**Conformity and Resistance: Accreditation of Hospitals in Iran.**

**Abstract**

The aim of this paper is to examine the operation of an accreditation programme for hospitals in Iran. The paper explores the process of accreditation as an external regulatory control system and analyses hospitals’ responses to this type of control system. It draws on Broadbent and Laughlin (2009; 2013) and argues that the accreditation system is transactional in nature. Our findings show that hospitals show resistance to the scheme but also conform to its requirements. We argue that a reorientation response occurs through both resistance and conformity. We shed light on the reasons why there is little evidence of improvement in hospital performance when adopting accreditation in hospitals. On a wider policy level, our study shows that accreditations as control systems only offer the accreditor the opportunity to impact on how activities are undertaken, but hospitals require incentives in order to make the necessary organisational changes.

**Key words**: healthcare, hospitals, Performance Management, accreditation, Iran.

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**1. Introduction**

Societal regulatory control systems exist in many forms and broadly are aimed at directing organisations at focusing on societal objectives. Whether these broad 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 societal regulation, that of accreditation. Accreditation programmes are external monitoring systems aimed at assessing organizational performance against explicit standards (Shaw, 2004; de Walcque et al., 2008; Pomey et al., 2010; Braithwaite et al., 2010; 2012). 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 Business Schools seek accreditation from the Association of Business Schools (AMBA and EQUIS) for this purpose (Cooper et al., 2014; Zammuto, 2008; Cret, 2011; Urgel, 2007). This paper, however, examines accreditation in the Iranian healthcare system where it is mandatory and it is employed by the government to annually evaluate and rate all types of hospitals in terms of their performance against pre-set standards (MOH-Ministry of Health, 1997a). Annual mandatory accreditation systems are unusual because, if the purpose of accrediting is to encourage organisational change, the limited time period between accreditation visits may impact on the ability of organisations to respond to the controls within the process.

Accreditation processes, arguably, are control processes containing (as they do) an assessment and an evaluation of organisational performance against prior established standards. As control processes, they aim to change organisations and steer them towards these standards. At the organisational level, the accreditation process may put organisational change processes into motion as organisations prepare to be assessed and evaluated. Some research has considered the change processes contained in accreditation systems. For instance, Cooper, Parkes and Blewitt (2014) in a recent paper ask whether accreditations of Business Schools foster organisational changes towards social responsibility and sustainability issues. In healthcare, Pomey et al. (2004) have examined the dynamics of change in French hospitals as they prepare for accreditation visits and have found that it created opportunities for organisational participants to reflect on their processes and activities. Touati and Pomey (2009) compare French and Canadian hospital accreditation systems and argue that both systems show mixed signs of bureaucratic coercion and some organisational learning. Our particular focus is on how and why internal organisational participants may offer resistance to control elements contained in accreditation systems. Whilst most studies of health accreditation systems have appeared in health policy journals, there is a dearth of accounting studies that consider internal organisational reactions to the control aspects of accreditation.

The purpose of this paper is to examine the operation of the Iranian National Accreditation Healthcare programme. This accreditation system is a mandatory system that requires all hospitals to be assessed annually against pre-established standards. Being a compulsory system, a hospital cannot opt out of the scheme and may be put under pressure to make organisational changes. However, being an annual process, hospitals may not have enough time to introduce the organisational changes necessary to achieve the goals the accreditation system. The system therefore may be resisted in subtle ways, further weakening it. Investigating how hospitals react to this situation may help to develop our understanding of conditions that may make accreditation processes more effective as systems of control. We achieve our purpose by analysing the perceptions of hospital participants who are subjected to this particular form of accreditation. Iran is currently administered by a political system constituted by theocratic and democratic elements (Hashemi and Postel, 2010) and thus the underpinning religious values provide an interesting context in which to explore those factors associated with accreditation programme that might affect the perceptions of hospital staff towards what we argue is an external control mechanism.

The paper adopts Broadbent and Laughlin ideas of steering and accounting controls as encapsulated in Broadbent and Laughlin (2009; 2013) and Broadbent et al., (2010). It argues that accreditation programmes are examples of “societal steering mechanisms” that seek to regulate the activities of hospitals. Broadbent et al. (2010) suggest that these mechanisms are the societal equivalent of Simons (1995, p. 7) ‘organisational levers’ of control, in that their aim is to achieve governmental strategies. Accreditation systems are argued to be societal mechanisms of control. Previous studies have analysed organisational responses to institutional processes in healthcare organisations using New Institutional Theory (e.g. Modell, 2001; Abernethy and Chua, 1996) and have found legitimacy seeking rationales to be key in explaining organisational responses. Drawing on Broadbent et al. (2010) theoretical model enables an analysis of the *nature* of societal regulation, whether they are transactional or relational, as well an analysis of the responses the organisations make to them. Our central argument is that, when the value systems underpinning organisational systems are similar to those contained in the societal regulatory system, there can be both conformity and resistance to societal controls. Transactional steering fosters conformity, because of the force of the law and also because funding remains important for organisations. Resistance on the other hand occurs because the desired organisational changes contained in the transactional steers may be perceived as unrealistic and unattainable.

Our paper contributes to the control literature in two ways - empirically and conceptually. Firstly, we illustrate empirically Broadbent and Laughlin’s concepts of transactional and relational steering to demonstrate that they are not necessarily dichotomous – i.e. where there are strong shared values (such as in this case Islamic values), transactional steering occurs with relational elements. 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 is perceived by organisational members. Secondly, at a conceptual level we contribute to the understanding of reorientation strategies, in a developing country context. Whilst Broadbent and Laughlin (2013) explain reorientation through absorption and boundary management, we introduce the reorientation through both conformity and resistance without any specific organisational processes changing.

These contributions are important, because 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. WHO-World Health Organisation), 2003; Shaw, 2004b; Shaw, 2004c; Scrivens and Lodge, 1997 & many others). Our work intends to shed light on the reasons why there is little evidence of improvement in hospital performance when adopting accreditation in hospitals (Greenfield and Braithwaite, 2007; Griffith et al., 2002; de Walcque et al., 2008 & others). Furthermore, research related to accreditation programmes in developing countries has received scarce attention within the existing literature (Hopper et al., 2008; Hoque, 2014).

The paper comprises 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 systems of control. In section three we explain the main elements of Broadbent et al. (2010) theoretical framework, whilst in section four we discuss our research methods. Section five provides our empirical findings including a contextual introduction to the Iranian healthcare accreditation system, and the analysis of organisational responses to this mechanism. We conclude the paper by discussing the findings and addressing the implications for policy and further research.

**2. Accreditations and Management Control Systems**

* 1. *The Nature of Accreditation Systems*

In broad terms, accreditations are external assessments of a service provision. Accreditations provide an external endorsement to the organisation, that the organisation, its services and outcomes meet prescribed thresholds. In the education sector, for example, accreditations are external quality reviews used to scrutinize institutions, and education programmes with the goal of improving the quality of provision (Cooper et al., 2014; Eaton, 2006; Stensaker and Harvey, 2006; Invargson et al., 2006).

A significant amount of accreditation takes place in the healthcare sector. De Walcque et al. suggests that healthcare accreditations are “initiatives [that] externally assess hospitals against pre-defined explicit published standards in order to encourage continuous improvement of the health care quality” (de Walcque et al., 2008, p. i). Where the hospital achieves the threshold and compliance is achieved, they receive a certificate of accreditation, which is valid for a specific period of time - from one to three years (Scrivens, 1995a).

