ACCREDITATION IN HEALTH CARE AND EDUCATION: THE PROMISE, THE PEFORMANCE, AND LESSONS LEARNED

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THE BUSINESS OF HOUSING

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I. Introduction

Regulation is a hallmark of contemporary society. Even where it appears that transactions are left to the workings of the free market, the regulatory hand is everywhere. Every product available in a supermarket, convenience store or home building centre is subject to laws or regulations designed to ensure minimum standards of safety and quality. "Let the buyer beware" may be a wise dictum, but society does not leave buyers to their exclusive devices very often, even in the used car industry. Whether society should have rules and processes to assure or promote quality is no longer in question. The quest is to find the best way to organize the legal and regulatory framework in order to achieve public interest goals.

Law, regulation, and inspection cost money. In their best form these costs are investments that produce excellent returns. For instance, standardized railway gauges, equipment specifications, and building material dimensions greatly increase economic efficiency. In human services, many forms of regulation impose costs, and it is important to weigh them against benefits. If the rules and oversight are too lax, quality will suffer and so, too will the people served. If rules are too stringent, the marketplace may be overly restricted, and the direct and indirect costs of compliance may be unreasonably high.

Two circumstances strengthen the public interest case for regulation: when the risks and consequences of market failure or unsafe practice are high, and when it would be unreasonable to expect consumers to make uniformly astute judgments of quality. While the mantra of modern times is consumer choice, for many goods and services it is the last thing we want to have to make. People do not want to have to independently assess the structural qualities of the bridge they are about to drive over, the safety of the water coming out of the tap, or the qualifications of the person making a diagnosis. They want to be able to assume quality and competence, and happily delegate the job of quality control to various agencies.

With a century of accreditation experience behind us, there is now greater understanding of what it can and cannot deliver. The first point to consider is that it is a means to an end, not an end in itself. No one supports accreditation for accreditation's sake. It is justified when it results in better quality, greater safety, and other improvements. Many organizations achieve excellence without a formal accreditation process. Even where it delivers on some counts, it may at the same time constrain innovation and creativity by (necessarily) imposing at least some uniform standards and requirements. Some view a certain degree of uniformity as inherently desirable, while others see it as overly confining. Accreditation incurs both monetary and non-monetary costs, and the question is whether they are worth bearing.

This paper reviews the theory and practice of accreditation, and outlines its potential benefits and unintended consequences. Its 3 main purposes are:

1. To explain the major purposes of accreditation in health care and education in Canada – their intended effects and benefits.
2. To outline how accreditation has evolved to increase its value and impact, and to reduce or eliminate unintended consequences.
3. To discuss and assess accreditation in the context of other contemporary approaches to maintaining and improving quality.

II. The Purposes of Accreditation

Accreditation emerged in response to unacceptable variations in the quality of educational institutions, and later spread to other sectors, notably health care. Accreditation was designed to accomplish for programs and facilities what self-regulation was thought to do for professions: the defining of standards and qualifications that would reliably produce better quality than would be the case without them. It would also take some of the guesswork out of decisions about whether to enrol in a certain institution, hire an employee, or seek services from a certain provider.

The specific goals of accreditation vary with the nature of the service, but in general, they are:

1. To protect public safety – especially in services that have the potential to cause harm (e.g., health care, transportation).
2. To ensure an acceptable level of quality among providers of services or products.
3. To stimulate ongoing improvements in quality through self-assessment, external review and measurement, public reporting, and enhanced standards.
4. For public services in particular, to create a mechanism between government and the programs it funds that provides more objective and less politicized measures of performance. The buffer may prevent government from arbitrarily imposing its own standards, glossing over shortcomings in the programs its funds, or putting quality at risk by underfunding.
5. To reduce variations in quality, particularly by eliminating or reducing risks and mandating improvements where problems are revealed.
6. To facilitate portability between jurisdictions or institutions (of credentials, educational credits, etc.) by guaranteeing a reliable level of performance.
7. To help people make more informed choices about services and products.

III. What Does Accreditation Accomplish? Some Recent Evidence

The main claim of accreditation is that it produces results that are not achievable without it. Such a claim demands two proofs. One is empirical: accredited organizations do better than non-accredited ones on accepted measures of performance. The other is both theoretical and empirical: there are no other equally effective means by which standards can be assured, and quality improved.

