Accreditation System for Health Facilities

Challenges and Opportunities

In the context of weak regulatory systems, increasing demand for good quality care from the middle class and the entry of private health insurance companies, there is a need to examine mechanisms such as accreditation for improving the quality of health services.

SUNIL NANDRAJ, ANAGHA KHOT

Health care delivery in India is multifaceted, consisting of diverse practitioners and institutions, mixed ownership patterns and differing systems of medicine. The last several decades have brought about improvements in the health system, with strides being made in the achievement of demographic, infrastructural and epidemiological indicators. However, deficiencies persist with respect to access, affordability, efficiency, quality and effectiveness of health services. The utilisation data [NSSO 1998] indicates that the private sector pre-dominates in terms of provision of care, with 80 per cent of ambulatory care and 60 per cent of inpatient care being sought in the private sector. The quality of care available in both the public and the private sector has come under scrutiny. Evidence for the dismal state of the public health services is well documented. There is increasing evidence of poor quality private sector care, as measured by reported and actual diagnostic and treatment practices; inadequate facilities and equipment; over-prescribing and the subjecting of patients to unnecessary investigations and interventions; and failure to provide information to patients [Yesudian 1994, Nandraj 1994, Nandraj and Duggal 1996, Uplekar et al, 1998, Bhat 1999]. These serious deficiencies exist in the context of international and national policies promoting increased involvement of the private sector in the delivery of health services [World Bank 1993, World Bank 1995] with the government gradually playing a minimalist role in the growth and provision of health services.

In most states in India, there is an absence of legislation for regulating private health care facilities, laboratories and various types of health centres nor have standards of medical practice been prescribed in terms of qualification of staff employed, equipment needed, administration or treatment offered. Attempts at enacting legislation for clinical establishments have not met with success in face of opposition from health care providers and their associations. Hence, factors contributing to poor quality of care in private hospitals include lack of monitoring by statutory authorities; outdated and inadequate legislation; and the inability or failure of the government to enforce existing regulations [Jesani 1996]. Such unchecked functioning by the private sector and provision of poor quality of health services places a major risk on the life of people using facilities having deficient standards. The lack of any kind of quality assurance mechanisms (such as accreditation) not only makes it difficult for people to make informed choices in selecting health providers but also limits their capacity to demand optimum services. Simultaneously, the opening of the health insurance sector to private participation makes it imperative for health care providers to provide quality care. There is a growing demand from consumers for better quality health care, especially from the middle classes, as reflected in the growth in use of consumer protection legislation to substitute for the inadequacies of the existing health care regulatory system [Bhat 1996]. In this context, there is a need to explore the potential of various mechanisms for ensuring safe, high quality health care that is viable, affordable and accountable.

It is clear that given the inadequacy or non-responsiveness of the current policies and processes (including legislation) to ensure provision of health care services of acceptable quality there is a need to examine alternative mechanisms of quality assurance such as certification, regulation, quality assurance programmes, peer review, consumer education and developing accreditation systems amongst a range of options.

Accreditation as a Mechanism

One approach that is gaining acceptance around the world is that of accreditation. Lewis (1984) defines accreditation as the awarding of "professional and national recognition to facilities that provide high quality of care. It is implicit that the particular health facility has voluntarily sought to be measured against high professional standards and is in substantial compliance with them." In accreditation systems, standards are clearly defined and graded, compliance is assessed by intermittent external review by health professionals and accreditation is awarded for a time-limited period. The performance is determined by comparing actual practice with agreed standards. The broad features of accreditation are that it is voluntary, educational, health professionals play a pivotal role within the body and ensure its functioning and implementation. These bodies are usually self-funding and sustain themselves through levying fees from health facilities seeking accreditation. Accreditation focuses on quality of care and is linked to strategies for improving quality of care and promoting best practices, rather than on merely ensuring compliance with minimum acceptable standards. Accreditation recognises the need to reach consensus among a range of stakeholders-government, professional organisations, consumers on what constitutes appropriate practices for the particular setting and the need to negotiate mutually acceptable ways of monitoring services and addressing quality shortcomings. It seeks to improve the practices of all participating providers, not just the weak ones, based on the principle that a rising tide raises all boats.