Having a certificate of accreditation arguably conveys several benefits for an organisation and the extent to which these benefits actually accrue has been widely researched (see for example Saufl and Fieldus, 2003; Montagu, 2003; Pomey et al., 2004; Pomey et al., 2010). The benefits can be categorised into those associated with the processes of providing and improving healthcare, those associated with the management of healthcare organisations and those associated with external stakeholder perceptions about healthcare. In the first category, accreditations may provide the organisation with a “verification of excellence” (Saulf and Fieldus, 2003, page 153) and may stimulate a focus on improving the quality of care within hospitals. Arguably, this focus on continuous improvement is the key goal of accreditation processes. The second group of benefits relate to impacts on people working within the organisations. For example, accreditations may provide recognition of the skills of personnel; it may motivate workers and may encourage staff education as they become more aware of best practices (Duckett, 1983; Cerqueira, 2006). The third category of benefits includes facilitating community confidence and improving the reputation of the service provider amongst its end users (Montagu, 2003; Pomey et al., 2010). Contained within this last category are suggestions that accreditation also enables the organisation to demonstrate public accountability and accountability to funders (Halverson, Nicola and Baker, 1998; Cerqueira, 2006).

A generic accreditation process is depicted in Figure 1 below.

Accreditations depend on the use of pre-determined standards of performance to measure and assess organisational activities against those standards (as shown in Figure 1 below). The choice of standards, their focus, and the level at which they are set is paramount in determining the tone, acceptability and nature of the system. Accreditation programmes may be focused on standards set for structures, processes or health outcomes (Zende, 2006). The structureapproach prioritises the structural facilities that are available to the hospital such as equipment, human resources, physical and space specifications and layout (i.e. hardware) in hospitals (Haigh and De Graaf, 2009). Standards are, therefore, established for these resources. Where processes are used as the standards, the accreditation programme focuses on quality assurance activities. The standards concentrate on the process of care, rather than the physical structures. Alternatively, the focus on the accreditation programmes can be on the health outcomes, relying on customer’s charters to assess the extent to which the healthcare system is accessible and acceptable to patients.



**Fig. 1.** Generic accreditation model

**Source**: Adapted from Braithwaite et al. (2011), page 2.

The use of standards is aimed at facilitating the systematic reviewing of complex systems. The credibility and the effectiveness of the accreditation process to a large extent depend on the reliability of the standards that are chosen to assess the activities. This is because they *should* facilitate the assessment of the current situation and consequently *should* help to identify the improvements needed in the processes of delivering healthcare services. Whether they actually do, is debateable and a number of studies have indicated the problematic nature of achieving these goals (Scrivens, 1997a; de Walcque et al., 2008). The standards are applied against current organisational activities typically by way of self-assessment (such as filling out questionnaires), desk appraisal of internal documents and or site visits, usually by peers (Montagu, 2003; Braithwaite et al., 2011).

Although all accreditations involve external assessment or an assessment by some independent authority they need not be compulsory, nor are they necessarily government requirements. The accrediting authorities may be public or governmental departments, or their agencies as in the case of healthcare accreditation in France and Italy (Montagu, 2003; Pomey et al., 2004; Pomey et al., 2010). But they can also be undertaken by private organisations that do not have affiliation to government. Eaton (2006) identifies four different types of accrediting bodies in the US education system. These include regional or state accreditors; national accreditors; faith based accreditors as well as career or professional accreditors. In Europe, Stensaker and Harvey (2006) similarly identify both the existence of private and public accrediting bodies. For example, the General Medical Council in the UK is a public accrediting body for medical education. Where the accrediting body is a public organisation, the accreditation often is compulsory and necessary for operating or providing the service.

This broad description has shown that accreditations take various forms and that the benefits associated with them are by no means certain. Our focus in this paper is on accreditations as an example of an external management control system and it is to this we now turn.

* 1. *Accreditation as (an) External Management Control System*

Management control systems are defined by Simons (1995) as “the formal, information-based routines and procedures managers use to maintain or alter patterns in organisational activities.” This focus on organisational activities suggests that management control systems are internal systems used by managers. Otley (1999) and Ferreira and Otley (2009) suggest key design features elements of these internal systems include *inter alia*, strategy formulation and the development of strategic objectives, budgets, the setting of performance targets and performance measurement, information gathering and sharing, the use of rewards systems to encourage goal congruence. However, increasingly recognition is being given to the fact that the design and implementation of management control systems may be prompted by external factors such as regulatory control systems (Broadbent and Laughlin, 2013; Broadbent and Laughlin, 2009; Agyemang and Broadbent, 2013). Key to this is the argument that internal management control systems cannot be separated from the context in which they operate (Adler, 2011). The external regulatory control systems context may trigger internal management control organisational changes.

Accreditation systems can be considered examples of external management control systems for several reasons. Firstly, in order to obtain the accreditation, organisations are assessed against externally designed standards. The standards cover all aspects of healthcare provision, looking at the organisation in terms of management and clinical performance (Braithwaite et al., 2011; Greenfield and Braithwaite, 2008; Pomey et al, 2010; Shaw, 2004b). Many of these standards often are defined in the language of control, for example as output standards, input standards and process standards that are used to measure the performance of the organisation (Montagu, 2003; Neely et al., 2001; Brown, 1996). In healthcare accreditation, the output standards reflects the outputs expected from the service such as number of patients treated, incidence of infection, accuracy of clinical diagnosis, patient satisfaction and may include both quantitative and qualitative measures. Input standards concentrate on resources and facilities used to provide the service. Process standards, on the other hand, consider how well activities are undertaken and increasingly require continuous improvement in the quality of care. Management processes and clinical processes are examined for their effectiveness. With this focus on standards and the evaluation of hospital performance across the spectrum of hospital activity, accreditations arguably are, in essence, external control systems. The standards act as targets and may represent formal controls, “deliberately articulated” (Chenhall et al., 2010, page 742) for control purposes with the inherent objective of fostering change. Through the examination of achievement of performance against standards, accreditation programmes are depending on performance measurement systems, as part of management control systems, to exert organisational changes (Zende, 2006; Gifford and Garcieri, 2007; Broadbent and Laughlin, 2013; Agyemang and Broadbent, 2013). Where organisations are not successful, i.e. they do not meet the requisite standard, after an accreditation process, they often are subject to further accreditation visits and reviews. Even where organisations are successful and receive the accreditation certificate, they often are still subject to further visits and reviews in subsequent years to ensure that standards are maintained and improved.

Literature has shown the potential for tension between the use of external measures of performance and internal organisational beliefs of what should be measured (Broadbent and Laughlin, 2013; Bevan and Hood, 2006b). In hospitals for example, the perspective held by some physicians, nurses and scientists, is that externally-defined performance measurements are simply too fraught and unpractical to use (Loeb, 2004). There is the argument that medical professionals tend to believe that, what are measured in healthcare organisations are frequently the easiest and cheapest aspects of care, which are frequently of least importance in improving quality (Loeb, 2004) and that the intangible and long-lasting outcomes are perceived as ignored, due to their problematic nature (De Bruijn, 2002; Fried, 2010). Furthermore, there is the problem that patients with seemingly similar conditions may respond in different ways to similar clinical treatment. External pressures through accreditation, as with other external controls, may impact on the behaviour of hospital management and medical staff in unintended, perverse, and dysfunctional ways as they attempt to resist the controls (Agrizzi, 2008; Lehtonen, 2007; Abernethy and Chua, 1996; Abernethy et al., 2007; Kurunmaki, 2004; Modell, 2001).

How accreditation systems operate as external systems of management control leading to organisational change has not been widely researched (Berry et al., 2009). Pomey et al. (2004) have looked at some elements of this by considering whether if and how accreditations lead to organisational change in hospitals in France (Pomey et al., 2004; 2010). They argue that the mandatory nature of the system created strong pressure for change within hospitals, and that it was in the preparation for the accreditation visit that some changes could be seen. Hospitals tend to react in bureaucratic ways; holding meetings to prepare the standards manual. Despite this, there was evidence of a more a consensual and participatory sharing of information and communication between all level of the organisation. Additionally, the process, “translated primarily into the development of values shared by the professionals of the hospital and the creation an organizational environment which is more conducive to fostering better treatment of patients” (Pomey et al. 2004, page 122). Finally they suggest that the preparation for accreditation lead to the introduction and use of performance indicators in the management of activities. Clearly, there was evidence of some acceptance and at least some reorientation in the management control systems to handle the pressures introduced by the accreditation system.

