Transforming and Scaling up Health Professional Education and Training

Policy Brief on Accreditation of Institutions for Health Professional Education

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Acronyms

GNI	gross national income
NCLEX	National Council Licensing Examination
NLN	National League for Nursing
WFME	World Federation for Medical Education
WHO	World Health Organization

Executive summary

Accreditation of institutions and programmes preparing health professionals for practice is widely accepted as essential. It has grown in importance over the past decades as private educational institutions have proliferated, and as health professionals increasingly study and work in international settings. Some radical new approaches in health professional education, and an increasing demand for accountability and quality assurance in higher education, have contributed to a stronger worldwide focus on accreditation.

The most common approach to accreditation has three components: self-evaluation based on published standards; a peer review that should include a site visit; and a report stating the outcome of the accreditation (full accreditation, conditional accreditation or no accreditation). Depending on the country, this may be undertaken by a Ministry, a professional regulatory body, a national accrediting body or a professional society. Sets of standards form the basis of the accreditation, and many of these have been developed by international professional organizations.

However, more than half the countries of the world appear to lack a credible, transparent and comprehensive accreditation system. In these countries, reviews of schools and programmes are either not being undertaken at all or are reported arbitrarily.

There is limited evidence about the impact of the accreditation of institutions and programmes on the quality of education and its relevance to professional practice. To better understand these relationships, targeted changes must be made in accreditation standards; measuring specific outcomes will help address questions such as whether pass rates in certification examinations are improved.

To improve the accreditation of institutions that train or educate health care workers, a variety of approaches could be employed:

- working towards an internationally sanctioned system for the accreditation of health professional programmes: this is in progress in medical education;
- helping regions to maintain existing regional accreditation initiatives that support global standards;
- in countries where accreditation systems exist for higher education institutions in general, encouraging the development of a related system of accreditation specifically for health professional education institutions.

1. Introduction

The World Health Assembly Resolution (WHA 59.23) on the rapid scaling-up of health workforce production urged Member States to affirm their commitment to building the competency of health workforces by promoting the training in accredited institutions of a full spectrum of quality professionals *(1, 2)*. For the purpose of this brief, accreditation is defined as a process of review and approval by which an institution or programme is granted a time-limited recognition of having met certain established standards *(1)*. Licensing means certifying an individual practitioner as having attained the standards required to practice a particular health profession. Both the accreditation of institutions and programmes and the licensing of individuals are components of quality management of higher education, and together they form one of the bases of professional regulation.

Over the past decades preparing an effective health workforce by accreditation of the preparing institutions has become increasingly important for the following reasons.

- Accreditation is believed to improve education by encouraging reflection, focus, motivation and team-building in educational teams *(1, 3)*.
- As interest in quality assurance and accountability in higher education grew, the accreditation of educational programmes became central to these debates *(4, 5)*. Without a national accreditation system, it is difficult to argue that good quality education is being offered. The Lancet Commission on the Education of Health Professionals links accreditation directly to social accountability, in the sense that it can direct health professional education towards addressing the priority health concerns of the community, region and nation *(6)*.
- The exponential growth in the private sector offering health professional education has created a need for accreditation to safeguard public and professional accountability *(1)*. For instance, 147 of the 191 new medical schools established in India in the past 30 years are private universities *(6)*.
- The increased variation between programmes following traditional teaching approaches and those adopting contemporary approaches has led to a need for accreditation to ensure patient safety and good quality clinical outcomes *(3)*.
- The impact of globalization on health professional education has further increased the need for accreditation *(1,3, 5, 6, 9, 10, 11, 12)*.
- Accreditation also helps students to make informed choices about where to study in order to attain their career goals *(24)*.

