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HEALTHCARE ACCREDITATION: A GAME-THEORETIC VIEW

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In India the demand for health care has been rising with increase in life expectancy, growing middle class affordability, recognition of the importance of preventive care, and overall consumer awareness. The government investment in the sector is meager given the size of the population and the needs of the citizens. Given the significant unmet needs of patients, private institutions have emerged to provide health care. This as well as the quality of healthcare offered by government hospitals, has led to the need for a national accreditation policy as a way to ensure quality and equity of care. As opposed to a government regulation, accreditation is on a voluntary basis. A hospital may or may not seek accreditation depending on direct and indirect costs and benefits. Direct expenses are the fees paid for accreditation, and indirect expenses are those required to attain and maintain the accreditation status. Specifically, indirect expenses refer to the cost of better practices, purchase of new equipment, recruitment of qualified staff in adequate numbers, and meeting customer needs. Presumably, a hospital would seek accreditation if improved quality generates additional business offsetting the cost of accreditation.

This paper examines national accreditation policy for Indian hospitals based on a game theoretic perspective. The paper illustrates the role of game theory in (a) evaluation of national policy for hospital accreditation, and (b) management strategy formulation for the accreditation agency, with potential implication for millions of people. The paper provides the rationale for how an accreditation agency could influence the health care provider to improve the quality of care and add value to the society at large. It seems that the current accreditation standards, while serving the needs of “elite” hospitals for the relatively rich and medical tourists, may deter weaker hospitals from participating in the accreditation process.

Key Words: Indian Healthcare sector, Quality of healthcare, Accreditation, Public Policy

JEL Classification: I11, I18, L38

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INTRODUCTION

Healthcare as a topic that garners a lot of interest globally. While the issues and concerns differ across nations, there is consensus that every individual should have access to good healthcare at affordable prices. The west-European countries with universal healthcare are concerned with service delivery, individual waiting time, and cost containment. In the USA, currently after the Supreme Court upheld the Obama-care in 2012 the concern is with implementation of the healthcare law such that it does not add to the national deficit and slow down the economic recovery underway. In India and several developing countries one of the main concerns is to ensure quality of care and patient safety besides health education, improved sanitation, better nutrition and timely preventive care. What makes the problem more acute is in identifying ways in which to deliver quality healthcare in an affordable and equitable manner.

In the 2011 Human Development Index out of 187 nations, India ranks 134 and health accounts for one - third of the index. (http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf - accessed on July 26, 2012). In general, Indian hospitals tend to be understaffed, crowded, inaccessible in many areas, and deficient in hygiene and quality of service. Long work hours for medical professionals is often cited as the cause of early burn out, wrong diagnosis and inappropriate treatment. Misuse of drugs, availability of spurious drugs and corruption are other issues aggravating the situation in the healthcare sector. In short, the health care infrastructure in India has not been able to keep up with the rising demand for quality services.

Consider the data from the World Health Organization (WHO) for several countries (<http://apps.who.int/ghodata/>). Table 1 below compares India's healthcare picture against Brazil, China, Russian Federation, the USA, and Bangladesh.

	Health expenditure	Govt. health expenditure as a % of total exp. on health	Govt. health expenditure as a % of total govt. expenditure
India 2010	4.1	29.2	3.6
Brazil 2010	9	47	7.1
China 2010	5.1	53.6	12.1
Russian Federation 2010	5.1	62.1	8
USA 2010	17.9	53.1	22.4
Bangladesh	3.5	33.6	7.4

Table 1. Health Expenditure by Selected Countries

It is indeed revealing that Bangladesh spends over twice the percentage (3.6% vs. 7.4% in the last column) of the Indian government when considering the government health expenditure as a percentage of the total government expenditure. USA spends 22.4% of its total expenditure on health and Brazil, China, and the Russian Federation spend more than India. India's total healthcare expenditure as a % of GDP (column 1) is only 4% compared to 17.9% for the USA and 9% for Brazil. Measured by the ratio of public to total expenditure, India has the lowest ratio (29.2% in the above Table) according to New Delhi's Economic Research Foundation (2006) study undertaken for the MacArthur Foundation, India. Moreover, the Government of India spends only 1.2% (= 4.1% * .292 in Table 1) of the GDP on healthcare.