Our aim is to add to this body of research and examine the Iranian accreditation system as an external control system attempting to steer changes on internal management controls systems of Iranian hospitals. We focus on the perceptions of hospital staff about the operation of the accreditation system and the extent to which it drives organizational changes. In the next section we develop the theoretical background employed to understand this accreditation system.

**3. Societal Regulatory Control Processes and Organisational Change**

As argued above, accreditations may be considered as examples of external control systems used to direct internal organisational systems. The work of Broadbent and Laughlin (2009; 2013) and Broadbent et al. (2010) provide a conceptual lens by which the relationships between external controls and internal organisational responses can be examined. They provide a “middle range skeletal framework” for studying regulatory control processes (Laughlin, 1995; 2004), offering a generic language to analyse these and to further develop the empirical analysis. This theoretical model is particularly suited to analysing public services such as healthcare, where funding flows and other regulatory processes are employed by government to change organisational actions.

Developing ideas from Habermas’s theory of steering (Habermas, 1984; 1987), they argue that institutions are developed at societal levels to regulate other organisational systems. These institutions are government departments that employ financial resources and the administrative power of law to direct organisational behaviour. Their role is to act as “societal steering media” whilst the organisation they steer have functional responsibilities. Thus, in the case of healthcare, a Ministry of Health would be an example of a societal steering media, whilst the hospitals are the organisations being directed to provide healthcare. Various mechanisms may be employed by societal steering media to as they attempt to direct organisational activities.

Broadbent and Laughlin (2009) identify two ideal types of mechanisms and discuss their nature in terms of the underlying rationalities used in their development. Where an instrumental rationality underpins the design, transactional mechanisms may be developed. Steering processes that take the transactional approach define the outputs and outcomes desired (the ends), and may also specify the means to be used to achieve these ends. The approach may be illustrated by the regulatory relationship that exists in the context of a contract to undertake a particular project over a definable period of time (Broadbent et al., 2010, page 508). The objectives of the contract are defined; the process is defined as well as the rewards (for achieving the objectives) which are usually financial. Transactional approaches have instrumental goals and tend to be “command and control” approaches with the key purpose of achieving specified ends operating as a “something for something” and without negotiation between stakeholders. Alternatively, where a communicative rationality underpins the development of the processes, more relational approaches are taken in the design of steering processes. Relational approaches, on the other hand, are based on negotiation and communication, and are less prescriptive. Thus, the goals of relational steering would have been agreed through deliberation and discourse between stakeholders, whilst with transactional steering the purposes are achieved through formal (and usually financial) exchanges. Transactional and relational steering processes exist on a continuum that represents “ideal types” of mechanisms. There are a range of hybrid possibilities that can demonstrate varying elements of these types. Table 1 summarises the differences between transactional steering and relational steering.

|  |  |  |
| --- | --- | --- |
|  | **Transactional steering** | **Relational steering** |
| Rationality | Instrumental | Communicative |
| Ownership by organisations | Most likely low | Most likely high |
| Development of standards | Prescribed and non-negotiable | Negotiated |
| Underlying authority | Legal | Reflexive |

 **Table 1.** Types of steering processes

**Source**: adapted from Broadbent and Laughlin (2009)

Being organisations in their own rights, both societal steering media and organisations that are being steered will have their own value systems, or interpretive schemes that give meaning to organisational members. Therefore, there may well be different “measures of quality, relevance or excellence” flowing from the societal steering media to the organisations and it is possible that those working within organisations may not understand “the imperatives behind them” (Broadbent et al, 2010, page 507).

In discussing how these value systems may impact on organisational responses to societal regulation, Laughlin (1991) identifies four possible pathways of change or organisational responses: Rebuttal, Reorientation, Colonisation and Evolution. Rebuttal as the name suggests relates to the complete rejection of the regulation by the organisation making some changes to its own control processes, but at the same time protecting its value systems. Often it is not possible for organisations to rebut external regulation especially where the regulation is backed by law and where it is transactional. In the Reorientation, the organisations accepts that the external regulations cannot be rebutted and do make some permanent organisational changes to processes and functions whilst keeping the interpretive schemes intact. Broadbent and Laughlin (2013) argue that reorientation is the most common response to external intrusions into organisational activity though there are different types of reorientation; absorption or boundary management. In the absorption situation, a specialist group is created within the organisations to cope with and “soak up” i.e. handle the disturbances whilst the main organisational activity continues (Broadbent and Laughlin, 2013, page 214). The absorption reorientation runs parallel to the organisational activities. On the other hand, the boundary management form of reorientation, a select group of senior managers lead changes the day to day activities of the organisations, whilst protecting the organisational interpretive schemes, acting as conduits for the external regulatory controls (Broadbent and Laughlin, 2013, page 227).

The other two change pathways, Colonisation and Evolution, both involve the underlying organisational interpretive schemes changing either through coercion (colonisation) or by agreement (evolution). Laughlin (1991) offers these pathways as conceptual frames, which can only be substantiated through empirical analysis.

Our argument is that accreditation programmes are examples of societal regulatory control systems that aim to steer hospital organisational activities through the standards they select. Whether the processes are transactional or relational is an empirical question. In the case of health systems, one could argue that some of the standards set, for example for hospital cleanliness, should not be set using relational processes but rather are rightly transactional. Furthermore, achieving healthcare extends beyond the goals of individual hospitals and therefore again are rightly be transactional (Halverson et al., 1998). On the other hand, having standards need to provide real world guidance and should be reflective of situations faced by healthcare organisations, if they are to act as a catalyst for change (Duckett, 1983; Halverson et al., 1998) suggesting also that there is a need for them to be negotiated. Relational processes may facilitate both the evaluation through the setting of appropriate standards and may satisfy the requirements of all stakeholders. This theoretical model provides us with is a language for interrogating the nature of the standards, the processes used in accreditation programmes and the responses of the participants to the programme. By empirically analysing the Iranian accreditation scheme, we aim to assess the extent to which the transactional or relational processes are effective in achieving change through analysing the responses of hospital participants to accreditation.

**4. Research Methods**

This study adopts a multiple case-study design using a purposive sampling technique for choosing the hospitals under inspection of the national accreditation program for hospitals in Iran (Yin, 2008; Ritchie and Lewis, [2003](#_ENREF_415)). The aim 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.

We adopted face-to-face semi-structured interviews[[1]](#footnote-1) (Pope and Mays, 2006) including participants working in eight hospitals and nine accreditation surveyors. A purposive sampling technique was also applied for selecting the respondents. The main criterion was familiarity with and involvement in the accreditation and evaluation processes of accreditation programme within the hospitals (see table 2)[[2]](#footnote-2). This provided further understanding of the participants’ actions and substantiated the data collected from the hospitals’ personnel in the absence of the surveyors.

|  |  |  |
| --- | --- | --- |
| **Position/Role** | **Public****hospital** | **Private** **hospital** |
| Hospital director | 1 | - |
| Hospital manager | 4 | 2 |
| Consultant | 2 | 2 |
| Matron | 6 | 2 |
| Supervisor | 3 | 2 |
| Head of Para-Clinic Department | 11 | 2 |
| Head Nurse (Sister) | 5 | 1 |
| Head of Accident & Emergency | 6 | 2 |
| Head of Nutrition and Food services | 2 | 1 |
| Quality improvement office | 5 | - |
| **Total** | **45** | **14** |

 **Table 2.** The number of interviews conducted in the hospitals.

The study entails eight hospitals. Six out of the eight are publicly funded, whilst two are private (Table 2). The private hospitals are owned by non-governmental organisations, bodies or individuals.