The evidence on the impact of accreditation, and the comparative performance of accredited vs. non-accredited organizations, is mixed. Evidence gathered and/or cited by accrediting organizations is almost invariably positive: accreditation and better performance go hand in hand. The overall picture portrayed in the academic literature is less positive. It is not that the accreditation research contradicts measures of the same outcomes produced by disinterested researchers; it is that they often measure different things. For example, the accreditation bodies generally report the aggregate performance of accredited and non-accredited organizations on selected major indicators. Organizations that have helped develop and are committed to certain indicator sets will naturally seek to perform well in those aspects. To some extent they "perform to the test." Others may not participate in accreditation because they prefer

other measures of performance. Organizations and researchers interested in producing the most robust measures of quality and performance may rely on data not routinely available to accreditation reviews. For instance, in health care, reviews of medical charts yields far more in-depth information on both processes and outcomes than summaries of routinely reported data. There is no naturally best set of indicators, and there are important and reasonable disagreements about which ones are most meaningful.

Similarly, independent research may have different measures of quality (e.g., a greater emphasis on outcomes and less on processes and standards compliance), and may also identify variations within the accredited and non-accredited categories. If, for example, accredited organizations *on average* outperform non-accredited ones, but significant numbers of non-accredited organizations do as well or better than their accredited counterparts, the role of accreditation per se becomes less certain.

On the positive evidence side, in the US, accredited health care organizations score consistently higher on indicators of percentages of people receiving recommended care. The differences are generally not large – a few percentage points on most measures – and on some measures the non-accredited facilities score better. But the aggregate results do favour accredited organizations.[1]

There are reports of more dramatic differences in quality between accredited and non-accredited drinking water testing laboratories in Canada. In one recent survey, accredited laboratories received unsatisfactory scores about 5.5% of the time, compared to about 17% of the time in non-accredited laboratories.[2] Conversely, a large American study found no difference in testing quality between accredited and non-accredited American medical laboratories[3], although a follow-up identified a higher rate of compliance with manufacturers' quality control procedures among externally accredited labs[4]. Both studies identified large numbers of problems, suggesting that accreditation alone cannot guarantee uniformly high quality.

Other evidence is more critical of accreditation. A general review of accredited vs. non-accredited health care insurance plans in the US reached this conclusion:

> Accredited plans have higher HEDIS [Health Plan Employer Data and Information Set] scores but similar or lower performance on patient-reported measures of health plan quality and satisfaction. Furthermore, a substantial number of the plans in the bottom decile of quality performance were accredited suggesting that accreditation does not ensure high quality care. Receipt of accreditation has been associated with increased enrollment in the early years of the accreditation program; however, plans denied NCQA accreditation do not appear to suffer enrollment losses.[5]

Other research found no relationship between the overall scores assigned by the Joint Commission on Accreditation of Hospital Organizations (JCAHO) and validated, robust outcome measures developed elsewhere.[6] A recent landmark study found no relationship between JCAHO accreditation scores and the Agency for Healthcare Research and Quality scores on quality and patient safety indicators.[7] A study of a Maine psychiatric facility found that rates of medication errors identified by chart au-

dit were 244 times higher than those identified by conventional self-reports on which accreditation surveys typically rely,[8] confirming a previous study that found no correlation between JCAHO accreditation scores and medication error rates[9].

The education literature on accreditation is large and spans a wide range of views, defences and critiques. Defenders assert that the accreditation of teachers and education institutions guarantees competence and creates the foundation for portability (i.e., the recognition of credentials and credits from one jurisdiction to another). Critics claim that the goals and standards are arbitrary, confining, stifling of innovation, and motivated to "produce" graduates who will conform to the prevailing ideology of the economy and its management.

The evaluative findings do challenge the long-held assumption that structures and processes are strong predictors of outcomes and quality. Such research has critical implications for accreditation in that it suggests a need to focus less on means and more on ends. Conceptually, it is hard to disagree, but the question then becomes, how do we know if an organization is likely to be able to provide safe, high quality service if the traditional measures are inadequate? How do we assess whether a new organization is fit to provide service? Since one of the goals of accreditation is to prevent catastrophes, the challenge is to find different kinds of structures, processes and relationships that better predict outcomes. Even more centrally, who defines the ends, and ultimately, does conformity trump, or even define, quality?