The Government of India plans to increase the public spending in the sector to 2.5% of the GDP by 2017 (Indian Express, March 1, 2012 - accessed on May 19, 2012). While the increase is overdue, it is still meager considering the current state of the health sector, the needs of the population, and the state of affairs in developed and even some developing countries. Unless the investment is sustained and increases over the years, it may not lead to greater access and improved delivery of healthcare to the growing population. As per India Knowledge@Wharton (2008), India has only 1.5 beds per thousand people, while China, Brazil, Thailand and Korea have an average of four beds per thousand people. Over a million people die every year due to inadequate healthcare facilities. 700 million people have no access to specialist care and 80% of specialists live primarily in the urban areas. Also, about 40% of the primary health centers in India are understaffed Rural Health Care System in India - <http://nrhmmis.nic.in/UI/RHS/RHS%202011/Rural%20Health%20Care%20System%20in%20India-%20Final%20-%202009.4.2012.pdf> (Accessed on March 13, 2013).

In India, despite relatively low government participation in healthcare, the demand for health services is rising given the increasing middle class, wealth, and life expectancy. As per the Price Waterhouse Coopers 2007 report on the Indian healthcare sector experienced a compound annual growth rate of 16% in 1990s with a market size of about \$34 billion. Currently, the market size is about \$50 billion and expected to double by 2015 to \$100 billion (Economic Times, January 28, 2011 - accessed on May 19, 2012).

Given the acute shortage of healthcare services in India, many private institutions provide health services besides the government or public system in order to satisfy some of the unmet needs. Often, the quality and timeliness of the services provided by the private institutions is superior. However, the cost of the service is high and not within the reach of most people particularly in rural areas. The private sector is usually profit-focused and is managed like a sophisticated business or corporation. With the changing landscape of providers the role of the government is also changing. In a public health system the government provides the actual service, finances it, and regulates the health sector. With the mushrooming of private institutions the role of the government has expanded to include that of a watchdog to ensure quality and foster standardization.

ACCREDITATION

Accreditation is a form of external review or audit attesting that a particular institution is committed to certain processes and procedures towards enhancing patient care. It need not be a regulatory requirement but arises as a way to signal to the market participants that the institution has put structures and policies to ensure patient safety and adherence to quality care. It can be considered a proxy for quality in the sense that the institution is striving via the structures, policies, and due care to improve the overall patient experience and care. Accreditation facilitates institutionalization of quality of care and is usually for a fixed number of years.

In India the healthcare sector is uneven and disparate both in terms of infrastructural capability and personnel qualifications. There is a vast difference in the quality of rural and urban healthcare, and the services provided by private and public healthcare systems accompanied by significant cost differential. Given the increasing demand

for health services, several private payers have stepped in with dissimilar goals and standards for care. Accreditation helps promote standardization in the delivery of healthcare. As argued in the indianhealthcare.in website, certification benefits all stakeholders, possibly to differing degrees.

A non-exhaustive list of benefits from accreditation include: (1) rise in revenue (due to reputation, and insurance business that requires accreditation), (2) better equipment and processes, (3) reduced legal and insurance costs (as accreditation helps establish that the facility follows approved standard procedures in patient care), (4) a draw for attracting and retaining talent, (5) management is able to focus on the company's main business as day-to-day irritants are removed by the accreditation process, (6) a draw for investors in the hospital, and (7) avoidance of direct government intervention. There are few negatives aspects of accreditation as well: (1) possible loss of efficiency in operations with fewer patients served per hour, (2) higher costs, and (3) the idea of accreditation by a private organization is like a "fox guarding the henhouse."

Dastur (2002) notes voluntary accreditation of nursing homes and hospitals began in the 1930s in India with some refinement to standards being set in 1952. Recently there has been a dramatic increase in stakeholder interest due to growing awareness of rights, media coverage, greater consumer (patient) involvement, increasing costs of care and medical tourism. Nandraj et. al. (2001) conducted a study in Mumbai India, of the various stakeholders to determine their enthusiasm, interest and acceptance of the healthcare accreditation system. The results demonstrate a mixed reaction. There is keen interest amongst the stakeholders tempered with caution due to the perceived advantages but also disadvantages.