> *"Quality improvement and quality assurance are among the most complicated problems facing higher education because they touch on almost every aspect of the system. It is much more than meeting some minimal standard measures of inputs – number of faculty members with PhDs, books in the library, ratio of computers to students. And if quality assurance is to be carried out effectively it must be seen as important to those involved, impart critical information to tertiary institutions, employers, and the public, and be meaningful to the international higher education community and other international actors." Hayward, 2006, p4.(43)*

2. Challenges facing accreditation

The implementation of a credible, comprehensive and effective accreditation system poses a number of challenges. First, the process has to balance the demand for quality assurance with that of quality improvement. If the accrediting body over-emphasizes quality assurance, institutions may develop a compliance mentality without implementing essential deep change. On the other hand, if quality improvement were the main focus, high risk-taking without adequate preparation or evidence of need might threaten quality in the longer term because quality control would be sacrificed for innovation *(12).*

Second, the accreditation process has moved away from focusing almost exclusively on input and resources (what it has) towards process and outcomes (what it does). Evidence of student learning has become the central concern (see World Federation for Medical Education [WFME] standards) *(13)*. This move has not been universally popular because many academics perceive the process to be intrusive and unnecessary *(1, 4)*.

Third, the cost of implementing such a system has been cited as a barrier in low-income countries *(1)*. However, there is no absolute relationship between the gross national income (GNI) level of a country and whether or not it has accreditation systems. For instance, many of the Anglophone countries in Africa that have accreditation systems, such as Kenya and Malawi, are designated as low-income countries according to the World Bank classification based on the 2010 figures for GNI per capita *(14)*. Conversely, many of the Middle Eastern countries that lack accreditation systems are in the lower-middle, upper-middle or high-income categories.

The accreditation of distance learning educational programmes poses particular and obvious challenges. Blended learning programmes (a combination of face-to-face teaching and distance teaching, using strategies such as computer-mediated or literature-based environments) are less problematic because of the opportunity to focus on the face-to-face element of the programme. Distance learning programmes highlight the concerns about curriculum quality in the absence of an internationally sanctioned mechanism for comparing different programmes *(15).*

Discussing the accreditation of programmes teaching people how to set up and run libraries, Berry *(16)* pointed out an additional problem: the quality of all accredited institutions is not as equal as the concept "accredited" seems to imply. When educational institutions are given only a short period pending re-accreditation, or a provisional accreditation, their accreditation clearly implies a less than satisfactorily complete adherence to standards. It is argued that such a qualified outcome should be clearly communicated to the public.

According to the Lancet Commission on the Education of Health Professionals *(6)*, private medical schools are less likely to go through an accreditation process than publicly funded ones. However, in some countries the opposite is true: for example, in Kenya, accreditation for nearly 2011 new programmes was requested by private higher education institutions, but not by public ones.

3. Statement of the issues

3.1 The extent of accreditation and re-accreditation of health professional schools worldwide

Information about the current (2013) state of accreditation is primarily drawn from previous consultative platforms and is presented by WHO region to facilitate planning and implementation activities. The situation is fluid, with various accreditation systems being developed in various WHO regions. Generally, where accreditation systems exist, they are different for undergraduate medical or nursing education and specialist medical or nursing education *(4, 21)*.

Table 1: The extent to which accreditation is performed across WHO regions

African Region (46 countries) *(9, 17)*	In most Anglophone African countries regulation is done by ministries or professional councils; ~11 countries have National Accrediting Bodies. In Francophone Africa WHO reports no regulatory bodies for medicine or nursing. In these countries the Conference of Deans of French-speaking Medical Schools *(CIDMEF: Conférence Internationale des Doyens des Faculté de Médecine d'Expression Française)* has the authority to carry out a form of accreditation of basic medical education, but seldom is requested to do so. Any initial accreditation of a new school is usually undertaken by ministries and no re-accreditation takes place.
European Region (53 countries) *(1)*	In Western and Central Europe accreditation is variable, with strong systems in some countries (e.g. United Kingdom, Ireland). In countries of the European Union all programmes have to adhere to the Directive on the recognition of professional qualifications *(18)*. In Eastern Europe and countries of the former Soviet Union, the situation is variable. Some countries (e.g. Kazakhstan) have strong systems of accreditation of basic medical education
Eastern Mediterranean Region (22 countries) *(1, 5, 19)*	Five countries have well-developed systems of accreditation of nursing education, but this is still not universal. Currently there is a joint initiative between WHO, the WHO Regional Office for the Eastern Mediterranean and WFME to develop a regional guide and standards for medical accreditation.
Region of the Americas (35 countries) *(1, 19, 21)*	Advanced systems of accreditation exist in the USA and Canada. In Latin America and the Caribbean many countries use a national accreditation system for all higher education, while others have specific bodies for medical education. The Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) is an accrediting body for medicine and other health professions in Caribbean countries.
South-East Asia Region (11 countries) *(7)*	Accreditation processes are limited. In nursing, out of 12 countries attending a 2007 workshop, only three had systems in place. The other nine are working on developing systems and policies.
Western Pacific Region (27 countries) *(3, 4, 8)*	Australia and New Zealand have well-developed systems of accreditation. China has limited accreditation systems. There is no accreditation of medical education in Japan, but a potentially strong system is under development.