Many countries have been developing and setting up systems for accreditation of health care facilities. Review of international experiences in this area indicates that the concept of accreditation has evolved from an approach involving simple, voluntary programmes which applied a few

minimum standards to application of evidence based standards. One of the longest experiences at accreditation is found in high-income countries, such as the US, which has strong central controls and sophisticated health care systems. In these settings, accreditation systems have evolved from relying on simple structural and process indicators of safety and good practice towards setting standards, which are based on health care outcomes [Scrivens 1995]. The US, which has been a pioneer in this area, began with a national accreditation programme for hospitals in the early 1900s with the purpose of establishing whether treatment received by every patient was effective. Over a period of time, this end-result system transformed into the Joint Commission on Accreditation of hospitals, subsequently renamed Joint Commission on Accreditation of Health Care Organisations (JCAHO) in 1987 a national programme accrediting over 5,000 hospitals in the US. The Canadian Council on Hospital Accreditation (rechristened the Canadian Council on Health Facilities Accreditation in 1988), was a breakaway from JCAHO. The initiative came from the medical profession and the hospitals association. It is an autonomous independent body and received its official recognition early in its existence, in 1958. It is the sole authority to accredit hospitals in Canada and has the monopoly of accreditation activities, which now encompass long-term, mental health and rehabilitation facilities as well as general hospitals. The Canadian Council on Health Facilities Accreditation (CCHFA) accredits 74 per cent of acute care hospitals, 32 per cent of long-term facilities, 79 per cent of mental health centres and 65 per cent rehabilitation centres. Countries like UK, Australia, and New Zealand are some of the other well established players in this process and lessons can be gleaned from their experience. Thus, an analysis of the leading proponents of accreditation systems indicates that in the late 1980s all of them began to consider ways of revising standards to make them more patient focused rather than professionally focused. In the 1990s, they have revised their standards to reflect the changing functions of hospitals, seeking to move away from a focus on departments towards one of patient experience of hospital systems and seeking the integration of hospital services rather than examining them in isolation. Finally, they have all begun to look at outcome measures instead of simple process standards for good practice [WHO 1993].

Other countries that have an accreditation system and those in the process of setting up one are Spain, France, Pakistan, South Africa, Italy, Taiwan, Netherlands, and Israel amongst others. These countries are learning from the experiences of other countries. An analysis of various country experiences with accreditation systems reveals certain common trends as well as contrasts in the manner in which accreditation as a concept has developed across the globe. The range of different country experiences determined by historical, political, cultural and health systems contexts, shows that a prescriptive blueprint approach is inappropriate. Each country's experience has been unique and should be viewed within the social, economic and political context of the health services within which it operates. However, despite the widespread interest in exploring the potential of accreditation for promoting quality health care in low-income countries with weak regulatory systems there is little published guidance on how this can be done [World Bank 1997, Brugha and Zwi 1998]. In the last two decades new, less formal accreditation programmes that focus on encouraging health care organisations to provide good, client-centred care have also arisen, such as UNICEF's Baby Friendly programme, the Gold Star Family Planning programme in Egypt, the Proquali Reproductive Health programme in Brazil and the emerging Adolescent Friendly Clinic programmes in Jamaica and South Africa. Thus, the field of accreditation is evolving rapidly, presenting many interesting and sometimes difficult issues to consider [Nicholas 1999].

The range of different alternative models for accreditation includes, government led accreditation bodies where the government sets standards and monitors performance. Experience suggests that the approach may be relatively rigid, and too limited in its ability to incorporate innovations and progress. Third party led systems have also emerged within which insurance companies determines standards and enforcement. It has the benefit of depending very marginally on resources from the governments since the third party payer generally generates revenues from its own operations or member organisations. A third model of accreditation is one that is peer-led, its strength and weakness is the strong involvement of providers in such a system.

Three major factors contributed to the success of the accreditation systems in various countries. The involvement of stakeholders in the accreditation bodies provided them opportunity to participate in the accreditation process. Secondly, in the absence of limited information being provided to the consumers by providers, accreditation played a major role in informing and educating consumers, thereby giving an impetus to the accreditation process. Thirdly, in many countries the accreditation process got a thrust when it was connected to state and third party payments.

Attempts at Improving Quality of Health Care in India

In India accreditation is not a novel concept. Accreditation organisations to monitor financial institutions and hotels have been in existence. Accreditation of universities, NGOs, computer and technical education institutions is being attempted with varying results. While the quality of service provided by a health care facility is a matter of supplier-client relationship and better services are bound to be made available on the basis of demand-supply relationship, it cannot be denied that it is necessary to prescribe a minimum standard for health care facilities. This is particularly important in view of the large-scale proliferation of private health care institutions in the country especially in urban and semi-urban locations during the recent period. The private sector health care delivery system is largely fragmented and uncontrolled, with larger private facilities concentrated mainly in urban areas and single practitioners dominant in rural areas.