To develop further understanding of the process of the accreditation system in Iran, several documents were reviewed and analysed, including two groups of documents - internal (related to hospitals) and external (issued by MOH). This process was supplemented by interviews held with the accreditation surveyors. This enabled us to gain a fuller understanding of the context of the systems as well as the underpinning their rationalities - i.e. whether transactional or relational.

Data was analysed both intuitively and through the use of computer-assisted qualitative data analysis software (NVivo-version 8 - CAQDAS). We employed the literature to identify quotes and phrases from the interviews relating to participant perceptions about accreditation standards and processes and we sought to identify whether these suggested the standards and processes were transactional or relational. Subsequently, our theoretical model provided us with a language to enable us to interpret our findings.

**5. The Iranian Accreditation System**

* 1. *The Iranian Healthcare System*

Iran is a member-state of the Eastern Mediterranean Regional Office (EMRO)[[3]](#footnote-3) of the WHO and the healthcare system has been restructured and steadily improved during the past three decades (Mohit, 2000). The MOH is the ultimate authority of the country’s healthcare – i.e. responsible for the aspects of planning, policy-making, leading, supervising, funding and evaluating the healthcare services and medical education (Mohit, 2000). In one document the MOH explains its responsibilities as:

*“…to define the principles of assessing, monitoring and controlling of healthcare institutions and to implement them.”* (cited in Majlis, 1988a, p.1)

The MOH specifies standards for healthcare services and is also responsible for financing health from public sources. Arguably, therefore, the role of the MOH is to steer in a transactional manner as it is responsible for financing, planning and assessment of performance of the healthcare centrally.

At the provincial level executive responsibility has been put on the Universities of Medical Sciences and Health Services (the UMSs). The task of providing healthcare services and training the required human resources at all levels of education also concerns the UMSs (Majlis, 1985; 1987; 1988a). The chancellors of the universities, who are also the deputies of the health minister in their respective province, are the executive directors of the provincial care services and in charge of all hospitals and healthcare centres. Provision of healthcare services in Iran is undertaken at three levels; primary, secondary and tertiary[[4]](#footnote-4).

The Iranian healthcare system comprises of both private and public care provision. Private hospitals can either be for-profit and not-for-profit (charity) categories and the public hospitals are subdivided into university and institutional hospitals. The university hospitals are governed and operated by the UMS. These are also divided into two groups: teaching hospitals (which provide clinical services and undertake medical training, education and research) and the clinical hospitals (which are responsible only for delivering clinical services). The former, unlike the latter, are mostly located in the big cities of the provinces. Hospitals are conventionally recognised as organisations with a clinical orientation, with their main focus on the provision of care (Jacobs, 2001). The hospitals examined here were not seen as exceptions to this argument. Staff indicated that their purpose is ‘serving the society as a hospital’ as the *raison d’être* of their organisation[[5]](#footnote-5). The review of the policy documents of the hospitals (e.g. strategic plan) and interviews showed that the core of their values and mission is ‘to deliver the high quality and safe services and increase the satisfaction of their internal and external costumers.’

Public hospitals are partly funded by the state through a central budget scheme. An amount of income for both the private and public hospitals is determined by their income from the clinical services they provide. Clinical services are priced based on the accreditation grade of the hospitals signalling the importance of achieving a good grade from accreditation process, and arguably suggesting that the accreditation scheme is set up as transactional or as “something for something.” Where hospitals accomplish a number of regulatory requirements set by the MOH, they are allowed to charge the highest rate for their clinical services. The higher the grade the private hospitals receive in their accreditation, the higher the tariffs they can charge for their hotel-type services, thus further increasing their income. Insurance organisations also reimburse the private hospitals according to their accreditation grade. This income for non - clinical hotel type services is a key stream of revenue for private hospitals. During interviews both private hospital managers and accreditation surveyors emphasised this point.

*“Our motive to complying with this accreditation programme is to get high tariffs; because without them it is difficult for us to survive. In fact, they are our main financial source.”* (Manager: Hospital C, a private hospital)

 *“The main reason for [private] hospitals complying with the accreditation programme is to get high tariffs, since most of them are suffering from low income.”* (Third-party surveyor)

Therefore, in the case of the private hospitals the accreditation scores can visibly have a significant impact on their activities. The public hospitals, on the other hand, are not as dependent financially on the results of the accreditation, since they do have significant income from the public finances.

*5.2. The Iranian National Accreditation Programme: an External Management Control System*

The first attempts to introduce an accreditation system in Iran took place between 1962 and 1967. It started simply in a form of a set of checklists and, at that time, this set was developed on the basis of what was considered by Iranian authorities as successful international experiences (Sadaghiani, 1997; Shaw, 2004c). Iran’s current accreditation system was introduced in 1997. Prior to 1997, only one surveyor used to assess all activities of each hospital. Since then specialised surveyors have been deployed to assess diverse areas of activities in the hospitals. Currently, the healthcare accreditation programme for hospitals in Iran is a compulsory, government-sponsored, state-run initiative. It is similar to approaches adopted by other countries such as France and Egypt (Giraud, 2001; Touati and Pomey, 2009).

There are several societal steering organisations that operate together to accredit the hospitals. The Centre for Healthcare Accreditation and Supervision is a division created by the Minister of Health for undertaking policy-making, planning and direction of hospital accreditation and evaluation activities. There is a subdivision within this centre known as the Healthcare Organisations Evaluation Group which deals directly with such planning and policy-making activities. A University of Medical Sciences (UMSs) is responsible for operationalising and implementing the accreditation and evaluation of hospitals within each province.

* 1. *Developing the Standards : Controlling for Resource Inputs*

The standards within the accreditation programme were developed at macro level in the MOH and officially dispatched to the various UMS at micro level to be used for the accreditation of the hospitals. The existing documentation on the initiation of the national accreditation programmes shows that, in 1997, the formal guidelines for the accreditation were developed under the Treatment and Medication Undersecretary of the Government, and then placed only once to the convention of the Chancellors of the UMS and their Deputies for Treatment, and then finally sent to the hospitals to be observed in their practices (Moghimi, 2004; Sadaghiani and Zare, 2005). This approach to developing the accreditation system suggests that from the outset the purpose of the accreditation was one of central control with the MOH taking the lead. This perception was constantly suggested by interviewees, as they argued that they could not affect the accreditation standards formally or informally as their feedback was not sought nor incorporated to introduce any changes. For example:

*“No feedback is asked from this hospital to improve the accreditation programme. We reflect on the problems though! But nothing has changed based on our views so far. What we say is mostly in an informal way and to the surveyors, because there is no formal process in place asking our feedback.” (Head of A&E: Hospital H. a public hospital)*

There are currently sixteen general domains of activity covered by the standards of the national accreditation programs for hospitals (Table 3). These standards have not changed since 1997. Each domain poses a number of questions and statements in the form of checklists in an attempt to cover all aspects of hospital activity (MOH, 1997a).

The set of accreditation standards listed on Table 3 indicates a considerable emphasis on the hospitals’ physical and structural aspects, input focus rather than processes and outcomes standards (e.g. standards 6- establishment and physical structures; 7- Safety equipment; 8- Non-medical equipment; 9- Medical equipment; and 11- Information system and medical records). These represent 28.9 per cent of the total score. Standards 2, 3, 4, 5 and 13 relates to the administrative aspects of the hospitals, representing 41.4 per cent of the total score. Few standards are associated with output standards. For instance, Standard 10 (patient satisfaction), which makes only 4.7 of the total proportion[[6]](#footnote-6).

