Accreditation or accreditations? A comparative study about accreditation in France, United Kingdom and Cataluña

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Summary

This article analyzes the dynamics and changes in the accreditation process in three different places - France, UK and Cataluña (Spain) - based on documents about their health systems organizations, funding sources and regulations. The objective was to find out about the relevant aspects of the strategies of these countries' institutions that adapted accreditation to national circumstances in the healthcare policy arena. Although there are similarities in the basic approaches and standards used, there are different models of accreditation. Setting standards raises the question of who should define them and how they should be monitored; accreditation's methodology cannot be seen only as a voluntary process for assessing quality in healthcare or perceived as tool for certification and regulation. Interests in accreditation can be driven by a number of different forces, which depend upon the model adopted. Therefore, it can only be understood in the policy arena of each country.

Keywords: Accreditation; health systems; health policy; quality management.

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Introduction

This article addresses the accreditation relations within the health systems, considering that these have associations with the proposals, guidelines and context of the policies established by each national government, that is, considering that these are internal relations of the accreditation with the health systems that give its meaning. For that purpose, the accreditation is considered as a political proposal of health service qualification, which when shaped to see to the needs and limitations of each country, modifies its characteristics and ceases to be a single model.

Starting with the logic of political proposals, the propositions for the accreditation procedure are not the same. Under this perspective, the interest is the consequence of adopting the accreditation in a certain system organization that has its financial support structure, its means of payment and instruments of coordination of the service network, characterizing its accreditation process.

Accreditation was created as a tool to evaluate the risks that occurred in the hospital environment, with the objective of protecting the professional that worked at these units. The tool is usually presented as a device, whose *modus operandi* provides quality production in hospitals and health services.

Malik and Schiesari[1] highlight the definition used by the Technical Accreditation Group, which explains that accreditation is an "evaluation system, voluntary and reserved, for the acknowledgement of the existence of previously defined standards in structure, process and result, aiming to stimulate the development of a culture of continuous improvement in the medical-hospital assistance quality and protection of the population's health."[1]

In the related literature, accreditation brings the idea of an easy-to-understand and feasible methodology, as it uses medical terminology. It addresses the appropriate conduct commonly known by the professionals in the practice, guiding, however, towards an optimal organization, which standardizes the procedures to allow the creation of viable indicators of comparison and recommends the written recording of policies and procedures of the institution that has become a candidate to the process.

The quality systematization of medical and hospital assistance started in 1913, with works published by Ernest A. Codman, a North-American surgeon. The idea grew stronger, the debate on hospital standardization increased and, in 1917 the American College of Surgeons (ACS) initiated the Hospital Standardization Program, of which objective was to evaluate the conformity of procedures carried out by surgeons in relation to a set of minimum standards. It is noteworthy that the first evaluation had an outcome that was considered to be of concern. At the time, 692 hospitals were assessed. Of these, only 89[2] were in conformity with the established minimum standards and the ACS, fearing the distress of the population, decided not to make this register public, burning then the documents related to the evaluation.

Currently, as a consequence of the development of this Program, there is the Joint Commission Accreditation of Healthcare Organizations (JCAHO), whose mission is to promote continuous improvement of health service quality, based on the search for excellence, instead of minimum standard for service performance. The fact consolidated the evaluation of health service quality through the adoption of accreditation in the USA. Moreover, it supported the creation of the Joint Commission International (JCI), of which mission is to help international health organizations, public health agencies, ministries of health, and others, in the development of quality and safety in patient care around the world[2].

Throughout this process, the USA was followed closely by Canada and Australia. Accreditation only came to Europe in the 1980s. It is worth mentioning that accreditation was called hospital accreditation, as it originally referred only to hospitals. Although accreditation has expanded to other health areas, the focus of the present study is to consider to which extent hospital accreditation could contribute to the quality improvement of the health system.

It is interesting to notice that efforts to disseminate accreditation emphasize the explanatory material and internal procedures to establish accreditation processes, and not the reasons to adopt it. Not present, however, are the considerations about the governments' decision to adopt accreditation and the consequences of the process, from the systems' point of view.

The article's objective is to analyze the dynamics of accreditation in three different realities – France, United Kingdom and Cataluña (Spain) – and to question whether there are significant differences in the implemented accreditation processes. Thus, we intended to reflect upon the homogeneities or diversities regarding accreditation and understand this movement of rapprochement between accreditation and the health systems.