As has been noted above, WHO policy on the promotion of accreditation of basic medical education was developed and agreed in a strategic partnership with WFME *(1)*. There is a related set of WHO/WFME guidelines on accreditation *(23)*. An extra stimulus to make sure that the standards and processes of accreditation agencies are satisfactory has come from the policy of the Educational Commission for Foreign Medical Graduates (ECFMG) of the USA on accreditation. ECFMG stated in 2010 that "...effective in 2023, physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited. To satisfy this requirement, the physician's medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria, such as those put forth by the World Federation for Medical Education (WFME)" *(24)*. It is likely that this policy will encourage many countries that do not, as yet, have accreditation systems for basic medical education to develop them.

In 2009 the International Council for Nurses (ICN) conducted an international study that focused on regulation in nursing, but also referred to accreditation in 172 countries *(25)*. It found that approval/accreditation of institutions was undertaken in a low percentage of cases for all models. The autonomous model, in which the regulatory body does the accreditation without the collaboration of the education institution, was employed in 0% to 67% of cases (the highest instance being in Africa). The collaborative model, in which the regulatory body collaborates with the educational institution in the accreditation process, was used in 0% to 27% of cases (the highest being in Europe). The model in which the regulatory body relies on a third party to carry out the accreditation was used in 0% to 67% of cases (the highest being the USA). The legislative requirement regarding theory and practice resources for the providing institution standards was very low, ranging from 0% to 11%, with the exceptions of Africa (67%) and the USA (90%).

In the USA, where accreditation of nursing education institutions is voluntary, a study was done in one state (Minnesota) to explore the low rate of accreditation *(26)*. The respondent schools listed the following five main reasons for not choosing to apply for accreditation:

- lack of faculty members with the requisite qualifications;
- the cost of site visits;
- the cost of the NLN's membership fees;
- the cost of staff time to complete the self-evaluation;
- limited experience of the accreditation process.

To address these barriers the state of Minnesota made earmarked grants and access to consultants available to schools willing to apply for accreditation.

3.2 Accrediting bodies

The following bodies carry out accreditation in various countries:

- professional bodies or associations, such as the Associations of Medical Schools (e.g. Mexico) or Nursing Associations (e.g. Myanmar);
- statutory bodies, such as Medical or Nursing Councils established by a federal decree or an act of parliament (e.g. Thailand) *(27);*
- national accreditation authorities that deal with all higher education, not just with health professional education, and are usually established by an act of parliament (e.g. Argentina). It should be noted that some authors believe that the position of a separate professional accreditation system, apart from the state evaluation and academic accreditation of the home institution, is becoming redundant

and merely adds cost to an already burdened system *(28)*; However, this is a minority opinion that has been firmly rejected by authorities that have compared health-care discipline specific accreditation systems with general higher education accreditation processes *(1)* (for example, see the Association of Medical Schools in Europe declaration on quality assurance in medical education *(29)*)

- ministries of health, higher education or similar; these may or may not follow a recognized accreditation process.