It seems, therefore, that the focus of regulatory control was on the physical resources to ensure that the hospitals were equipped to offer services. This focus on structures and input resources was something interviewees commented on and something they seemed not to agree with. For example:

*“Checklists are mostly concerned with physical and structural matters and not with hospitals’ processes, whilst both should be covered by the accreditation programme.”* (Matrons: Public Hospital F)

However, a key objective of the role of the MOH is to “provide facilities for public enjoyment of healthcare by establishing and expanding public health centres and improving their standard” (Malji, 1988) and therefore, from their perspective, it is important to ensure this happened. As the documentary analysis of the evaluation checklists showed, surveyors tend to spend a significant amount of time checking the physical capacity of the hospitals to provide care. It has also been acknowledged by the authorities that the main focus of the accreditation programme is on the physical structures of the hospitals (Moghimi, 2004).

In some cases, hospital departments exchange equipment to influence the accreditation scores whilst in other instances they claim to make unnecessary purchases.

*“…they [the accreditation surveyors] require expensive and unnecessary equipment that we cannot buy, so we may borrow them from other departments only for the period of the survey.” (Head of Laboratory: Private Hospital H)*

*“We are asked to buy some material or equipment that we don’t use too often and as a result of which the hospital incurs costs. But since it is a rule we must obey- e.g. buying a LP set, which is rarely used in this ward.” (Matron: Public Hospital F)*

The perception of the participants involved is that the focus of the accreditation standards is on aspects that hospitals cannot change. Because of this, they sought to create the impression that they had the relevant equipment as the quote above shows. Through this impression management, they sought to conform to the requirements of the standard. Arguably this is a strange and unusual response since by not meeting the physical resources standard they could perhaps argue for more resources to purchase the equipment.

As suggested earlier, some attempts are made to influence the process of standard development informally because staff recognised the absence of formal ways in which their views may be taken into account. Despite this, most interviewees indicated that they perceive the accreditation programme to be a top-down oversight system. The accreditation’s sole purpose, to them, is to remind staff of a need to meet a target number they considered to be meaningless and static. These suggest that the steering inherent in the accreditation is seen by hospitals as transactional, and underpinned by instrumental rationality. That is to say, the standards are not established in a relational manner, through dialogue and seemingly do not seek the agreement of stakeholders, but rather compliance (Broadbent and Laughlin, 2009; 2013).

|  |  |  |  |
| --- | --- | --- | --- |
| **Proportional core (%)** | **Range of the scores** | **Categories of the standards** | **Row** |
| 10 | 1400- 2000 | Religious and humane values | 1 |
| 6.8 | 700- 1600 | Management | 2 |
| 17 | 2160- 3600 | Medical staff | 3 |
| 7.3 | 880- 1600 | Nursing staff | 4 |
| 5.5 | 680- 1200 | Other personnel | 5 |
| 9.2 | 1100-2000 | Establishment and physical structure | 6 |
| 3.2 | 480- 600 | Safety equipment | 7 |
| 3.5 | 400- 800 | Non-medical equipment | 8 |
| 8.3 | 990- 1800 | Medical equipment | 9 |
| 4.7 | 600- 1000 | Patient satisfaction | 10 |
| 4.7 | 600- 1000 | Information system and medical records | 11 |
| 4.2 | 640- 800 | Sanitation and cleanliness | 12 |
| 4.8 | 640- 1000 | Hospital committees | 13 |
| 8.6 (6.9) | 467-1873 | A&E | 14 |
| 2.95 | 198 - 795 | Quality indicators | 15 |
| **100** | **11935-21668** | **Total** |  |
|  | 2000 | Other items\* |  |
| **\*** This score can be added equally to the final score for the teaching activities (education and research), ICU and CCU[[7]](#footnote-7), other special departments (e.g. Dialysis) and etc. based on the surveyors’ judgments. Source: Adapted from Moghimi(2004, p. 26) |

**Table 3**. Accreditation standards and corresponding scores for hospitals’ activities.

From 2004 attempts were made to introduce new qualitative standards (MOH, 2004). Such attempts were a result of a bid to make the programme more ‘quality-oriented’ (Moghimi, 2004). The idea was to update the standards gradually by adding more quality-oriented standards. The aim was to encourage a focus on the quality of the service delivery in the hospitals (MOH, 2004). The Ministry of Health launched a supplementary programme called the ‘Practical instruction for the quality evaluation of hospitals’ as a pilot scheme from 2003, and in a compulsory fashion from 2004 (MOH, 2004). These guidelines were expected to accomplish three important goals as follows:

*“To assist with improving quality in hospitals; to provide necessary information for decision-makers (possibility of informed decision-making; to enhance the level of accountability and regulation of HCOs.”* *(Ministry of Health, 2004, p. 2)*

The stated purpose of the accreditation process is to steer hospitals towards improving the quality of provision. These new standards specified what the government is looking for from hospitals, seemingly moving away from inputs to processes and outcomes. Table 4 provides the quality-oriented standards developed as a result of the Government’s policy introduced in 2004. They are, therefore, part of the current hospitals accreditation (item 15 of Table 3). The original plan was to develop and improve the standards annually. However, at the present date, only the indicators demonstrated in Table 4 have been introduced and they are a result of international experience and consultancy with different professional associations (Moghimi, 2004). Although these indicators reflect a progress towards measuring quality in the hospitals, they only represent 2.9 per cent of the overall score of the accreditation for hospitals.

|  |  |
| --- | --- |
| **Scope** | **Indicators** |
| **A&Es** | * The average length of time after which a physician visits the patient when s/he arrives at the A&E.
* The average length of time after which nursing services are delivered to a patient in the A&E.
* The rate of customers’ satisfaction of services provided in the A&E.
 |
| **Hospitals’ Quality indicators** | * The rate of Nosocomial infections in the hospitals
* Safe and sound injections
* Necessary assessments before any operation on elective patients
* The ratio of C-Section to whole natural births in a hospital
* Prescription of prophylactic antibiotics before operation
* Sedation of pains caused by scald (burning) and operations
 |

**Table 4.** Quality-oriented indicators of the accreditation programme

 **Source:**  adapted from MOH (2004)

The reaction of the hospitals was that they felt they had to comply with the standards though they did not agree with them. For example:

*“In the case of nosocomial infection, they insist that we find more cases of patients with this condition and, if we report fewer cases, they will assume that our case-finding system is not working properly, while we think the less cases should be better.”* (Manager: Public Hospital C)

Thus, what seems to be happening through the accreditation is the implementation of an *ex ante* accounting information system to monitor and control the hospitals irrespective of the views of managers and clinicians and irrespective of the interpretive schemes held by organisational members (Broadbent and Laughlin, 2013, page 78). Transactional *ex ante* information reflect exchange situations where something, is given for something else (usually money). In the accreditation situation in Iran, meeting the specified standard would have a financial impact and therefore was much conformity and even impression management in order to gain the requisite score. But the development of standards was not based on a dialogue as to how to improve performance. Although the quality standards were to encourage continuous improvement in performance, the hospitals did not see them this way. Pomey et al. (2004) suggest that in Canada, the development of standards for continuous improvements, involved more professionals and enabled them to identify their organisational weaknesses, improving communication, but only marginally improving clinical practices. This differs from the Iranian situation where it seems the participants do not consider the potential learning from the standards.

In many cases, the hospital participants showed they do not have the resources or the capabilities to comply with the standards.