The article is structured into four parts. The first addresses the accreditation theme from the logic of a policy proposal. Subsequently, the methodology employed is shown in this accreditation review in the three elected countries. Later, the results of the different forms of adopting the methodology are shown, in contexts of health systems. Finally, there is a comprehensive discussion on different formats of accreditation used in these countries.

Accreditation under the policy focus

The World Health Organization (WHO) report[3] defines a health system as a set of activities with the main objective of health promotion, recovery or maintenance. The definition does not imply the existence of integration among these diverse activities, but the manual points out that integration degree influences the quality and performance of health systems. The text depicts three main objectives

of health systems: to improve the health of the population they assist; to meet people's expectations; and to provide financial protection against the costs of lack of health.

This definition of systems by WHO is particularly useful, as it encompasses several fields in which the processes of accreditation were constituted in different countries. Each national health system, with its financial support structures, means of payment and coordination instruments of the service network will shape the accreditation process.

From the literature on accreditation, two authors stand out with distinct approaches on the subject. Ellie Scrivens[4] that ratifies accreditation essentially as a market product amidst the adaptations that the methodology underwent to remain attractive. On the other hand, the WHO[5], that understands the dimension of the accreditation market, but discusses accreditation as a methodology that increments quality in health systems. Scrivens[4] explores these adaptations from the point of view of several authors, such as, for instance, the government, health institutions and institutions that provide accreditation. To organize the alternatives of accreditation, the authors use the terms *advantage* and *disadvantage* as analysis categories and identifies these actors as clients. All terms used are characterized by being analytical, with strong emphasis on market dynamics.

Another characteristic worth highlighting on this tool is its voluntary feature, recommended by the literature. This quality makes sense under the market point of view explored by Scrivens[4], as the authors that participate in this type of context adopt this methodology, believing that the certification will bring them some advantage.

This voluntary feature, according to Malik and Schiesari[1], guarantees public interest as it offers transparency and exposes the concern over quality by those offering their services.

The WHO[5] defends accreditation by giving it another type of significance. Its objective is to revitalize the possibility of use of this tool in health-related environments, aiming its adoption by governments. In this sense, it presents a guide[6] for the European WHO governments that are considering or implementing accreditation programs, especially for hospitals and also forwards this document to financial support agencies, as a guiding model for financing directed at healthcare development. Shaw discusses, with this approach, accreditation as a quality-introducing mechanism[6-9] by national health systems. In their studies, they compare distinct mechanisms of healthcare service quality assessment, defending accreditation as the most adequate methodology for health environments, presenting the advantages and disadvantages of accreditation in comparison with other more often used methodologies, without, however, discussing the impact of the methodology on the quality of these health systems.

For these authors, discussion focus lies in accreditation as a tool that potentiates heath services and makes them more efficient, which can also result in higher quality. Having this discussion as starting point, what we intend to emphasize in this article is accreditation as a possible political strategy of health systems, a tool used by governments to induce changes in healthcare on behalf of quality.

The characteristics of the health systems are related to the guidelines and policy proposals formulated by their governments. According to Walt[10] the establishment of a policy depends on the process by which it goes through and the power of the actors involved in it.

Thus, it is considered that the adoption of an accreditation proposal by a government, in the presence of a national system, acquires a significance that is not the same as its technical instrumental dimension or its market dimension in relation to hospitals and it can only be understood within the health system associations. Therefore, the decision to adopt accreditation by a government must be seen as a policy proposal. It is noteworthy the fact that policy proposals have an intention, a formula of how to reach a certain objective, with adoption of this or that action.

Methodology

The study consisted of literature and documental review of health systems and accreditation models in three countries: France, United Kingdom and Cataluña (Spain). These experiences were chosen because they indicated the establishment of rather distinct accreditation processes, contributing to a more comprehensive view of this model. In order to better understand the characteristics of each experience, we constructed a comparative chart of the health systems, with the following aspects being emphasized as analysis variables: health system organization, financing, health system regulation forms and accreditation process. At the analysis of the accreditation process, we sought to identify from aspects related to the institutionalism and procedural normalization to guidelines, strategies and results obtained.

Results

France

French social security system started after the World War II and was associated with the idea of social democracy. It was created based on a health insurance funding network, a network organized by elected representatives, most of which were employees, and the remainder, employers.

The founders of the social security system were influenced by the Beveridge Report, from the United Kingdom (UK) and aimed at creating a system that would guarantee equal rights for everyone. However, they did not count on the opposition by some socioprofessional groups that already benefited from the existing coverage

and that were able to maintain their private health insurance systems. Currently, the French system lies between the Bismarckian and the Beveridgian systems[11, 12] (Table 1).