In India, concerns about how to improve health care quality have been frequently raised by the general public and a wide variety of stakeholders including government, professional associations, private providers, and agencies financing health care. Interest in formal accreditation and quality systems for health care organisations has been growing in India over the past few years. Recognising the absence of quality assurance systems and the need to decentralise the regulatory mechanism at the state level, the the Medical Council of India (MCI) and MOH and FW GoI organised a national workshop in August 1999 which included representatives from a wide range of large and small hospitals/nursing homes, Indian Medical Association (IMA), All India Private Hospital and Nursing Home Association amongst others. The recommendations of this workshop were further discussed in another workshop held in January 2000 wherein officials of the central government, health secretaries of the states/UTs, directors of health services, and representatives of MCI and IMA were present. The main thrust of recommendations of the two workshops was that there is need for mandatory registration/regulation of hospitals of all types and it is necessary that clinical establishments in the country maintain minimum standards. Some of the state governments have legislations to

provide for the registration and inspection of hospitals and nursing homes, for example, Delhi Nursing Homes Registration Act, 1951, Bombay Nursing Homes Registration Act, 1949, West Bengal Clinical Establishment Act, 1959. As can be seen these legislations are quite outdated, implementation is questionable and legislations focus on the registration alone and they do not prescribe minimum standards. A number of states that did not have a legislation have begun the process of drafting/enacting legislation for regulating clinical establishment in their respective states. Karnataka has drafted the Karnataka Private Health Care Establishments Bill 2000, which is yet to be approved, likewise many other states have also embarked on drafting legislation to monitor clinical establishments. The central government is also examining the possibility of legislation for clinical establishments in order to protect the patient against clinical establishments, which are fraudulently providing sub-standard services. The proposed legislation is aimed at fulfilling this requirement so that the patients get a minimum desirable standard of service in the clinical establishments. The proposed legislation would also assist states that are in the process of enacting similar legislations.

The governments at the central and state levels are also examining other ways and means to provide quality services. Some of the governments have begun testing how to incorporate quality assurance methods in the management of public hospitals and programmes. In 1999, the All India Institute of Medical Sciences held a national workshop on the Measurement and Management of Quality in Health Care. Its lead recommendations were that health care quality councils be established at the national and state levels. The ministry of health and family welfare had initiated a panel on quality assurance to map out a course for the development of a quality improvement in health care in India. The panel's work was to form the basis for national and state councils on quality in health care. To enable the panel to arrive at appropriate decisions, concerning important aspects and procedures to be adopted for quality assurance, four sub-panels were formed to assist in this task. The sub-panels were organisational options for quality assurance, clinical standards, quality systems and physical standards. Various groups with required expertise and knowledge were identified to carry out the said tasks with specific terms of reference.

In the health sector the department of science and technology has established an National Accreditation Board for Test and Calibration Laboratories (NABL) covering all clinical and forensic science laboratories in the country. Due to the opening of the health insurance sector to the private sector, financial credit rating agencies have begun the process of grading hospitals. CRISIL has begun accrediting hospitals in the country. Having assigned health care grades to hospitals in Delhi and Chennai, the rating agency is evaluating 12 more hospitals since it launched the health care grade product a couple of months ago. There is a growing concern among hospital owners that if they do not organise their affairs the insurance companies would step in and dictate the standards which is taking place in a gradual manner. However some health care facilities are not only questioning the competency of these financial agencies but also alleging that grading can be manipulated for consideration.

The other stakeholders such as hospital and medical associations, non-government organisations have made efforts at hospital accreditation in a small scale. Indian Hospitals Association (IHA) at Mumbai and Delhi attempted to promote a voluntary accreditation system in 1993. The response to the scheme was lukewarm. In the recent past there are efforts underway for the formation of an accreditation body, namely, Accreditation Council for Health Care Standards in Mumbai. Presently, the council is at a very formative level in terms of its evolution. The council is developing standards and considering issues concerning grading, method, period of assessment and how to finance it. This is the first time in India that the medical associations, NGOs, consumer organisation and other stakeholders have established a body, which tries to address the needs of all stakeholders through open dialogue.