ROLE OF ACCREDITATION AGENCIES

Quality of care is a major concern in the healthcare sector and particularly in the case of hospitals. Normatively speaking, the facilities must be up-to-date, doctors, nurses, technicians have to be competent at their jobs, and the hospital must meet the hygiene, safety and environmental standards. But the reality is that hospitals compete on both price and quality. Often quality and minimum standards become victims in pursuit of profit, lack of knowledge or managerial skills. While quality of care is hospital

specific, competition (sort of a market agency) may serve to bring about convergence as each hospital responds to the service provided by the competitors. Thus, the quality of care or service depends not only on one hospital's actions but also on what other hospitals as a group are providing, the level or standards in the industry, and the government regulation and policies.

In India where the healthcare system is already stretched for resource and with no proper infrastructure, several hospitals may not seek accreditation despite the advantages of accreditation stated above. A critical point to note is that while accreditation provides a good signal of the processes and procedures in a hospital, it does not ensure perfect quality and hygiene nor does it necessarily improve business performance and efficiency of operations (Greenfield and Braithwaite 2007).

When considering accreditation and hospital performance few key points emerge: (1) Accreditation is costly (time & money) and may not be sustainable for several rural institutions (Brasure et. al. 2000), (2) Disclosing an accreditation score seems to influence and enhance institutional accountability and transparency (Ito and Sugawara 2005), and (3) Accreditation does not automatically reflect improved patient satisfaction (Lutfiyya et. al. 2009, Mays 2005, Miller et. al. 2005, Sacks et. al. 2010).

While a minimum standard of hygiene and patient care are necessary the western standards of care may not be feasible or work in the Indian setting. Accreditation metrics may need to be county-specific and economy-specific once a minimum standard in patient care, processes and policies is achieved. Considering that in India quality improvement in healthcare delivery is necessary and that resources are in short supply, the goal of the accreditation agency may be to improve hospital service quality with minimum cost impact. In other words, it may be necessary to ensure that quality improvements are taken in achievable steps and over time rather than in one move from status quo to the Western level. The next section highlights the accreditation practices in India. The following section offers the main theoretical findings of this paper. It makes the case that imposing western standards may result in a loss of a serious opportunity to improve quality of healthcare in India. The theoretical findings point to the need for a correction in the government policy.

NATIONAL ACCREDITATION BOARD FOR HOSPITALS (NABH)

NABH was set up in 2006 by the Quality Council of India (QCI) to develop appropriate standards and provide accreditation service to healthcare delivery organizations in the country. Its board consists of various stakeholders, encompassing those from industry, government and consumers. NABH is an institutional member and board member of the International Society for Quality in Health Care (ISQua), an international body overseeing the healthcare accreditation agencies in member countries. Hospitals accredited by NABH will be seen as meeting global standards in terms of quality healthcare.

NABH seeks to standardize delivery of healthcare and aims to institute standards akin to those in the West. The vision statement on their website states, *“To be apex national healthcare accreditation and quality improvement body, functioning at par with global benchmarks.”*

Further, NABH notes that the accreditation standards it released in November 2011 are, in turn, accredited by International Society for Quality in Healthcare (ISQua). In its defense the NABH states that the “approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have international recognition. This will provide boost to medical tourism.”

The hospital accreditation program of NABH has 102 standards and 636 sub-standards or objectives that an institution must satisfy to obtain the accreditation certificate. The detailed metrics are available as part of the self-assessment tool kit (<http://www.nabh.co/main/hospitals/documents.asp>). Broadly, these metrics focus on patient experience and organizational set up with the goal of instituting process and policies to ensure high quality of care (<http://nabh.co/main/hospitals/standard.asp>). On the patient side, the metrics evaluate a hospital from the registration procedures, admission details, treatment and surgery, medication, post treatment care, and patient rights and education. On the organizational side, the metrics deal with both the management and the infrastructure. On the management front, clarity on the roles and responsibilities, governance structures, human resource processes and administration play a role. On the infrastructure front, safety, proactive infection prevention,

facilities management, information systems, and equipment up-gradation are key elements that are evaluated. The NABH measures can be considered as streamlining and reforming the overall operations of a hospital and standardizing it across various institutions.