The French accreditation was an initiative of the public government, which laid its principles in Law # 96-346, of April 24, 1996[13], on the reformation of public and private hospitals and defined the need to create a department to be charge of it, which was to become the *Agence Nationale d'Accréditation et d'Évaluation en Santé* - ANAES, on April 8, 1997[12].

Among ANAES functions is the responsibility to develop an accreditation process for public and private hospitals (in April 2002, 150 hospitals were accredited)[12].

Accreditation aimed at the procedures, professional practices and results, jointly, and encompassed process mechanisms from several contexts that already existed in Europe and the USA, with the objective of overlapping the differences obtained from different contexts in relation to its implementation. Its use was directed at all hospital sectors of the country and all services or activities of these facilities.

The French accreditation is mandatory and health units do not have autonomy to decide whether or not to participate in the process. As established by the 1996 Law, the hospitals should initiate the accreditation process until the final date of April 24, 2004. In cases where adherence to the process was not "voluntary", it was induced by the *Agence Régionale de l'Hospitalisation* - ARH, regional financial and administrative tutor of hospitals, with this attitude being established by the aforementioned Law.

On the other hand, the *modus operandi* of the accreditation process starts identically to processes initiated in other countries. However, there are marked differences such as the existence of the ARH, which induced the process in units that did not do it within the period determined by the 1996 Law and which must be informed regularly on the stages of all processes occurring in the region by which it is responsible. Another difference is the fact that this accreditation is more detailed, each sector of a health institution must be accredited, practically individually, so that the institution, as a whole, can be considered accredited.

French accreditation occurs in a context of economic reorganization of the mechanisms of health financing. Results are public and disseminated, invariably, to ANAES and ARH, but, in contrast with other processes of accreditation, the result does not result in a certification; what is stimulated is initiating the accreditation as a strategy aimed at the creation of a quality culture, with the possibility of transforming the French health system.

In this scenario, one can affirm that accreditation in France constitutes a mechanism of control for health establishments and two paradoxes must be considered, at least: accreditation is not voluntary and does not yield a result, a certification, which are characteristics of North-American accreditation.

The United Kingdom

The British National Health System (NHS) started operating on July 5, 1948 as a single organization that consisted of 14 councils of regional hospitals. Its health service and financing standard had been established in the Act of 1946, under the influence of the Beveridge Report and introduced the principle of collective responsibility, on the part of the State, in relation to the health system. That is, health services should be available for the entire population, without any cost. Health care services for the population were based on its needs and not the possibility of payment[14].

The consensus for its construction was created in tune with other initiatives of welfare state, in areas such as social security and education, which had been developed at the same time. However, several representatives from different medical specialties and family doctors or general practitioners – GPs – only supported this structure in return to concessions. For instance, GPs were authorized to work as private providers, depending on the question, for NHS itself and even though the specialists were employed by the system, they had some degree of control regarding their contract conditions. In spite of the changes caused by these reformations, these work relations persist to date.

A historical detailing of all reformations undergone by NHS is out of the scope of this article. However, the system underwent a great change in 1989, with radical modifications that gave it a market referential, with the objective of preventing health system financing crises. To adapt to these changes, health providers started to work as independent organizations that should compete for better contracts. However, Robinson, Dixon and Mossialos[15] make it clear that existing method, based on taxes, was efficient in its purpose to restrain the increase with health costs. This acknowledgement made the ministry reluctant to interfere with the health financing mechanisms and redirected its attention to the way the services were being organized, managed and distributed.

Currently, the health system configuration has eight regional health authorities, which have been converted into regional executive offices and district health authorities, responsible for financing funds of general practice and of NHS. District authorities are responsible for surveying the health needs of the population relative to its area and for distributing its fund according to these needs. The scheme is established through contracts between the parts. That is, hospitals are administered as small enterprises, but are restricted by the rules of public service[15]. Segouin[11] emphasizes that the concern over quality in the health system

Table 1 – Characteristics of financial support, hospital network and the accreditation process in France, United Kingdom and Cataluña (Spain)