The above mentioned body was an outcome of a study that was undertaken to assess the views of the various stakeholders for an accreditation system in Mumbai. The study considered the viewpoints of hospital owners and administrators, specialist associations, consumer associations, government functionaries, financial and insurance companies and patients on the need for accreditation and their views regarding its introduction for private hospitals and the form it should take. There was an overall consensus regarding the need and willingness for an accreditation body. Most of them were of the opinion that the hospital owners, consumers and government should play a leading role in the establishment of the body. There was a high level of support for the classical features: voluntary participation, a standard-based approach to assessing hospital performance, periodic external assessment by health professionals, and the introduction of quality assurance measures to assist hospitals in meeting these standards. The stakeholders were of the view that it should function as a non-profit body, hospitals need to be graded, and assessments should be done by participating hospital followed by external team and recognition should be provided to hospitals. Hospital owners, professional bodies and government officials all saw potential – though different – advantages in accreditation: for owners and professionals it could give them a competitive edge in a crowded market; while government officials reckoned it could increase their influence over an unregulated private market. Areas of disagreement emerged; for example, hospital owners were opposed to government or third party payment bodies having a dominant role in running an accreditation system, on issues such as monitoring number of hospitals and beds in a geographical area, professional fees and hospital charges, incorporation of patient's redressal, disclosure of assessment findings among other aspects [Nandraj, Khot, Menon 1999].

Accreditation could serve a number of purposes. It would provide a suitable environment for clinical practice, monitoring the safety and effectiveness of provider practice thereby demonstrating to government, purchasers and the consumer that safety standards are being adhered to. This would ensure that the profession retains control over professional standards. It would also provide comparative information to service purchasers to assist in their choice of health care providers and guarantee optimum care is provided to promote health goals, especially where the for-profit private sector has a dominant and growing role.

Framework for India

The major concerns that need to be addressed for establishing an accreditation system for health care facilities relates to purpose of accreditation for different stakeholders, defining who should be involved, mechanism for implementing monitoring systems, determining the role and levels of functioning of the accreditation bodies, dimensions of quality and the validity of such measurements and how to mobilise resources for this task.

The establishment of accreditation bodies calls for representatives from the various stakeholders involved in health care delivery with checks and balances in place. This is necessary in order to make the system acceptable to all and to ensure its creditability from the start. In countries such as the US, Canada, Australia, Taiwan among other countries, the effort is to achieve a balanced representation on the

bodies. The process has to be of consensus-building which includes hospital owners/administrators and professional bodies, alongside government, consumer body representatives, insurance companies, financial institutions and NGOs, as this group would have the best chance of charting the way forward towards a sustainable system. Sustainable commitment is only likely if participating hospitals foresee a future competitive advantage from their participation. The basic purpose of accreditation should be to assess the hospital's compliance with standards and provide recognition to those that do. The accreditation body needs to upgrade standards in the light of a changing health care environment. In deciding what dimensions of quality and standards to set and measure, and how often, a pragmatic approach would be necessary, while acknowledging at the same time the rudimentary nature of most hospital information systems and the transaction costs to participating hospitals in India. The standards developed could be based on a grading scale; minimum, optimum and commendable. The standards need not be static but dynamic, to be upgraded on a periodic basis. Initially, standards could be based on simple structural and process indicators. They could be facility assessments, evidence-based guidelines and protocols for key public health priority diseases and programmes, clinical standards, quality systems, participation of staff in regular continuing medical education programmes, etc. It should be noted that measurement and compliance is difficult and costly, even in resource rich settings with established monitoring systems. It is suggested that trained non-medical surveyors could use simple checklists that form the basis of facility assessments, with follow-up visits by teams of professional colleagues to discuss results and identify training or resource needs to improve practice. The accreditation process could involve pre-survey, on-site survey and post-survey aided by protocols, manuals and developed guidelines. Being surveyed by one's peers may be more acceptable to the providers and they would have the necessary expertise and understanding of the contextual factors that determine and constrain clinical practice. However they may be reluctant to give poor ratings to their colleagues or remove accreditation approval if payment is linked to the accreditation. Other aspects that need to be examined are the training and expertise of staff for assessment, and the period of granting accreditation.