The NABH hospital accreditation process is estimated to take 8-9 months for the entire process to be complete. Various timelines have been developed to keep the momentum of the process going. There are several checkpoints and feedback procedures built into the accreditation process. Part of the accreditation process involves on-site training by qualified NABH personnel, workshops and educational support to hospitals seeking accreditation. Accreditation once obtained by a hospital is valid for a period of 3 years and can be renewed with a reassessment process.

As of December 2012, 154 hospitals were accredited and 481 hospitals were at various stages in the accreditation process. In India there are Joint Commission International (JCI) accredited hospitals as well and some institutions have sought both types of accreditation. Yet, given the size of the country and the number of hospitals, the percentage of accredited hospitals is rather meager. It immediately begs the question, why? Are the standards laid out by NABH too stringent with no or limited flexibility? Do the hospitals not see much benefit in obtaining the accreditation certificate or is it due to the lack of infrastructure and support network for institutions seeking accreditation? It could well be a combination of these various factors. While these are questions requiring theoretical and empirical work, this paper is focused on the theoretical investigation.

THE ACCREDITATION GAME

This paper attempts to present and analyze the dynamics of the accreditation procedure from the perspective of a two-player game. The two players are the accreditation agency and the healthcare delivery institution. The game is sequential with the accreditation agency making the first move by choosing a standard of quality s in the interval $[m, M]$. Next, the hospital either seeks or does not seek accreditation. If the hospital does not seek accreditation, it would continue with the status quo q . If the hospital seeks accreditation, it would comply with it (by assumption the accreditation enforces the standard).

Accreditation being a signal of quality may bring in more business to the hospital and have a positive impact on the revenue. Improved quality of care may attract more patients who are willing to pay more and thus increase the revenue or output. The overall customer experience may also improve due to better treatment and services. Yet higher standards affect hospital costs adversely. Impact of the cost includes but is not limited to the direct fees of accreditation plus indirect costs of improved services, facilities, and human resources. Improved services necessitate better equipment and infrastructure, which add to the cost. Attracting better doctors, and better nursing staff to provide the improved quality of care would also raise the cost to the hospital.

The payoffs of the two players are as follows: For a given hospital, let $R(q)$ = the hospital's revenue at status quo standard q , and $C(q)$ = the hospital's cost at q . It is assumed that each quality level q determines a unique demand curve using which the hospital solves its maximization problem; see Appendix I for an example. Assume that $R(q) - C(q) > 0$. Let $R(s)$ = the hospital's revenue at standard s , and $C(s)$ = the hospital's cost at s . The Accreditation agency's payoff when the hospital seeks and obtains standard s is simply s ; any increasing function of s would do just as well. The accreditation agency's payoff when the hospital does not seek accreditation is normalized at zero. The game is depicted in Figure 1.

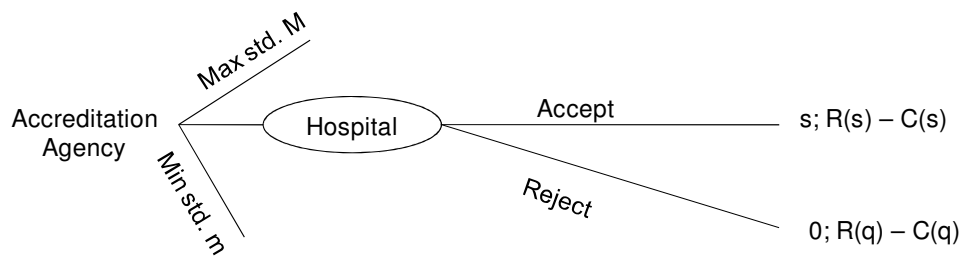


Figure 1. Accreditation Game

A rational hospital would choose to accept the standard s if and only if $R(s) - C(s) > R(q) - C(q)$. The goal of the accreditation agency is to attain the highest standard s^* such that hospital accepts it, meaning $R(s^*) - C(s^*) \geq R(q) - C(q)$. Obviously, from the hospital's point of view the magnitude of the cost increase depends on s^* , the standard chosen by the accreditation agency. The choice of s^* has to be such that the