Accreditation processes are often complex and may require assessment of dozens of indicators and areas. If the criteria are weighted equally, organizations that comply with a high percentage of standards may be deficient in critically important areas. A study of American medical school accreditation found a high degree of compliance with 42 of 48 standards, but widespread inattention to critically important performance areas. Only 8% of surveyed schools produced evidence that their faculty were knowledgeable about "pedagogy, curricular instruction, and the evaluation of students" and only 2% of schools demonstrated that administration and faculty had knowledge of methods to evaluate students.[10]

IV. Critique of Accreditation

A critical question is whether accreditation is an end in itself, or instrumental to the attainment of more substantive goals. Critics would like to see a stronger link between accreditation status or scores and meaningful outcomes (positive or negative) such as complication or readmission rates in hospitals, or student scores on standardized examinations. Taken to its extreme, if accreditation were defined entirely in terms of results, it would be almost redundant: the outcomes would speak for themselves, and people could select programs, institutions, or services on the basis of whatever performance measures are most important to them. In practice, no accreditation scheme is ever that simple, and structures and processes remain central elements alongside outcomes. Indeed, these 3 – structure, process, and outcome – form the core of Avedis Donabedian's highly influential concept of quality in health care.

The problems with accreditation identified by theorists and empirical research including the following:

1. Based on substantial evaluative research, it does not deliver (many of) the goods. In health care, accreditation scores do not identify some critically im-

portant deficiencies, and many accredited facilities perform poorly on more focused measures of performance. Landmark reports in Canada[11] and the US[12] revealed huge error and quality problems in health care. Even if accreditation processes and criteria prevent even worse performance (or so the argument would go), they are not good enough to perpetuate, especially given the burden they impose on participating organizations.

2. It is too "soft," resulting in excessively positive results. Because both health care and education are classic examples of public services that are prone to market failure, the public need reliable indicators of quality and safety. If accreditation truly delivered on this promise, one would expect higher accreditation failure rates. It is extremely rare for a health care program or facility to be denied accreditation status. That the accredited also fund the process creates an obvious conflict-of-interest.

3. There is not enough spread in the results – scores tend to be highly compressed. Assigning one, two or three year accreditation does provide some discrimination, but as noted, important variations in performance persist in institutions with similar or identical overall JCAHO scores.

4. There are better methods for assessing and ensuring quality. In education, there is a long history of evaluation of student performance in multiple dimensions. Some provinces have standardized exams and the results are reported by school.[1] In health care, advances in information technology and performance measurement can generate real-time information at various levels of disaggregation.

5. It is too occasional and general to identify persistent quality deficiencies or prevent adverse events. The paediatric cardiology debacle in Winnipeg (where a surgeon was found to have caused numerous avoidable deaths), the Bristol Infirmary scandal in the UK, and the 8 recent Alberta deaths caused by medication errors all occurred in fully accredited facilities. Variations in cardiac surgery mortality rates in New York hospitals, which led to major changes in delivery (including some hospitals getting out of the business), were not identified by accreditation, but by other research.

6. It tends to be as much or more reactive than forward-looking. Because it is periodic rather than continuous, and often relies heavily on a short site visit, it can only take snapshots of performance, and identify point-in-time deficiencies. The organization may then make considerable effort to remedy these problems while newer, more serious issues arise that may go undetected by accreditation for another 3 years.

7. It values uniformity over performance, which can both conceal general sectoral deficiencies, and stifle innovation. In this sense it may be inconsistent with newer theories of quality improvement, which focus on continuous improve-

[1] It is important to present and interpret these comparisons fairly. Some schools have more challenging student populations. Similarly, hospital patient outcomes will be influenced by the severity of the case. Fair comparisons have to take these differences in what service providers have to deal with.

ment, experimentation and measurement, lifelong learning, and learning through error.

8. It relies on incomplete and possibly inaccurate data. Self-report rather than statistically reliable auditing and evaluation are the hallmarks of many accreditation processes. In health care, accurate and complete data would require a culture and practice of disclosure of error and "near misses," which has yet to become the norm. A 3-day visit and review of facility-prepared documents cannot possible match the rigour and comprehensiveness of more painstaking research.
9. It may be used to extract more money from governments on dubious grounds. It is not uncommon for programs to welcome an unfavourable accreditation review that recommends the addition of resources. Since the accreditation process is largely self-defining by the sector in question, it has the potential to ramp up requirements and expectations unrelated to verifiable public interest goals. This can create a "race to the top" that unduly influences public policy resource allocation decisions. For example, in Canada, there is currently a major move towards requiring a master's degree as the entry-level credential to for physiotherapy and occupational therapy. The national accreditation bodies have the power to deny accreditation to a baccalaureate program, which virtually forces provinces to approve the upgraded credential and fund any additional costs. More often than not, no evidence has shown that the baccalaureate programs produce substandard graduates.
10. It is too slow to adapt to changing concepts of quality and performance. Once it becomes entrenched, with many participants, it inevitably becomes less agile. Change requires arduous consultation and consensus-finding exercises. It is hard to abandon or change performance indicators. Organizations used to the historical processes and criteria may prefer them to stay intact simply because it is less burdensome than learning a new system.