The organisation of the accreditation system could be at two levels, namely, at the national and state level. The national level accreditation body could be entrusted with overall policy-making, provision of support to state level accreditation bodies in education and establishing training institutions and modules for the accreditation process and liaison with other accrediting bodies. It could develop national level standards, guidelines and protocols, conduct research, documentation, information dissemination and evaluating the state level accreditation bodies. The national level organisation could consist of representatives from the state accreditation bodies, function as a federation of the state accreditation bodies and play a more supportive role. The state level accreditation body would have the primary responsibility of accrediting. It is envisaged that there would be a governing board (GB) that would have representation from various associations and organisations as well as the government and other stakeholders. The representatives could be from hospital owners, medical associations, consumer organisations, NGOs, insurance companies, and government representatives. In its composition, care should be taken to allow each of the stakeholders to be equally represented. This would prevent the GB from being monopolised and taken over by dominant stakeholders. The main function of the accreditation body would be to assess whether clinical

MDI GURGAON

(Nodal Centre for AICTE) *announces admission to*

Doctoral Level Program

(Beginning July 2004)

for Faculty Members of AICTE recognized Business Schools under the Quality Improvement Program

With a view to promote quality education, the All India Council of Technical Education (AICTE) provides opportunities for faculty members of management institutions to improve their qualifications by registering for Doctoral Level Program at the following Institutes:

- **Management Development Institute, Gurgaon**
- **Indian Institute of Management, Lucknow**
- **Narsee Monjee Institute of Management and Research, Mumbai**
- **Faculty of Management Studies, Banaras Hindu University, Varanasi**

Doctoral Level Program: The duration of the Doctoral Level Program is 3-4 years. However, the period of residentiality, program structure are specific to the institutions offering these programs.

Eligibility: Faculty Members of AICTE recognised Business Schools, with a minimum of three years teaching experience as on 1st July 2004.

Financial Assistance: Selected candidates shall be provided with scholarship of Rs. 6000/- per month for first two years and Rs. 6400/- per month for third year, besides an annual contingency grant of Rs. 10,000/- for three years. The monthly scholarship shall be paid for the residential duration of the program only. In addition, the salary and allowances are to be paid by the sponsoring institutions.

Selection: Candidates who wish to be considered for Doctoral Level Program of the above listed institutions are invited to submit a detailed application in the prescribed form available from the Institute. All short listed candidates shall be called to MDI Campus for the test and interview process for final selection.

How to Apply: The Information Brochure and Application Form shall be available free of cost from 8th December 2003 onwards. Applications, clearly mentioning the choice of institutions, are to be submitted through proper channel duly sponsored by the Head of the Institution. The last date for receipt of completed application form is January 15, 2004.

For more information, please contact

The Principal Coordinator (QIP)
MANAGEMENT DEVELOPMENT INSTITUTE
Mehrauli Road, Sukhrali, Gurgaon 122001, India
Phone: 0124-2340153, 2340173, 5013050-62
Fax: 0124-2341189
e-mail: chairmanfpm@mdi.ac.in

UNIT 83

establishments comply with set standards, to assist them in upgrading their standards and to play an educative and informative role. To carry out these functions such as assessment, educational, marketing, administration and so on staff needs to be employed. The staff could work either full-time or part-time depending on resources available. The staff at various levels would be responsible to and report to the governing board.

Implementing accreditation requires resources both to establish as well as to run the accreditation bodies, and to train and employ surveyors to conduct assessments. One major issue is how to finance and provide resources to such a system. The resource implications are considerable, whether external hospital assessment visits are conducted by full-time employed professionals or by using a larger panel of part-time volunteers, who would also need to be trained and recompensed. Various options such as insurance companies funding the body, government providing financial support, participating hospitals paying fees for accreditation could be explored in financing such bodies. In the absence of evidence to persuade private hospitals working in a highly competitive, poorly resourced settings, where third party payment systems have low coverage, government may have to take a leading role in driving and resourcing the establishment of accreditation bodies. The consumers need to play a major role in the accreditation system. The importance of the consumer lobby, means that there is potential to not only include a consumer quality of care perspective, but also to explore the potential of using accreditation status as a way of signalling service quality levels to potential users, and therefore using consumer choice as a way of driving the accreditation process.

The above framework is by no means a blueprint or a technical feasibility report but it touches upon broad areas that need to be examined in-depth, discussed and debated before implementing any initiative. Lessons learned through pilot projects are needed before more widespread programmes are attempted.

Conclusion

The design and performance of health systems is increasingly occupying centre space on the international health agenda. Most countries including India faced with rising demands, spiralling health costs and limited resources are acutely concerned with the performance of their health systems and are grappling with developing alternative mechanisms to achieve quality health care. It is obvious that current policies and processes are inadequate to ensure that health care delivery is of high quality and malpractice is prevented. The years of neglect and the lack of a comprehensive system for addressing quality issues in the health sector are already well known. The need for regulation has been an enduring concern, although we feel that regulation would have to be part of a wider agenda designed to bring quality health care within the reach of all. Accreditation is one possible way of ensuring good quality – there could be other mechanisms too – but it cannot tackle inequities in the distribution of health care. This would require re-distribution of health facilities as well as a unifying framework of financing, provision and regulation.