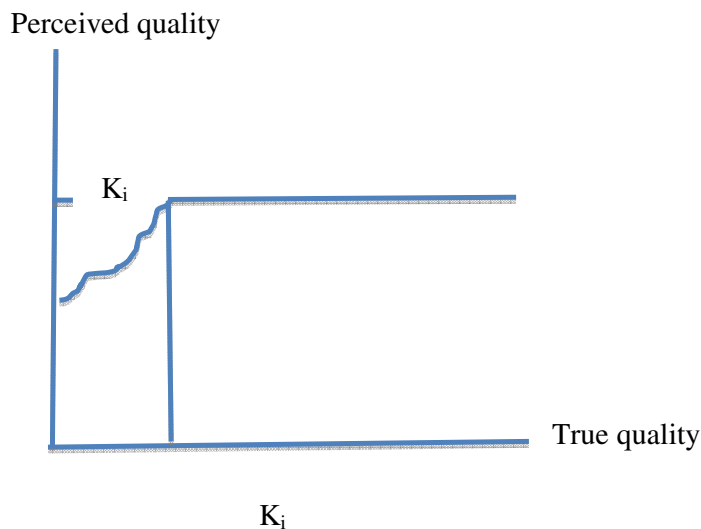
revenue increase to the hospital from the status quo is no less than the cost increase. It is assumed without loss of generality that when a hospital is indifferent between the status quo q and s^* , it would accept s^* .

ECONOMIC ANALYSIS

The western standards reflect the economic and political situation in the USA (or Western Europe) as it evolved over time; e.g., high incomes and the associated tradeoff between Type I and II errors, industry lobbying, and strict liability standards pertaining to hospitals. The policy questions that arise pertaining to India are:

- Given the current healthcare environment in India, does it serve the larger population to have western standards for accreditation of hospitals?
- Are there some ways to improve the Indian quality of care without unduly increasing the cost of care?

I begin by making several assumptions. First, *without accreditation*, the true quality (on the x-axis) and perceived quality (y-axis) are assumed to bear the following relationship:



For true quality of hospital $i > K_i$, the perceived quality remains at K_i . If the true quality is greater than K_i , the hospital cannot communicate it to the world-at-large. For hospital i 's true quality $< K_i$, there is some relationship whereby the perceived quality is more or less equal to the true quality. Quality levels up to K_i may be

attributable to the infrastructure and some sort of minimum medical services, and hence, more or less observable.

To communicate quality $> K_i$, hospital i must secure accreditation. Accreditation for quality K_i implies (a) hospital's true quality is K_i , and (b) the people correctly perceive the quality to be K_i . Thus it is assumed that *with accreditation*, the quality is perfectly communicated so that the line joining the true and perceived qualities is a 45-degree line (not shown) for all values of the true quality.

It is assumed that there exist weights such that the weighted average vector of attributes of quality is a scalar represented along a single dimension. Thus, it is possible to speak of higher or lower quality. It is further assumed that the hospital has *single-peaked preferences* over quality. By preferences I mean the value attached to quality by the hospital. This value could be profit in the case of for-profit hospitals (this is the approach taken so far in the paper), and social value in the case of non-for-profit hospitals. The underlying idea, applicable to both for-profit and not-for-profit hospitals, is that improvement in quality enhances value but at a cost. The difference (Value – Cost) of a given improvement in quality can be zero, positive or negative. Representing quality on the x-axis and net value on the y-axis, we get a curve of hospital's preferences over quality. The assumption of single-peaked preferences implies that there is some quality K_{\max}^i for hospital i at which the hospital's preferences are maximized, provided that the hospital is accredited. K_{\max}^i is called the ideal point of hospital i . Appendix-I offers a numerical example of a hospital with its preferences in quality being single-peaked.

Different hospitals can have different K_{\max}^i , and each hospital has its own K_i beyond which it cannot communicate its true quality in the absence of accreditation. Consider a single hospital with its own K_{\max} and K (the subscript i suppressed). The hospital faces, it is assumed, a monopolist accreditation agency. The agency wants to maximize the quality level of the hospital such that the hospital participates in the accreditation process.