	France	United Kingdom	Cataluña (Spain)
Health system organization	• Bismarkian system / Beveridge: social security • Most part of healthcare-related costs are financed by social security	• Beveridge system: universal system, financed by taxes. • Private system, marginal and substitutive, accessed through health insurance	• System influenced by the Beveridge system. • Private substitutive system
Financial support model	• Until the 1996 reformation: global budget for public and private hospitals • After the reformation: budget negotiated with regional tutorage through the regional hospitalization agency	• Most part of the financing: carried out through contracts established with the districts • The remainder: carried out through contracts of care acquisition with generalists and private insurance	• Based on contracts established between the government of Cataluña, for public hospitals and those that treat the diseases in the public sector • Private insurance for private commercial hospitals
Healthcare system regulation type	• National, per type of service provider and per region	• National budget, distribution per district. • Contracts with the hospitals	• Contracts established between financial supporters and providers
Name and type of accreditation organs	• ANAES created, by Law, in 1997. Public administration establishment, created by the government during the healthcare system reformation, based on the rationalization and quality. Took the already established structure, created by the Medical Development and Evaluation Agency.	• There are several accreditation organs, of which the most important one is KFA, an independent foundation. Accreditation is put into practice by a demand of the professionals and as an extension of the organizational auditing established by the 1991 reformation.	• Service of authorization, accreditation and ministerial evaluation of health and social security – Government of Cataluña, created through the Ministry. Accreditation goes through three experiences in the years 1981, 1983 and 1991: establishment of the dominant objective of improving the quality of the establishments.
Characteristics of hospitals	• Public hospitals • Private hospitals: nonprofit organizations, participants or not in the public network; commercial – not significant numbers • 4,000 hospitals (1/4 of the hospitals are public) • 490,000 beds (2/3 are public) • 8.4 beds/ 1,000 inhabitants	• The majority of the hospitals are public • Some private commercial hospitals • 2,192 hospitals • 275,000 beds • 4.5 beds/ 1,000 inhabitants	• Public hospitals • Private hospitals: most charity organizations and some non-profit organizations • 188 hospitals (80% are private) • 30,581 beds • 4.56 beds/ 1,000 inhabitants (1,9 public beds/ 1,000 inhabitants)
Type of accreditation	• Mandatory	• Voluntary	• Theoretically voluntary but in practice, mandatory for contracts established with the Ministry
Manual creation	• In 1998	• Last version in 1998 with the first being created based on the Australian manual.	• In 1992, based on the: Australian, American (JCAHO) and Canadian (CCASS) manuals.
Accreditation process focal points	• Accreditation of healthcare establishments and healthcare networks	• Hospitalization establishments, generalists (GP's) offices, community services nursing centers.	• Currently, emergency hospitals
Process duration	• Not determined	• From 9 to 12 months	• Depending on the hospital and availability of inspectors, generally in 1 year.
Accreditation process result	• Do not issue a certificate, but a report, with recommendations and due dates for new visits of accreditation, which must occur every three years	• In the case of KFA, a report is issued with recommendations for improvements. • In the case of HAP there is a certification at 4 levels: complete accreditation, temporary accreditation, temporary accreditation adapted to a control and granted accreditation.	• Certificate of accreditation or not accreditation, with a recommendation report.
Consequences of accreditation	• If the hospital does not enter the process, according to what was established, possible license suspension • As for the process result, there are no official consequences	• None to date, except for the private hospitals that are service providers for insurance companies.	• Allows contracts between the hospitals and the ministry. However, hospitals without this type of contract remain.

Source: Segouin[11], Sandier, Paris and Polton[12]; Robinson, Dixon and Mossialos[15] and Durán, Lara and Waveren[16] respectively for France, United Kingdom and Spain/ Cataluña.

was introduced by the NHS, with the strictest regulation issues being applied to private hospitals. The author refers to the adopted contractual system as a system that induces situations close to rivalry, which in this context would transform quality into a marketing criterion. However, this same author attenuates this situation by affirming that the long wait in lines is the main concern on the part of the British population, stated by methodologies as a means to establish quality degrees.

Quality verification in public hospitals in the UK occurs through regular publication of statistics aimed at quality, which are compared with national and local means. The practice does not prevent or hinders the financing from the districts, the main financial supporters of public hospitals, which continue to provide the necessary care to maintain a coverage zone responsible for a specific part of the population. This situation, according to Segouin[11], also attenuates the competition feature that might exist, if quality were effectively a marketing criterion. The quality issues, therefore, are restricted to some marginal activity of the hospital.