V. Defence of Accreditation

In any human system, perfection can be the enemy of the good. Accreditation cannot be all things to all people. It cannot both adopt universal standards and be infinitely sensitive to the nuances of individual programs. It cannot provide reliable comparisons between organizations over time and be constantly changing. It cannot make objective judgments of programs and firm recommendations without ever offending governments.

The defence of accreditation includes the following arguments:

1. It does guarantee a minimum level of quality and reliability that would almost certainly be lower in its absence. Even if it cannot prevent every adverse event, outcomes would be worse if accreditation disappeared.
2. It creates a reliable basis for comparison, which is the foundation for both quality improvement and choice. Even if some of the standards and criteria are debatable, they are (or should be) transparent, and consumers and analysts can assign their own weights to the factors they consider most meaningful and important. Standardization is in itself a major achievement.

3. It has evolved in response to critiques and changing circumstances, and is more in tune with quality improvement theory and practice than it used to be. There are ongoing attempts to validate criteria and focus on structures and processes that better predict outcomes. There are more outcome-oriented indicators.
4. It does raise standards over time. Participating organizations do compare themselves to each other. Obsolete standards are dropped and new ones are implemented.
5. It is relatively inexpensive, constituting a tiny fraction of major organizations' budgets.[2]
6. While it can be labour-intensive for the participating organizations, the time spent on preparing for accreditation gets people reflecting on performance and recognizing where improvements are possible. Progressive organizations should do these things as a matter of course. Hence the time spent should not be charged entirely to the accreditation account – it is not just overhead.
7. It saves a great deal of time and money for employers, institutions, governments, and individuals who can rely on its findings, ratings and counsel rather than independently judging the value and transferability of programs, personnel and credentials. In this sense it generates a significant return on investment.
8. It relies on the best judgments of committed professionals, which remains the best of all possible systems for defining and maintaining quality – even if the processes and measures are imperfect.
9. Without it, government would by default judge performance, and government is prone to pressures and influences that can compromise fairness and objectivity. In this sense accreditation is a safeguard against arbitrary government decision-making, and therefore contributes to the democratic balance of powers and interests.
10. While it has not prevented all catastrophes, it has certainly prevented many, and because these successes are by definition invisible, they do not register in our consciousness as "positives".

VI. Alternatives to Accreditation

If accreditation is one means to desired ends, what are the others? There are several, each with its own characteristics, advantages and disadvantages. Among the major options are:

1. **Continuous Quality Improvement (CQI).** Accreditation has largely been based on quality assurance; QI is a more dynamic, ongoing concept that has taken hold in many sectors, and health care in particular. The basic idea is

[2] This may not always be the case. There are certain fixed costs inherent in accreditation, irrespective of the size of the organization. So thorough and complex accreditation processes could become a significant financial burden on small organizations. Moreover, the visible costs – the amount paid to the accreditation body – may be modest, but the costs in terms of staff time and energy to prepare and respond to the process can be considerable, even in larger organizations.

that organizations should be constantly striving to improve performance through measurement, comparison, goal setting, and adjustment. Small-scale experimentation is encouraged. One current approach is called "PDSA": plan, do, study, act.