I treat the monopoly accreditation agency as the agenda setter (Romer and Rosenthal, 1978). Only the accreditation agency can propose a standard that a given hospital may seek or not seek. As stated earlier, the hospital's preferences over NABH

standards are single-peaked. In other words, the profit (or value) to the hospital increases as the standard s increases, attains a maximum, and thereafter decreases. The idea is that as the standard s increases, initially the benefits exceed the cost, then profits attain a maximum and beyond that the costs become increase faster than the benefits. Figure 2 below depicts the situation graphically.

Hospital's profit

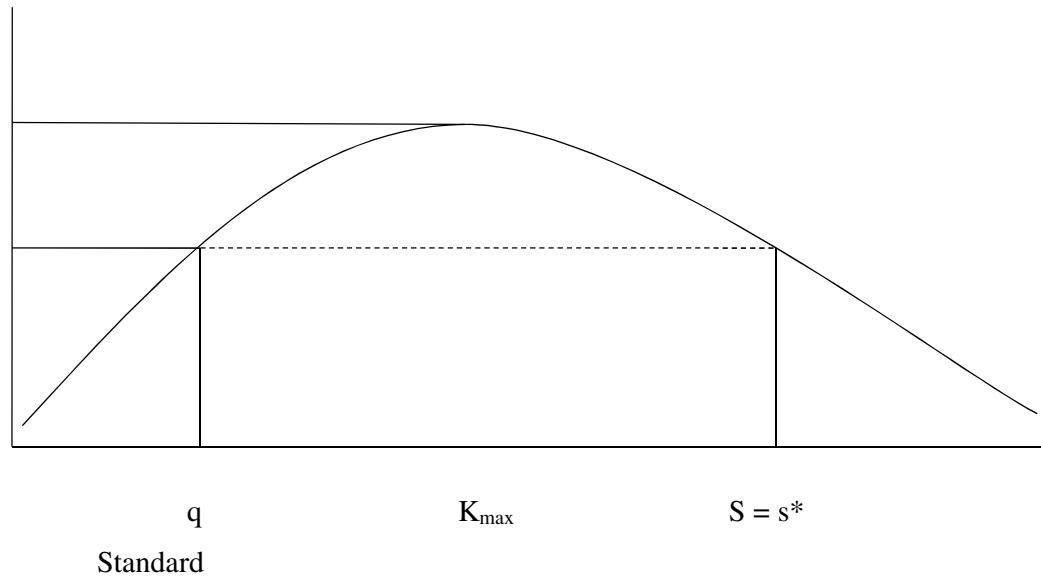


Figure 2. Profit as a function of Standards

In the graph above assume that a hospital is currently operating at status quo standard q with the profit $P(q)$ measured along the y -axis. As the standard increases the profit of the hospital increases, reaches a maximum at K_{max} where the profit is P_{max} and then decreases. When the standard reaches s^* the profit to the hospital is the same as if it were operating at q . The hospital would be indifferent between operating at q and s^* . If NABH were to choose any standard between q and s^* , it would be acceptable to the hospital. Given that NABH would like the highest standard possible, s^* would emerge as an equilibrium outcome. This is a sub-game perfect Nash equilibrium, where NABH would propose s^* , and the hospital would accept s^* if and only if $q < s^*$. If the accreditation agency selects a standard greater than s^* , then the hospital would reject it and maintain the status quo. For standard exceeding s^* the cost to the hospital would be greater than the revenue it might generate, and thus not a sustainable option. A key point worth noting is that the optimum standard s^* is not the

standard at which the hospital's profit is maximized. Thus NABH could choose any point between the status quo and s^* for the hospital to accept it.

The following proposition is thus established:

Proposition: At sub-game perfect Nash equilibrium, the accreditation agency would propose s^* , and the hospital would accept any s if and only if $q < s < s^*$

- If the accreditation agency selects s^* , the hospital would accept it and that would be the equilibrium outcome
- If the accreditation agency selects $s > s^*$, then the hospital would reject it and maintain status quo

SEGMENTATION OF HOSPITALS

Using the above framework and model it is possible to provide one potential reason why only a few hospitals have sought and obtained the NABH accreditation so far. For simplicity let us assume that hospitals can be segmented into two categories: elite and non-elite. Elite hospitals are those that are currently operating at standards which are close to the western standards, or at times exceed the western standards that NABH seeks to attain. These hospitals would readily accept the standard $S = W$. Non-elite hospitals are those that operate at standards significantly below the western standards that NABH seeks to attain and for them the standard $S = W$ would be beyond their optimum operational point. For such hospitals, at $S=W$ the cost of adhering to the standard is not justified by the rise in the revenue (benefits). The details are shown in Figure 3.