The funding of accrediting bodies comes from a range of sources: fee for service[1], income generated from conducting seminars and conferences and producing publications, government funding, and grants and legacies *(25)*. In some countries the government funds accreditation from its own revenue, whether the system exists within a government department or as an independent statutory body. In others creative funding strategies have been used. For instance, the Malawi Nursing Council owns the office building from which it operates, and rents out some space, which helps them to fund their organization. The funding of accreditation bodies in medicine tends to be more secure than in nursing, for example by fees from accredited institutions or by registration fees from graduates of accredited institutions.

Competency in developing accreditation standards should be developed by all stakeholders, and not just in one or two constituencies. The WHO/WFME Task Team on Accreditation *(1)* identified the following stakeholders in this process: the public, all levels of government, health regulators, health service entities, funding agencies, students, licensing bodies, teaching staff, universities and other health professions. An understanding of the process and the development of standards should be inclusive to promote buy-in. WHO regional forums have done significant work in capacity building in this regard. The Internet also provides a wide range of tools and capacity building material (e.g. the Council for Higher Education Accreditation website at www.chea.org). Schyve *(30)* confirms that specific expectations of accreditation are likely to vary among cultures, nations and regions, depending on values and priorities, and interest in culture-specific health care accreditation is escalating around the world.

3.3 Mechanisms and standards used for accreditation

There are several accreditation models, but the most commonly used, and apparently the only one used in health professional education, is the process model. This consists of self-evaluation based on published standards, followed by a peer review which should include a site visit, and a report stating the outcome of the accreditation (full accreditation, conditional accreditation or no accreditation) *(12)*. The other two models are more internally driven, and reflect the achievement of goals or standards set by the institution *(12).* No evidence of use of these two models in health professional education was found in the literature.

The stages of accreditation include steps such as permission to apply, provisional accreditation or authority, registration of the institution or programme, approval of the candidacy for accreditation, accreditation and re-accreditation after 4 to 10 years *(17)*.

A range of standards are in use internationally. In medicine, standards include those of WFME *(13)*, of the Liaison Committee for Medical Education (USA), the General Medical Council ("Tomorrow's

1 The challenges that this method of funding engenders is discussed in Sutherland K and Leatherman S, Regulation in quality improvement: a review of the evidence, The Health Foundation, London, UK, 2006. This source also discusses the measurement of effectiveness of accreditation.

Doctors") the Australian Medical Council, and others. In nursing, some have been set by the National Accreditation Authorities, for instance: the standards of the National League for Nursing (NLN) Accrediting Commission in the USA, which accredits nursing schools and programmes; the UK National Medical Council standards of proficiency for pre-registration nursing education *(31)*; and the Uganda Health Professionals' Council (32) Standards for Continuing Professional Development. Other standards are international guidelines adapted by countries for national use, such as the WHO guidelines for evaluating basic nursing and midwifery education and training programmes in the African region *(9)*.

Although this paper has concentrated on nursing and medicine, there are also standards and good practice in other health care disciplines, such as public health (for example, the Association of Schools of Public Health in the European Region, ASPHER) and pharmacy (the International Pharmaceutical Federation, FIP).

The WFME Global Standards for Basic Medical Education *(13)* are a good example of standards, and are believed to be in use in about half of all the medical schools in the world. The standards are classified into nine areas and 36 sub-areas. The categories are very similar to many other sets of standards, and address the following areas:

- mission and objectives
- educational programme
- assessment of students
- students
- faculty/staff
- educational resources
- programme evaluation
- governance and administration
- continuous renewal.

Another aspect of the accreditation or standard setting process is public disclosure of the results. It is a key element of accountability, and the actual level of disclosure will reflect the approach taken to accreditation. Some institutions keep all the information about the accredited organization (except its accreditation status) confidential, while others release more detailed information to the public. For some, emphasis is on the evaluation process as the major source of feedback, while others emphasize the consultation that accompanies the evaluation process *(30)*. Regardless of the style used, relevant information should be available to all stakeholders in support of the purpose of the process.

Public transparency is the ideal to strive for, but, given the absence of accreditation systems in more than half the world's countries, the public inevitably has limited access to such information.

