to complement NHIA's efforts aimed at improving the quality of healthcare delivery nationwide.
5. That future research must be conducted on the factors that influence NHIA accreditation outcomes.

6.3 Contribution to policy

This study will be one of the basic documents for the formulation of policies concerning the NHIA accreditation process and support their implementation. Secondly it will also be a guide for post accreditation monitoring to ensure adherence to standards as anecdotal evidence suggest that some facilities rent or borrow staff and equipment just for the accreditation survey.

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