For the elite hospitals the standard W is feasible but for the non-elite not so. This illustrates the idea that the philosophy of one size fits all may not be applicable to hospital accreditation policy in India. For the non-elite hospitals the standard s^* is attainable for many hospitals but since the standard chosen was W , they would probably continue at their status quo. NABH can influence and ensure better quality of care over time by choosing a standard s^* such that a sizeable number of hospitals can comply with that standard. In other words, the standard chosen by NABH should be such that it is in the self-interest of a majority of hospitals to comply.

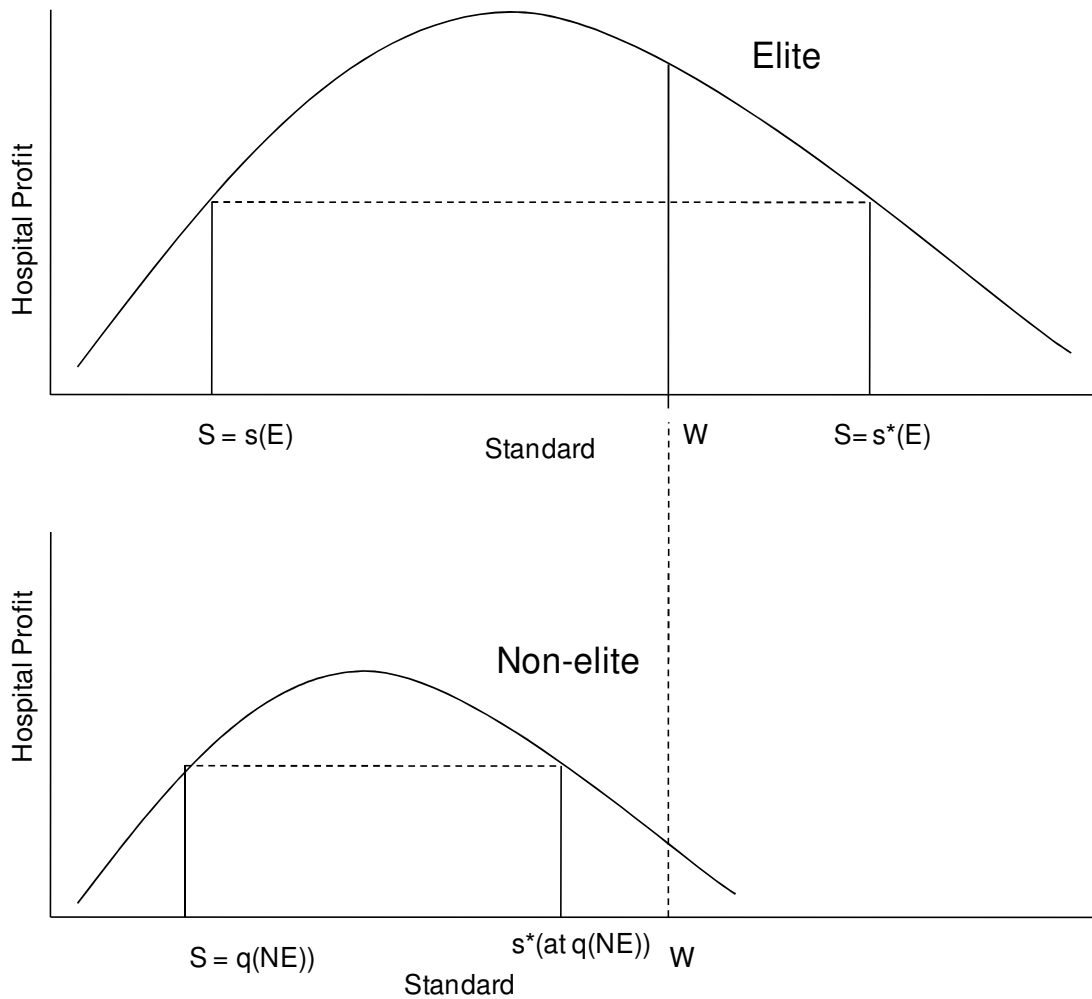


Figure 3. Profit vs. Standard for Elite and Non-Elite hospitals

In Figure 3, S refers to standard. $q(E)$ is the status quo for elite hospitals and $q(NE)$ is the status quo for non-elite hospitals. The point $s^*(E)$ is the maximum that an elite hospital would accept. The point $s^*(at\ q(NE))$ is the maximum that a non-elite hospital would accept. W is the western standard. Clearly, W is acceptable to the elite hospitals but not to non-elite hospitals. The non-elite hospitals stay away from the accreditation process representing a loss of opportunity for the society to raise the level of non-elite hospitals.

Hospitals can be classified in several different ways. Classification of hospitals need not be dichotomous as assumed. The number of categories and the rationale for the classification of hospitals has to be driven by data and expert knowledge. This paper has assumed a hypothetical classification to demonstrate that for a developing country like India where a great number of hospitals are in the rural area, operate under severe shortages and cater to a large number of patients the standard chosen by NABH needs to be determined after much deliberation and analysis. Having just one set of standards for all hospitals may not be the model that works for a developing country like India. There could be a set of standards that have to be met and are mandatory and depending on the specialty or type of hospital the other standards may have to be flexible. For example using a new needle to draw blood from a patient may be compulsory but the requirements on the building and facilities may well be flexible (once a minimum standard is achieved). The process of attaining the optimum quality of care may have to be done so by achieving it in various intermediate steps. It may not be possible for several institutions to move from the status quo to the optimum level of quality required to obtain accreditation in one sweep.

CONCLUSION

The standard of care in USA (or Europe) reflect the economic and political situation as it evolved over time, high incomes, industry lobbying, and strict liability laws. Adapting those to the Indian context without the necessary infrastructure and institutions in place may not be beneficial especially when considering the degree of the unmet need of patients. The Indian healthcare policy has to balance the quality, affordability, availability and equity in developing an implementable course of action.