In this context, accreditation is offered by several independent organizations. Experiences that should be highlighted are those of the King's Fund Audit (KFA) and the Hospital Accreditation Program (HAP) (Table 1). The first institution is an independent foundation which mission is to improve the quality of management in the NHS and that developed a process closer to that of national accreditation. To develop its process, KFA had an initial experience with JCAHO standards, and later established a scheme for a small number of hospitals, with a peer-review and standards adapted from the Australian model. The second experience became what is currently known as the KFA auditing scheme.

Conceptually, this process is similar to the original accreditation process. The hospital that intends to initiate the methodology must be a volunteer for the process and receives the manual. As in the original methodology, result indicators are sought and evaluation visit is made by a physician, a nurse and an administrator.

However, the result of the visit is handed directly to the institution that paid its participation fee in the accreditation program and an open session is carried out with all staff members, so that the evaluation commission can disclose the general results. This process does not issue any type of certificate, but only a report on the situation found in the institution that volunteered to undergo the process, and improvement recommendations. However, soon the KFA intends to adopt the certification scheme at the end of the process. The second institution developed an accreditation scheme that is particular to the UK and close to the North-American concept of accreditation that grants a status of accredited[4], by issuing a certificate at the end of evaluation procedures.

HAP clients are the low-complexity community hospitals directed at rural communities that have little access to higher-complexity hospitals. However, the proceedings toward the final visit are, in some aspects, identical to those of KFA. As in most accreditation processes, the organizations have to prepare for the process and the visit is pre-planned, being accompanied by only two examiners instead of three and their certificates are valid for two years in comparison to the three years of the American certification. That HAP issues a certificate with the accreditation status after the approval by a board of directors. In the UK, the lack of an accreditation system resulted in a complex scheme with several accreditation systems, stimulated by regional authorities as incentive to process monitoring. Each one of these systems reflects the interpretations of different categories of health professionals. Actually, the logic of the hierarchic control of public hospitals and the stable contractual system are capable of maintaining quality in NHS health units.

Cataluña

Cataluña is the most economically important autonomous community in Spain and it was the government of Cataluña that initiated the first experiences with accreditation. Spain is a parliamentary monarchy that consists of a central State and 17 regions with their respective governments and parliaments[16]. The Spanish constitution establishes the boundaries of responsibility that are exclusive to the central government, the ones related to the regions and those that must be shared between them. Issues regarding health regulation are the responsibility of both the central and regional governments. Therefore, all planning and legislation initiatives for this area require a consensus.

Currently, taxes are the most important source of healthcare funds, a model adopted in 2001 with the intention of ensuring self-sustainable funding. The autonomous communities also have taxes as health funding sources, but equally persist with the central government allocations.

Specialized care is the central element of the Spanish health system and its provision model varies among the autonomous communities. Most hospitals are public and the majority of the staff consists of employees, who have the status of civil servants. The Catalonian Health Service (SCS) is linked to the Ministry of Health and is at the center of the regional government. It is responsible for the health budget and planning in the community and has a relative autonomy in negotiations with public hospitals. The autonomy identical to that of the General Department of Sanitary Resources, on which the Accreditation Service depends. However, the accreditation does not belong to the same department that supports healthcare.

The process of accreditation in Cataluña was created in 1981 and was the first one in Europe. In this region, accreditation is voluntary, although hospitals that wish to have contracts with SCS must be accredited. Therefore, regardless of its nature, public or private, the most important hospitals started accreditation processes close to the one we currently know. However, accreditation process in this region went through two notable phases[16].

At the beginning of the process, the hospitals could only count with minimum standards needed to obtain functioning authorization. The intention to initiate and develop accreditation aimed at improving the quality of hospitals that had not developed actions directed at the possibility of improving their processes and environment. This first phase was notable, as it resulted in the closing or reconversion of 20% of existing hospital units, although the proposed standards were considered average. Subsequently, the situation was reconsidered, with the perspective of re-structuring the health system as whole.

Second phase of accreditation in Cataluña was initiated in 1983. In this phase, the region was going through a financial crisis and accreditation was limited to the standards that could be attained, considering the financial situation. According to Segouin[11], at this time, accreditation was used as a mechanism to face the financial crisis.

In 1989, the Avedis Donabedian Foundation (FAD) was created, with the objective of promoting the quality of healthcare systems. The foundation hired JCI to start the accreditation, based on the North-American manual. In 1991, accreditation was replaced by a global planning and organization policy for health funds, with the objective of improving hospital care. Currently, the governmental program is limited to acute-care and non-psychiatric hospitals, and has three physicians that organize this process: one inspector, one directed at public health and another directed at health administration.