3.4 The impact of globalization on accreditation and the impact of accreditation on the migration of health professionals

Health professional education has not escaped the trends of international economies. It has become a business, seen as both an investment and an export commodity *(14)*. One of the fastest growing areas of transnational education is nursing specialty courses. These courses are delivered either by academic institutional partnerships or by online courses offered directly to individuals.

Another trend has been the creation of political blocks such as the EU and the Southern African Development Community. They have stimulated a quest to harmonize health professional qualifications and to make registration transferable *(11, 18, 33)*. If accreditation standards are harmonized across the countries within such blocks, the migration of health workers is facilitated. Easy migration allows for a more flexible and diverse health workforce among the countries in the block, and creates increased educational and career opportunities for health professionals.

Various initiatives within higher education which attempt to address the quality of transnational/regional education, and which could be used by health professions in designing their own programmes, are listed below.

- European initiatives, in which considerable attention was paid to reconciling cultural diversity with standards, as reflected in the Bologna Process, towards implementing the *Code of Good Practice in the Provision of Transnational Education, 2008* of the Lisbon Recognition Convention *(34)*.
- The United Nations Guidelines on Quality Provision in Cross-Border Education, 2007 in the Asia-Pacific region *(35)*.
- The World Bank African region's Quality Assurance and Accreditation of Higher Education in Africa initiative *(17)*.
- Some of the goals defined as a result of the US experience are as follows *(12)*:
  - maintain respect for differences between academic institutions and their programmes;
  - consider outside-in as well as inside-out approaches. Outside-in means that academics pay greater attention to the views and needs of its constituencies outside academia. Inside-out means that non-academic constituencies have a greater commitment to quality issues and work more closely with academics on collaborative models;
  - affirm the centrality of student learning to accreditation.
- The work of the WHO-WFME Task Force on Accreditation of medical education institutions is also relevant here *(1)*.

3.5 The results of accreditation

According to the Global Standards published by WHO *(2)* research has demonstrated that a more highly educated nursing workforce not only improves patient safety and quality of care but also saves lives. What is less clear and lacks empirical assessment is the impact of accreditation activities. Cost-benefit studies may confirm the added value of accreditation to the education process. Clearly, bodies such as ECFMG regard accreditation as well worthwhile *(24)*

To date, there is limited evidence of the effectiveness of accreditation on educational and service outcomes. In the case of medical education two systematic reviews have compared the results of a change in standards (duty hour's reform) for specialist education. Jamal et al. *(36)* looked at outcomes in surgical residency and found mixed results, although the majority of studies, especially high quality studies, showed positive results. Fletcher, Reed & Aurora *(37)* reviewed the same standard change, and reported inconsistent results for patient safety indicator "complications", and for operational experience ("level of experience" and "quality of experience"). However, patient mortality figures were significantly improved and medication errors significantly decreased.

One difficulty in obtaining evidence for the effectiveness of accreditation in medical education is that some of the longest-established accreditation systems (for example, in the UK, Australia and the USA) produced such dramatic improvements at the time of their introduction that the benefit of accreditation may be regarded as self-evident.

In the case of nursing education, only two studies could be found, and both compared the pass rates of nurses' certification examinations from accredited and non-accredited programmes *(38, 39)*. Gropper *(38)* studied nine associate degree programmes in Maryland, USA in terms of the pass rates of the National Council Licensing Examination (NCLEX) over five years. She found no significant differences in four of the five years, and non-accredited programmes did significantly better in one year. However, the NLN study *(39)* compared accredited programmes nationwide with programmes with unclear accreditation status over two years (2008 and 2009). They reported a higher than national average pass rate in accredited schools in all categories: RN NCLEX, repeat pass rate, associate degree, diploma, and masters programmes. Mondiwa of the Nursing Council of Malawi *(40)* reported that their accreditation process resulted not only in three of the 16 nursing education institutions in the country being closed, but also to the positive spin-offs of a significant increase in pass rates at the certification examination and increased recruitment of nurse educators and student nurses.