*“It is not based on the hospital’s capability. We don’t think they evaluate what we have or are capable of doing.”* (Supervisor: Private Hospital E)

Therefore, there are problems with how the standards have been developed. Transactional steering approaches may lead to some conformity but resistance and the non-acceptance of accreditation standards is also discernible in the reactions of hospitals. Cooper et al. (2014) suggest that accreditations create institutional pressure for change in systems and organisations. Shaw et al. (2010) also suggest that in many countries, hospital systems change in preparation for accreditation. Where the standards are seen to be irrelevant, as in the Iran case, the participants may not feel any desire to meet them. Hospitals may attempt to rebut the controls, but being unable to do so, may attempt to reorient their internal activities. Further organisational resistance is shown to the accreditation system in response to how the standards are applied.

* 1. *Applying the Standards: Non-Negotiable and “unfair” tempered by shared religious values*

During two-six months period and prior to the accreditation visit, hospitals are given the relevant forms to self-assess their performance against the indicators specified in Table 4. The completed forms are then handed to the surveyors. The surveying groups typically include two consultants from different disciplines such as internal medicine and paediatrics, two paramedics including one radiologist and one laboratory technician; one nurse; one medical equipment engineer; one establishment and construction expert, one administrative and personnel expert, one financial and budget expert, a team coordinator; healthcare management expert and other experts if required. A representative from insurance organisations is also a permanent member of this surveying group (Moghimi, 2004, p. 8).

The surveyors score the hospitals on the basis of the self-assessed information. The surveyors act as peer reviewers, drawing on the self-assessment forms filled by the hospitals to conduct their review. Some guidelines are provided to assist the surveyors to assign related scores to the activities of the hospitals. Nonetheless, in most cases there are no guidelines, apart from the surveyors’ judgement decided from their observation and interviewing. The interviewees suggested that the manner in which the accreditation is conducted to apply the standards may be considered somewhat simplistic and non-negotiable, tending to depend mainly on the subjective view of the surveyors. For instance, the surveyors check the list of equipment and award scores, but they do not assess whether the equipment is used or not.

“*The surveyors only check the existence of equipment; they have never checked whether we can use it or…*” (Head of Para-clinic Dept.: Public Hospital F)

The hospitals also suggest that there is a coercive element to the accreditation which forces them to comply with surveyors requests. For example;

*“Sometimes they (surveyors) for instance ask for the provision of a new service that is not to the benefit of the hospital, but we must comply with them in any case. It has a few times happened that the surveyors have asked for some documents that we do not think are worth preparing, but it is obligatory and we must draw up, when asked.”* (Manager: Public Hospital C).

The subjective approaches used in scoring hospitals lead to many concerns, primarily because hospitals do not understand how the scores are derived and, secondly, because they feel different types of hospitals are treated differently.

*“Scoring process is not clear for us. It is totally up to the surveyors’ judgements what score to give to the hospital. Therefore, we do not know how to perform to get the full score for an activity or process.”* (Member of quality improvement office:PublicHospital F)

A more relational approach to the application of standards could help hospitals to understand what changes the accreditation system is attempting to achieve, so staff could hold a more constructive view about the accreditation process. Pomey et al. (2004) for example, suggests that positive incentives such as training and accreditation awareness lectures could help accreditations to serve as an agent of change. Tension between private and public hospitals is visible because private hospitals hold the perception that the accreditation programme benefits the public hospitals. As Tables 3 and 4 portray, standards for both public and private hospitals are the same, since the main objective is ‘continuous quality improvement’ at all levels of hospitals’ activities (Moghimi, 2004, p. 5). However, participants from private hospitals feel aggrieved.

*“Surveyors assess this hospital more strictly than the public hospitals. They normally carry a negative view towards private hospital … I know that the requirements of the accreditation programme are not properly observed in the public hospitals, as I have worked there. However, they normally get better grade than us very easily.”* (Head of A&E: Private Hospital H)

*“… I feel they [surveyors] don’t give us a fair score, because I don’t think it is fair to compare us with the other advanced public hospitals and evaluate our work by the same checklists of standards.”* (Manager: Private Hospital E)

*“They compare this hospital with publicly-funded advanced public hospitals, which is not fair in my perception.”* (Supervisor: Private Hospital E)

Private hospitals also indicate they are always distrustful of the evaluation results, because they do not have a representative in the evaluation team and the evaluation is performed by the surveyors of the universities and the Ministry of Health who belong to the public sector. Nonetheless, the public hospitals also echo their lack of faith in the accreditation system:

*“They (the surveyors) do not consider our “out-of-hand” limitations and capabilities in their evaluation.”* (Manager: Public Hospital B)

Both private and public hospitals seemed to share a distrust of the accreditation scores, albeit that they imputed different reasons for this disbelief. Arguably, the similarity in views stems from the underpinning rationalities associated with the accreditation scheme. As Broadbent and Laughlin (2009) suggest with transactional steering,

*“Measures come first and either assume to seek to define the implied values underlying these numbers…. ‘Ownership’ of the performance measurement systems may be difficult to achieve if the required ends do not reflect the taken-for granted organisational values”* (Broadbent and Laughlin, 2009, page 287).

Despite this, there is one aspect of the accreditation standards that all the hospitals are supportive of, since it is founded on shared interpretive schemes. Ten per cent of the total score relates to religious and humane values. We found a number of spiritual guidelines concerning healing and helping patients to recover displayed on the hospital notice boards as well as stated in the instructions of the hospitals’ evaluation (e.g. Ministry of Health 1997a, 1997b). Questioning, ignoring or rejecting those standards is considered highly inappropriate, since they are grounded in shared religious and humane beliefs, which is a key element of the underpinning Islamic values of the country. Some groups, especially the frontline staff of the hospitals, suggest that these shared religious beliefs and humanitarian values provide the motivation for complying with the demands of the accreditation programme (Jayasinghe & Soobaroyen, 2009).

*“…our motive for complying with the accreditation programme is helping patients. We hope that its guidelines help us to do this invaluable task ...”* (Sister: Private Hospital E)

*“In any situation, we basically observe the religious values.”* (Manager: Public Hospital D)

They believe their religious values help patients to recover and are keen to take on board any initiative that can assist them in this purpose. Higher scores are often received by hospitals for these standards.

“*We do not feel they (the surveyors) are constraining our freedom and independence. They even try sometimes to help, but they are just performers of the evaluation.”* (Matron: Public Hospital C).

These sentiments suggest that, although the accreditation seemed to be transactional in approach, the strong shared religious values possibly mediated for the control elements within the system such that accreditation process is not seen to be excessively intrusive.

*5.5. Periodic Site Review and Accreditation Outcomes*

The hospital accreditation visit is conducted annually beginning with a pre-arranged site visit by a team of surveyors. The visit usually lasts one week depending on the size of the hospitals and the number of in-patient beds. The site review is undertaken into two stages. The first review visit is to the accident and emergency (hereafter A&E) department, and is conducted independently of the remainder of the hospital. The second visit is the whole hospital assessment and it only takes place if the A&E obtains acceptable scores. This means there it is considerable pressure on both managers and clinicians to meet the standards for A&E. There are tensions between the managers and the clinical, which becomes evident during the preparations for the periodic site reviews element of the accreditation.

Managers complain about the attitude of the clinicians. Many clinicians remained disengaged from the process, despite attempt by the hospital managers to find ways to encourage them to comply with the requirements of the accreditation programme.

*“Surveyors frequently refer to some problems related to the activities of our consultants (e.g. their low rate of attendance in the hospitals committee and meetings). But, this is not under our control.”* (Manager: Public Hospital B)

*“We have problems with the clinicians who don’t comply with the requirements of the accreditation programme (e.g. filling the patients’ record completely). We try to encourage them to do so, because we lose points if it is not done properly. I try to do this through senior managers [director] of this hospital.”* (Sister: Private Hospital E)

Interviews with physicians indicate that they are either unaware of the accreditation programme or see it more as a ‘formality’ than a quality improvement mechanism. Their tight schedules also seem to impact on their indifference toward the accreditation programme.