This heightened interest has created a unique climate for health care managers, policy-makers and decision-makers. It is difficult to keep up with the rapid pace of change in medicine today. At the same time the roles and responsibilities of health professionals are evolving and the introduction of new technologies into medicine is making quality management more challenging. Various methods like licensure, certification and accreditation are being used to determine the level of quality achieved by an individual or organisation. Selecting the right approach or combination of approaches requires a careful analysis and prioritisation of user needs. Whatever approach is adopted, the focus should be on creating more effective care processes, identifying and creating centres of excellence, ensuring efficient use and allocation of limited resources, enhancing consumer education, creating an facilitative environment which encourages and supports professionals to improve quality of care. For any such initiative to be successful it is imperative that assuring quality health care services becomes a priority for all stakeholders involved and is translated into an implementable plan of action. Stimulating debate between public and private providers, policy-makers and consumers on what practices conform to the latest reliable evidence and what standards to set will promote the wider dissemination of knowledge. The establishment of accreditation system in India would pave the way for the provision of good quality of health care. The government's commitment to quality health care for all needs to translate into sustainable mechanisms for the delivery of effective health care. Above all, the need of the hour is to develop an enabling environment in which high quality of health care can flourish throughout the country. EPW

[The authors thank David Peters and G N V Ramana for useful comments on an earlier version of the paper, while taking full responsibility of the remaining errors and omissions. This article draws from the authors earlier work, contributions of Sumita Menon and Sri Vidya are acknowledged.]

Address for correspondence:
nandraj@vsnl.net
anagha_khot@rediffmail.com

References

Bhat, R (1996): 'Regulation of the Private Sector in India', *International Journal Health Planning Management*, 11: 253-74.

– (1999): 'Characteristics of Private Medical Practice in India: A Provider Perspective', *Health Policy Plan* 14 (1): 26-37.

Brugha, R and A Zwi (1998): 'Improving the Quality of Privately Provided Public Health Care in Low and Middle Income Countries: Challenges and Strategies', *Health Policy and Planning* 13(2): 107-20.

Jesani, A (1996): 'Laws and Health Care Providers', Centre for Enquiry into Health and Allied Themes, Mumbai.

Lewis, C E (1984): 'Hospital Accreditation' in New Zealand Hospital, September 15-17, New Zealand.

Nandraj, S (1994): 'Beyond Law and the Lord: Quality of Private Health Care' in *Economic and Political Weekly*, 29(27): 1680-85, July 2, Mumbai.

– (2001): 'Report of the Sub-Panel on Organisational Framework for Hospital Accreditation System in India', MOHFW, GoI.

Nandraj, S and R Duggal (1996): 'Physical Standards in the Private Health Sector: A Case Study of Rural Maharashtra', Centre for Enquiry into Health and Allied Themes, Mumbai.

Nandraj S, A Khot, S Menon (1999): 'Accreditation of Hospitals: Breaking Boundaries in Health Care', Centre for Enquiry into Health and Allied Themes.

National Sample Survey Organisation (1998): *Morbidity and Treatment of Ailments*, NSS Fifty-second round (July 1995-June 1996).

Nicholas, David (1999): 'Using Accreditation to Improve Quality', (ed) QAP Brief, Volume 8, Number 2, Quality Assurance Project, US.

Scrivens, E (1995): 'Accreditation: Protecting the Professional or the Consumer'? Open University Press, Buckingham.

Uplekar, M, S Juvekar, S Morankar, S Rangan, P Nunn (1998): 'After Health Sector Reform, Whither Lung Health?' *International Journal Tubercle Lung Disease* 2 (4): 324-9.

World Health Organisation (1993): *The Contemporary Use of Standards in Health Care, Division of Strengthening of Health Services*, District Health System, World Health Organisation, Geneva.

World Bank (1993): 'World Development Report', *Investing in Health*, Washington DC, US.

– (1995): 'India: Policy and Finance Strategies for Strengthening Primary Health Care Services', Report no 13042-IN South Asia Country Department II (India), Population and Human Resources Division, Washington D C.

World Bank Group (1997): *Sector Strategy: Health, Nutrition and Population*, World Bank.

Yesudian, C A K (1994): 'Behaviour of the Private Health Sector in the Health Market of Bombay', *Health Policy Plan* 9 (1): 72-80.