4. Policy options

Some recommendations regarding the future of accreditation of institutions for health professional education are:

- establish an international sanctioned system for accreditation of health professional education programmes that is standards based;
- maintain support for regions to proceed with current regional accreditation initiatives in support of global standards;
- include health workforce training in higher education institutions, thus subjecting these programmes to national higher education accreditation processes, with the proviso that health-workforce education accreditation must include specific processes for the examination of education directly related to health-care, and to education in the health care setting *(29)*.

All these activities could be combined into a global strategy that incorporates the best of all practices with clear targets and specified outputs.

5. Recommendations

Global standards for health professional education

It is important that a global set of standards for the process of accreditation be developed inclusively, with bodies representing medicine, nursing, midwifery and the other health professions all being involved. One example of a framework for such global standards was developed during a WHO/WFME workshop in 2004 *(1)*, as summarized in Table 2 below. Although these standards indicate that accreditation should be voluntary with incentives, this might be a risky option in the light of the growth of private schools. It is therefore recommended that this policy should be changed. Furthermore, to support the transformative and scaling-up agenda, it is important to add some standards to the accreditation focus to introduce the idea of social accountability. The additional standards should be as follows.

Transformation and scaling up:

- institutions and programmes should address population needs;
- holistic health professional education should be provided, including aspects such as human rights, social responsibility and ethics;
- evidence should be shown of concern with health workforce needs.

What is needed to move the accreditation process forward?

The steps involved in developing and implementing a national accreditation system have much in common with those required in developing a project. The World Bank *(41)* has identified four broad factors that characterize successful projects:

- consistent commitment by stakeholders to the project's objectives;
- consideration in the project's design of underlying constraints;
- flexibility in the implementation of the project, and allowance for modification;
- encouragement and support for institutional and organizational development throughout the project's duration.

These factors should serve as guiding principles for teams developing and implementing accreditation systems for health professional education.

Table 2: Proposed global standards for the accreditation process of the education of health professionals *(8)*

Requirements ("must haves")		
	1	Accreditation must be based on standards
	2	It must be supported by legislation
	3	It must be undertaken independently, without dominance by any stakeholder
	4	The process must be transparent
	5	The system must not be run for profit
	6	The accreditation team must represent all major stakeholders, but be independent
	7	The system must be efficiently administered
	8	The system must be nationally legitimate
	9	The system must have the authority to accredit and sanction
	10	The process must include at least self-assessment, external review and a site visit
	11	The results must be reported to the institution with the opportunity for response
	12	To ensure adequate human, material and financial resources, the core budget must be publicly financed
	13	The system and process must be periodically evaluated
Desirables ("should haves")		
	14	Accreditation should be time-limited
	15	The system should be acceptable
	16	The system should be credible
	17	The system should be feasible

Provision should also be made for on-going technical guidance to regions for:

- developing quality management processes;
- establishing the key elements and principles of an accreditation process;
- developing tools to support these processes;
- identifying measurable indicators of good quality health worker education.

Finally, health professional education should be included in higher education. Since there is a strong movement internationally to establish national accreditation authorities for higher education, one way of promoting the need for accreditation of health professional education is to support moving such education into higher education. While this might not be the solution for all categories of health workers, it could be a cost-effective option for the professional cadres. Health professional education might also benefit from the strong educational quality framework on which the national higher education accreditation systems are based. At the same time the higher education accreditation systems may also benefit from the strong professional focus of health professional education.

6. Potential areas for research

The most crucial area of research is the impact of accreditation on educational institutions and the graduates they teach. Another area of interest is comparative studies on the process of accreditation, using criteria such as purpose, cost, implementation of the system, transparency and social accountability.

> *"The accreditation of health professions education institutes in the Region is required for several reasons. Firstly, the national health systems are undergoing major reform which necessitates relevant reform in health professions education. Secondly, competent health professionals are needed to ensure an acceptable quality of health services at national and global levels. Relevant and good quality education is needed to train skilled professionals to participate in developing efficient health systems. Accredited education is an essential ... tool that levers not only education, but the role of schools in meeting these goals. Accreditation guarantees quality and relevance of education and also protects institutions against unplanned pressures, such as increase of numbers of enrolment." Al Sheikh, 2003 (44)*

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