*“I know there is an evaluation programme, but I am not aware what it does and what its standards are.”* (Consultant: Public Hospital F)

In fact some clinicians suggested that the accreditation scheme does not have an impact on their work.

*“I don’t suppose the accreditation programme limits my freedom and independence, because it is only an annual checking system which stays just for a few days with us in the hospital.”* (Head of ED: Private Hospital E)

Seemingly, then, the accreditation scheme is neither intrusive nor freedom-reducing (at least for the clinicians) as is typical of transactional regulatory processes. Other studies on accreditations have shown that it is the nurse managers who take leadership roles in preparing for accreditation visits. It is in this respect that our findings are similar to these studies (Duckett, 1983; Pomey et al., 2004). Both the private and the public hospitals demonstrated the two types of logics, professional (held by the clinicians) and managerial (held by the managers), often associated with healthcare organisations (Abernethy et al., 1996; Kurumanki, 2004; Modell, 2001, Lehtonen, 2007). Nonetheless, whilst other studies show that accreditation preparations lead to “sharing of information and greater service integration” (Pomey, et al., 2004, page 122), here there is a sense that clinicians are very powerful and they can choose not to engage. Most of the interviewees indicated that the quality improvement activities involving consultants do not progress properly, because they are reluctant to participate in and cooperate with such activities.

*“Surveyors frequently refer to some problems related to the activities of our consultants (e.g. their low rate of attendance in the hospitals committee and meetings). But, this is not under our control.”* (Manager: Hospital B)

*“…consultants tend to not attend the time requirements of the hospitals, because of the power they hold.”* (Third-party surveyor)

Supposedly, if the underpinning ethos of the accreditation scheme is relational, all stakeholders would have a shared concern for ways of improving processes and practices and this would emanate through the whole preparation for the visit. Transactional approaches are more attentive to outputs, the ends rather than the means.

Where A&E departments do not achieve a satisfactory score (i.e. falling into the non-compliant category – grade 4; between 10869 – 13218, Table 5), the hospitals are given three months at most to rectify the problems and prepare for a re-evaluation of its A&E department. This scheme tends to force hospitals to neglect their main activities to obtain higher grades for their A&E accreditation and then be able to move to the second phase of the process.

During the second phase the surveyors investigate different aspects of the hospital activities, looking at medical equipment and clinical and paramedical spaces in an attempt to evaluate the hospitals holistically. They interview medical staff (mainly nurses) and sometimes patients, and finally they review the related documents.

At the end of the accreditation visit, the surveyors hold a meeting with hospital managers to discuss the problems and to brief them on existing non-compliances against the standards. The final written report of the review is usually sent to the hospitals within a month of the site visit. Table 5 displays the range of scores and corresponding grades granted to the hospitals. The grade is used as a threshold for hospitals eligibility to raise their tariffs for hotel-type services (MOH, 1997a).

|  |  |  |
| --- | --- | --- |
| **Explanation** | **Grade** | **Score** |
| Excellent | +1 |  21669 and more |
| Good | 1 | 18369 - 21668 |
| Intermediate | 2 | 15869 - 18368 |
| Poor | 3 | 13219 - 15868 |
| Substandard (Non-compliant) | 4 | 10869 - 13218 |
| Unauthorised | - | 10868 and less |

**Table 5.** The scoring system of the accreditation programme for hospitals

**Source**:Moghimi (2004, p. 12)

Where a hospital is considered as non-compliant, namely achieving a grade four, it is given three months to improve its deficiencies and to solve the problems identified during the evaluation process. A final decision is made after a second visit to substandard hospitals. Hospitals considered ‘substandard (Non-compliant)’, after a second visit are prevented from providing services to society and those classified as ‘unauthorised’ can only work as a limited-surgery clinic, rather than a hospital. Thus, there are clear financial penalties and consequences when a hospital fails to meet the required standards. On the other hand, the opportunity of gaining financial rewards, as a result of earning higher accreditation grades, is not perceived by the participants as offering significant enough rewards to change in the hospital circumstances. At the societal level, a formal link between the hospital performance and incentives does not exist. Nevertheless, the hospitals prefer clearer financial incentives to be associated with a higher grade.

*“There are no organised financial incentives for the departments that get higher score. They might get some rewarding leave or overtime hours which are very limited.”* (Head of quality improvement office: Hospital D-Public)

The lack of a clear reward and punishment system could remove the incentives for making efforts to achieve a better grade and performance (Custers et al., 2007).

In summary, the accreditation system as applied in Iran, although aimed at continuous improvement in quality of healthcare delivery, rather relies on many input standards. The accreditation scores of hospitals depend on subjective assessments made by survey teams. The outcome from the accreditations has some financial impacts, and thus the control system seemingly is transactional in its steering approach. Whilst the hospitals showed some resistance to the process, they do comply with its requirement, suggesting some amount of reorientation or organisational activities. The shared societal religious values tend to make the accreditation seem less intrusive than it might have done. The next section discusses these organisational responses to accreditation system and concludes our study.

**6. Discussion and Conclusions**

An accreditation programme, we argue in this paper, is an example of an external management control system attempting to change hospital activities through the standards against which they are assessed. Understanding organisational participant perceptions of these standards, the accreditation process and the outcomes are important for assessing the effectiveness of accreditation systems and whether they can lead to organisational change. In this paper we analyse the perceptions of hospital participants in Iran to the Iranian National Accreditation of Hospitals Programme. Our findings show that, whilst there is much resistance to the scheme, hospitals conform to its requirements, in some cases even using fabrication and impression management to demonstrate compliance. The key factors explaining conformity include the compulsory nature of the process, the financial impetus and the shared religious values. In effect the transactional nature of the process and the outcomes associated with the accreditation enable conformity. Resistance, on the other hand, is driven by the perceived inappropriateness of the standards. These reactions together (i.e. conformity and resistance) are suggestive of a reorientation response (Broadbent and Laughlin, 2013; Laughlin, 1991). However, there is no evidence of hospitals making permanent changes to organisational processes.

6.1. *Reorientation Resistance*

Broadbent and Laughlin (2013) suggest that reorientation strategies, where there is resistance to regulatory controls, take place through absorption practices or through boundary management. With absorption, the organisation manages “unwanted intrusions” by soaking them up through the activities of specialist working groups thereby protecting the core activities (Broadbent and Laughlin, 2013, page 213). With reorientation by boundary management, senior managers act as a conduit for the external regulators, whilst protecting the interpretive schemes of the organisation. In both cases there are organisational changes, but the core values are protected from the intrusion. In this particular case of accreditation of hospitals in Iran, the responses made to the accreditation processes were attempts by organisations to conceal their inability to meet the standards*.* Reorientation took place in the form of some amount of gaming and impression management. For instance:

*“We get prepared for the evaluation* [by the NAPH] *- sometimes superficially. We put some medical equipment such as “infusion pump or incubator” in our A&E which we do not use, and we believe they are not necessary… …we take them away and return them to its previous ward after the evaluation.”* (Head of A&E: Hospital B-Public)

*“We must prove the average time, after which a physician visits or nursing services are delivered to a patient arriving at the A&E, has reduced during a period of six months to get the related evaluation score. In practice, to be honest, this might not always happen in this department because of our shortage of staff. In busy times we bring staff from other departments to keep the waiting times down, but this is not possible in the long term... although their score is very low, they must be met, according to the regulations.”* (Head of A&E: Hospital E-Private)

This form of reorientation takes place because the nature of the standards set to grade hospitals activities are perceived as unrealistic, outdated and static. The perception is that the accreditation standards do not highlight the strengths of the hospitals nor do they reveal their weaknesses and mistakes. Hospitals simply receive a list of grades related to their main activities, but they do not get explanations and/or suggestions on how to improve them. Hospitals are assessed on aspects over which they have no control over (e.g. human resources), which has led to a sense of indifference, lack of ownership and sometimes indignation. Shaw et al. (2000) suggests that standards should be developed to reflect national legislation, economics, culture and demand; there was no sense that this was the case in Iran since the standards are international.

