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Conforming to accreditation in Iranian hospitals

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ABSTRACT

This paper examines the operation of an accreditation programme for hospitals in Iran. It explores the process of accreditation as a regulatory control system and analyses hospitals' responses to this type of control. We draw on the notion of steering and argue that the accreditation system is transactional in nature. Our findings show that hospitals conform to the scheme, although they also resist some of its requirements. On a wider policy level, we suggest that accreditations offer the accreditor the opportunity to impact on how activities are undertaken, but hospitals require incentives in order to make the necessary organisational changes.

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1. Introduction

Regulatory control systems exist in many forms and are broadly aimed at directing organisations towards meeting societal objectives (Broadbent, Laughlin, & Gallop, 2010). Whether these goals are achieved often depends on both the nature of the controls and also on how the organisations being regulated respond to the controls contained within the regulatory system. This paper focuses on one particular system of regulation, that of accreditation. Accreditation programmes are regulatory control systems aimed at assessing organisational performance against explicit standards (Braithwaite et al., 2010, 2012; de Walcque, Seuntjens, Vermeyen, Peeters, & Vinck, 2008; Pomey et al., 2010; Shaw, 2004b). In many countries, accreditation programmes represent an endorsement of the quality of provision of a service and are often voluntarily pursued by organisations for this very purpose. For example, many UK Business Schools seek accreditation from the Association of Business Schools (AMBA and EQUIS) for this purpose (Cooper, Parkes, & Blewitt, 2014; Cret, 2011; Urgel, 2007; Zammuto, 2008). This paper, however, examines Iran's national accreditation programme for healthcare organisations which is the sole regulatory control mechanism used to promote quality and safety in hospitals across the country.

All accreditation systems provide certifications for compliance and for the meeting of pre-set standards (Braithwaite et al., 2010, 2012; de Walcque et al., 2008; Pomey et al., 2010; Shaw, 2004a, 2004b). The processes underpinning the attainment of the accreditation certificate, arguably, are regulatory control processes containing an assessment and evaluation of organisational performance against prior established standards. Previous research provides mixed messages about the nature of this control. For example, Touati and Pomey (2009) compare French and Canadian hospital accreditation systems and argue that both systems show signs of bureaucratic coercion. Hinchcliffe et al. (2012) acknowledges that

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accreditations are complex organisational interventions and suggest that there are contrasting messages about the extent to which professional (clinician and managerial) attitudes towards accreditation processes impact on the effectiveness of the method in promoting change. Whilst some research reveals professionals' positive views of accreditation leading to improved patient safety and care and also positively impacting on staff satisfaction, other research, for example in Egypt, suggests accreditations are considered overly expensive, bureaucratic and tend to deter organisational improvements (Al Tehewy, Salem, Habil, & El Okda, 2009). The Iranian healthcare accreditation system was introduced in 1997 with similar approaches adopted by other countries such as France and Egypt (Giraud, 2001; Touati & Pomey, 2009). It is a mandatory system intended to evaluate and rate all types of hospitals (both public and private) in terms of their performance against pre-set standards. Non-compliance to the accreditation is considered an offence that may lead to prosecution (Farzianpour et al., 2011; MoH – Ministry of Health, 1997). However, unlike other accreditation programmes, the Iranian system includes a significant number of religious standards in addition to the clinical and organisational standards, against which hospitals' performance is compared. This provides an interesting context in which to explore the perceptions of hospital staff towards accreditation as a regulatory control mechanism, mainly because research has pointed to the re-emergence of religion in the public sphere (e.g. Beckford & Richardson, 2007; Boehle, 2010; Kamla, Gallhofer, & Haslam, 2006; Lewis, 2001).

The aim of this paper is to gain an understanding of the perceptions of the organisational members in relation to the accreditation system, and to assess the extent to which they consider the system as transactional or relational. In order to do so, we analyse the views of clinicians and managers working in eight hospitals; six of which are publicly funded whilst two are private. We analyse their perceptions about the development and application of the accreditation standards, the periodic review process used to implement the accreditation system as well as the outcomes from the accreditation visit. Our findings show hospital participants complying with the requirements of the accreditation whilst at the same time resisting some of the requirements of the process. The main novel finding is that religion plays an important role in this context, explicating and ensuring conformity to external controls. On the other hand, resistance occurs because participants observe that the standards against which they are measured are not reflective of their organisational or national capabilities.

The paper adopts Broadbent and Laughlin's (2013) notions of "steering"[1] to theorise the findings, arguing that accreditation programmes are examples of "societal steering mechanisms" that seek to regulate and control the activities of organisations (Broadbent & Laughlin, 2013, page 66). These steering mechanisms may be transactional, supported by the force of law or funding, or may be negotiated and relational. Societal steering mechanisms, as explained later, create environmental disturbances for organisations that may lead to four possible responses: rebuttal, reorientation, colonisation or evolution (Broadbent & Laughlin, 2013; Laughlin, 1991). This theoretical framing enables an analysis of the nature of accreditation as a form of regulation, as well as an analysis of the responses the organisations make to them. Our central argument is that in Iran hospitals conform to accreditation because of the force of the law, the funding ramifications associated with the regulation and also because of shared religious values. Despite this, there is a latent resistance because the desired organisational standards contained in the accreditation steers are perceived as unrealistic and unattainable and out of synch with organisational values.

Our paper contributes to the control literature in two ways – conceptually and empirically. Conceptually because, while previous literature have suggested that transactional steering may achieve its societal goals due to the force of law and funding, we argue that strong shared values (in this case Islamic values) may also lead to conformity to transactional steering. Whilst there may be resistance to transactional steering systems, such resistance may be mediated by shared religious values. These have a moderating effect on the way societal steering control mechanisms such as accreditation are perceived by organisational members. At an empirical level, we contribute to the understanding of reorientation strategies in a developing country and within an Islamic context. Whilst Broadbent and Laughlin (2013) explain reorientation through absorption and boundary management, we introduce reorientation through both conformity and resistance, without any specific organisational processes changing. These contributions are important for two reasons – the dearth of research considering the perception of participants to the control elements contained in accreditation programmes, despite the fact that accreditation is the longest-established and most widely known method of evaluation of healthcare services in the world (e.g. Scrivens & Lodge, 1997; Shaw, 2004a, 2004b; WHO – World Health Organisation, 2003 and many others) and given the scarcity of research related to accreditation programmes in developing countries (Hopper, Tsamenyi, Uddin, & Wickramasinghe, 2008; Hoque, 2014).

The paper consists of six sections. The next part discusses accreditation systems generally and also specifically in terms of healthcare. An argument is made as to why they can be considered regulatory control systems. In section three we explain the main elements of Broadbent and Laughlin's (2013) theoretical framework, whilst in section four we discuss our research methods, including a contextual introduction to the Iranian healthcare accreditation system. Section five provides our empirical findings and our analysis of organisational responses to this mechanism. We conclude the paper by discussing the findings and addressing the implications for policy and further research in section six.

[1] The work of Broadbent and Laughlin with respect to steering was presented in several academic articles, and they collated all their work in a single text in 2013 – i.e. Broadbent and Laughlin (2013).

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