An important question that this paper addressed is that given the current healthcare environment in India, does it serve the larger population to have western standards and accreditation of hospitals based on that? The western standard may be needed for medical tourism to grow but currently does it actually improve the quality of care provided to the masses? A broader strategic issue might be to consider if there are some ways to improve the quality of care provided without increasing the cost of care. By choosing a standard too high, in the current environment the process of improving the quality of affordable care and ensuing equity may be hampered.

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<i>Abstract:</i> <p>In India the demand for health care has been rising with increase in life expectancy, growing middle class affordability, recognition of the importance of preventive care, and overall consumer awareness. The government investment in the sector is meager given the size of the population and the needs of the citizens. Given the significant unmet needs of patients, private institutions have emerged to provide health care. This as well as the quality of healthcare offered by government hospitals, has led to the need for a national accreditation policy as a way to ensure quality and equity of care. As opposed to a government regulation, accreditation is on a voluntary basis. A hospital may or may not seek accreditation depending on direct and indirect costs and benefits. Direct expenses are the fees paid for accreditation, and indirect expenses are those required to attain and maintain the accreditation status. Specifically, indirect expenses refer to the cost of better practices, purchase of new equipment, recruitment of qualified staff in adequate numbers, and meeting customer needs. Presumably, a hospital would seek accreditation if improved quality generates additional business offsetting the cost of accreditation.</p> <p>This paper examines national accreditation policy for Indian hospitals based on a game theoretic perspective. The paper illustrates the role of game theory in (a) evaluation of national policy for hospital accreditation, and (b) management strategy formulation for the accreditation agency, with potential implication for millions of people. The paper provides the rationale for how an accreditation agency could influence the health care provider to improve the quality of care and add value to the society at large. It seems that the current accreditation standards, while serving the needs of “elite” hospitals for the relatively rich and medical tourists, may deter weaker hospitals from participating in the accreditation process.</p>					
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