Pomey et al. (2004) argue that the institutional pressures created by compulsory accreditations need to be backed by incentives to encourage organisations to engage meaningfully in the process, through learning and training. In effect, the processes of accreditation (standards development, application of standards, self-assessment etc.) can be used to encourage organisational change. We do not see this happening in this case study. Cooper et al. (2014) also signal the important role powerful interests (in their case, academic Deans) can play in championing issues within the standards to instigate change. Rather, what we see in Iran is a focus on standards perceived to be inappropriate and the accreditation process therefore being considered unrealistic.

As Broadbent and Laughlin (2009, 2013) argue in transactional approaches to control, the measures come first and are developed on assumed values. A more relational and discursive approach could create an opportunity for hospitals to reflect on and improve on their own performance as their values, and knowledge become subsumed in the definition of standards. Where more relational mechanisms are used to regulate and there is more discussion of the causes and effects of actions between organisations and their regulators (Broadbent et al., 2010), they develop a shared understanding of issues pertaining to hospitals. Quality of care may require standardisation but it should not discourage autonomy and creativity.

6.2. *Reorientation: Conformity*

Whilst the Iranian case shows resistance, there is also some level of conformity to the accreditation programme. The following comment is typical of both resistance and conformity.

*“In this A&E I am always busy, but I should try to find time to fill the forms of triage (part of the evaluation process) for each patient. We cannot leave them for another time because it should be completed at that time. But, when we have too many patients or those with critical condition, it might take our time and attention away from the patients. …I don’t know why this information is collected, I only know it is taking too much of my time, even the surveyors acknowledge that filling these forms will need too much time.”* (Head of A&E: Hospital E-Private)

Whilst the beginning of the quotation signals conformity, the end shows the resentment associated with the time it takes to comply with the accreditation requirements. Hospitals conformed to the accreditation because of three reasons, the financial benefits associated with it, its compulsory nature, and the shared religious values that all parties held.

Firstly, the accreditation programme in Iran is premised on the transactional approach of “something for something” for the financial transfers the organisations receive there is a need for performance accountability by meeting the accreditation standards. However, the financial impacts of accreditation performance differed between the private and the public hospitals. The financial consequences for the public hospitals are negligible since the public sector hospitals in Iran are funded by the Government and, therefore, have a stable source of funding. There is no noticeable financial penalty for the public hospital management team in the event of them not achieving the desired standards of the accreditation system. Likewise, no financial reward is formally set for hospital managers who obtained high grades. The public hospitals in Iran had a shared culture of public service and were prepared to conform to the accreditation. This is similar to the French example highlighted by Touati and Pomey (2009).

The situation was different for the private hospitals that faced constant and continuing financial difficulties. It was therefore, imperative for them to achieve a high score, which impacted on the tariff they set for their services. The fabrication of pre-evaluation documents was an attempt to meet the demands of the A&E standards (table 4) in order to gain the financial resources. The fact that they are prepared to go to this extent (arguably) shows the significance of money as a steering mechanism (Broadbent and Laughlin, 2009, page 292). It also demonstrates the problems that transactional societal regulatory processes may face when there is not a market to set prices to deal with the transfers of money. The expectations of the regulators (in this case the desire for improved quality of health care) stand the risk of not being achieved where the financial flows are necessary but not considered sufficient enough to drive the organisational changes necessary to meet the standards.

Despite this, all the hospitals did participate in the accreditation programme, because it is legally required. The mandatory nature of the programme means hospitals cannot opt out: the accreditation has legal support. The accreditation is a mode of governance that can exert disciplinary power over the hospitals by preventing them from providing services. Therefore, there is conformity because of the fear the hospitals have of being closed down if they do not reach the required standard. The state has enormous power and could wield this on hospitals. The gaming practices (such as the borrowing of equipment) were undertaken to ensure that standards appeared to be followed. It was not clear the extent to which the surveyors responsible for implementing the accreditation were aware of the gaming. The hospitals suggested that:

*“Their [surveyors] behaviour is interactive and cooperative and we don’t feel that they (the surveyors) restrain our freedom or discretion.”* (Head of ED: Hospital B)

*“We do not feel they [the surveyors] are constraining our freedom and independence. They even try sometimes to help, but they are just performer of the evaluation and real decision maker about the programme is the Ministry of Health.”* (Matron: Hospital C)

Both these comments suggest that although mandatory, there was not a “command and control” approach being taken with the accreditation. A close look at the case seems to suggest that the hospitals’ interviewees are prepared to conform to the accreditation requirements, because of shared religious values. Thus, even if the accreditation programme is transactional, it is *perceived* as a relational process, although it is not based upon deliberation and negotiation. In discussing relational steering, Broadbent et al. (2010) do not develop the bases on which relational steering may be founded. Nevertheless, they point to the complexities associated with actual practices. For example, in their study of Higher Education in the UK, they argue that many of the regulatory controls pass through intermediate organisations that can reshape the transactional controls, making the processes more relational. This study suggests that, whilst the accreditation standards reflect transactional definition of standards, or the ends required, the means or processes of working towards these standards may be underpinned by shared religious values. In effect, transactional steering need not be undertaken in a “command and control” manner.

To conclude our specific case, we have argued that the hospital accreditation programme of Iran is a societal management control system developed centrally that shows signs of transactional steering. However, in the context of Iran, and the shared underpinning religious beliefs in which the programme is implemented, the dichotomy of transactional and relational steering may not be as sharply divided as may be the case in other settings. This recognition reasserts the importance of studying control systems in the context in which they operate.

On a more general policy level, our study has shown that accreditations as control systems offer the accreditor an opportunity to impact on how activities are undertaken. Nonetheless, as with other systems of control, the goals of the control system need to be agreed and shared by all stakeholders who will have a part to play in achieving the objectives. Healthcare organisations need to work with the accreditor (the government, in this case) on all the three stages - i.e. developing and applying standards and the periodic review to enable an effective accreditation programme to impact on the quality of healthcare.

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1. One of the authors went to Iran on several occasions to conduct the interviews, as he is fluent in Persian. Equally, all the other sources were then translated and cross referenced and checked against other available primary data. Nonetheless, the interviewees were mostly cautious about giving data to someone studying abroad. [↑](#footnote-ref-1)
2. One of the authors participated in one accreditation of the hospitals in order to observe how it takes place in practice and to perceive the interactions between surveyors and hospitals’ staff. [↑](#footnote-ref-2)
3. EMRO includes countries from the Middle East and the northeast of Africa, such as Yemen, Lebanon and Morocco. [↑](#footnote-ref-3)
4. Primary care is mostly provided in rural areas by some basic health centres whereas second care includes the more advanced services and initial access to district hospitals. The tertiary care includes the UMSs and hospitals, which provide the most advanced healthcare services. [↑](#footnote-ref-4)
5. Even the private hospitals highlighted this point, despite their profit-making purposes – i.e. the interests of the shareholders were also mentioned as their strategic target. Nonetheless, there was clear indication of other priorities, such as staff health, safety and satisfaction, expansion of their services and promoting medical education (in the case of public hospitals). [↑](#footnote-ref-5)
6. There are several studies finding no relationships between accreditation and patient satisfaction (e.g. Greco et al., 2001; Heuer, 2004). Similarly, patient-reported measures of quality and satisfaction of both accredited and non-accredited health plans could not be differentiated (Beaulieu and Epstein, 2002). [↑](#footnote-ref-6)
7. Intensive Care Unit and Coronary Care Unit [↑](#footnote-ref-7)