The beginning of accreditation differs in its *modus operandi* from French and British models, which have been previously explained. The evaluation visit, in the case of Cataluña, occurs right after accreditation manual is received. Its objective is to help the diagnosis of the institution, after which the latter has a period of time to adequate to the proposed standards. In this case, the accreditation service's task is to help the hospital to attain these standards and the hospital must, at the end of the process, provide proof of its adequacy.

The manual has only a Catalan version, which might be considered a complicating factor or an indicator that the concern of the Catalonian government refers only to its hospitals. The process has not reached Spain as a whole (Table 1). That means, the process as it is does not change the Spanish system and perhaps, they have no intention to do so.

Discussion

Results depicted in Table 1 allows us make some remarks. There is no single accreditation process. Its *modus operandi* has changed in the analyzed countries and incentives to adhere to the accreditation process have been diverse. Accreditation process results were also diverse in the three countries.

In France, the accreditation, of which nature is depicted as voluntary, is mandatory. The hospitals that did not voluntarily adhere to the process had them initiated, nevertheless, by the ARH of the areas where they are situated. The hospital that did not "voluntarily" adhere to the accreditation process ran the risk of being penalized and of losing its license.

Another noteworthy characteristic of the French accreditation is result obtained. Accreditation does not result in a certificate and does not generate sanctions against the hospitals. For that country, the important thing is to initiate the accreditation process. It can be perceived that the reckoning implicit in the political proposal of French accreditation considers that the accreditation process triggers another: the quality improvement process. It bets on the creation of a quality culture and therefore, allows us to differentiate the accreditation process from other quality tools.

In the UK, the health service design is structured by the contractual scheme developed by NHS and the British accreditation format has maintained its characteristic of voluntary adherence to the process and does not provide specific stimuli to the adherence. It is noteworthy the fact that the accreditation experiences in this region are little significant, as several institutions can play the part of collocutor for this process.

British accreditation, in opposition to the French one, can be hardly differentiated from other quality assessment tools. In the UK, accreditation is placed side by side with other certification methodologies, such as ISO system, an alternative certification, which can also be successfully used in healthcare environments, although its origin is the industrial area[7].

There has been no policy proposal for accreditation, which has resulted in a disperse scheme and one that has little influence on the health system of that region. The contracts establish the characteristics that are necessary for the hospitals and the other quality assessment tools perform their role well, even when originated from other areas. It can be inferred that, in the British context, the contribution of accreditation for the promotion of quality in the national health system is not clear.

As for Cataluña, the accreditation process had remarkable phases, regarding the restrictive aspects in relation to its results. In the beginning, the Catalonian process generated heavy sanctions to the regional health system, culminating with the closing of certain health units.

Subsequently, the accreditation process was used as a budget control tool, as a means to face the severe financial crisis the country was going through.

In this region, the "voluntary" feature, inherent to the nature of accreditation, persists. However, it is a required condition for health institutions that aim at establishing contracts with the ministry responsible for the health area. Therefore, one regards the existence of a dissemination process being induced by financial strategies, to consider it mandatory in a future political accreditation proposal.

On the other hand, the accreditation process is so restricted to Cataluña that the manual found in Spain is written in Catalonian, not in Spanish. However, the accreditation development process in Spain is still undergoing changes, which means the possibility of creating an ongoing accreditation policy proposal.

The health systems analyzed here have different ways to connect financial support and the provided health system service (public or private). The accreditation acquires distinct meanings regarding these distinct relations and the policy proposals that regulate and/or coordinate the national systems of health in different countries. When accreditation is considered mandatory, or when it is established as a condition to have access to certain types of financial support, or when it established (or not) sanctions or privileges to a provider depending on results of its accreditation process, the policies end up changing the meaning of the accreditation process, as well as its contribution potential to promote quality in the system as a whole.

Conclusion

We conclude that certain characteristics, inherent to the accreditation nature, depend on how health systems internalize this methodology into their contexts. Therefore, accreditation cannot be understood only as a quality assessment tool that demands hospitals' voluntary adherence. It can only be understood in the context of policy proposals that limit their application in concrete health systems, as well as in relation to the characteristics of the health service structure in these systems.

That indicates the need to study in depth policy proposals that adopt accreditation in concrete health systems. It is expected that accreditation processes be different, but how can one look at this object so as to express the policy and social options of each nation? It is necessary to understand the conditions and the procedural forms of nations that internalize it, so that we will know which accreditation we are talking about.

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