2. **Performance Measurement (PM) by third parties.** An example is the Ontario hospital report card, which measures performance in several dimensions among the province's hospitals and reports them publicly.
3. **Peer ranking of organizations.** This is an increasingly popular option, from Maclean's magazine's rankings of universities and health care regions, to the league tables published in the UK on geographic area health care performance. In the US, there are rankings of academic departments based on surveys of faculty in a discipline (e.g., the top 10 sociology departments, etc.).
4. **Performance contracts and pay-for-performance incentives.** To increase accountability and improve performance, governments have increasingly turned to contractual relationships with service organizations that specify the nature, amount, and quality of what is to be delivered. Either as part of or separate from these agreements may be financial incentives (organizationally and/or individually) for achieving certain targets (which can include quality). In the UK, the National Health Service plans to base up to 90% of agency budgets on "Payment by Results".[3]
5. **Standardized examinations.** The education sector pioneered the development of standardized tests to measure ability and performance, notably the Scholastic Aptitude Test, licensing exams for professionals, specialty certification exams, etc. Proponents of these tests argue that they are more objective measures of performance because they focus on the desired outcomes, not the credentials of teachers or the educational processes.
6. **Surveys of employers, graduates, service users**. These sources of information are incorporated into both accreditation and other performance-oriented approaches. The theory is that the views and experiences of people who are clients of but not internal to an organization are the "gold standard" for assessing organizational performance.
7. **Evaluations.** Large organizations are multi-faceted and a composite score or measure can mask important variations. The remedy is to evaluate the discrete programs and services at the level required to reveal strengths and weaknesses, and what to do to improve. In some cases the individual might be the source of variation (surgeon-specific mortality, teacher performance); in other cases it is the team or unit.
8. **Real-time performance measurement.** Instant, up-to-the-minute information is the most essential tool for continuous quality improvement. Perhaps the most famous example is Wal-Mart, whose information system is so sophisticated that their stores operate with just-in-time inventory (reducing storage space, returns, and carrying costs), and produce a system-wide financial state-

[3] This is highly controversial; critics charge that it is based on the assumption that health care should be thought of as a market good rather than a public service, and that the PBR experiences to date have created unintended consequences such as refusal to treat difficult cases.

ment every day. An ideal IT system not only produces a huge amount of current information; it is accessible to people with different information needs (senior executives, department heads, individual service providers) and can generate a wide variety of reports tailored to these needs. This approach to information contrasts with the traditional periodic snapshots and reports that are hallmarks of accreditation and other external review processes.

In theory, none of these is incompatible with accreditation; some accreditation processes have adopted some or several of them. Progressive organizations already have IT that produces customizable and comparable data to support decision-making at the governance, management, and practice levels. Public disclosure of performance data, a culture of continuous improvement, and policies based on real-time, valid information can deliver far more than even the best accreditation process.

In health care, such information-rich environments exist in several jurisdictions. Yet organizations that have embraced these tools for improved quality and safety have not abandoned accreditation. There does not have to be an either/or choice. The two can be mutually reinforcing; it remains to be seen whether they will eventually fuse into a more or less unified system of measurement, accountability, and certification. As these new approaches become the norm, accreditation will almost certainly have to anticipate and adapt to remain relevant.

Ideally, accreditation would reinforce and add rigour to the improvement efforts. Measurement is meaningless in a vacuum; good and poor performance have to be defined. Accreditation sets criteria and standards that may overlap with or also be part of performance contracts and agreements. Nothing prevents accreditation from requiring core elements of a CQI process or proven technologies such as electronic drug ordering in health facilities. Quality improvement standardizes vocabulary, definitions, and measurement, and so does accreditation.

Some have criticized accreditation for being excessively oriented toward structures and processes, advocating a purer outcomes focus. Accreditation has moved in this direction. However, an exclusive focus on outcomes carries its own risks. The outcomes measures can be narrow and may reflect not only organizational quality and effort, but also random variations in performance. Consensus processes that choose the outcomes to be measured may exclude indicators deemed highly relevant in some organizations. Organizations may focus on the listed performance dimensions to the exclusion of just about everything else. This could produce uniformly good outcomes on the selected measures, but also neglect of important but less measurable attributes, poor performance in areas that affect fewer people, and a loss of diversity. A further alleged shortcoming is that outcomes are measured after the fact, which diminishes preventive capacity.

VII. Conclusion

Several lessons emerge from accreditation experiences. Among the most important are:

1. It is not, nor does it claim to be, *the* sole guarantor of excellence or the total solution to organizational problems.
2. Whether to launch an accreditation process depends on what problems (current or anticipated) one wishes to solve, and whether accreditation is the most effec-

tive and efficient way to solve them. It makes a difference if the main goal is to prevent catastrophes versus promoting excellence.

3. Even after a century of implementation, experimentation, evaluation, and adjustment, accreditation remains methodologically contested and uneven in performance. Accreditation scores and rankings do not reliably predict other important measures of quality and performance.

4. The key to any successful accreditation system is to be clear about the definition of good performance – addressing all important dimensions – and to develop, test, and refine measures that relate to desired outcomes. If the goals are vague or unspecified, accreditation may emphasize structures and processes (including formal qualifications and credentials) that are less than reliable predictors of concrete performance. This in turn can create a self-perpetuating guild that arbitrarily imposes standards, excludes potential entrants to practice, and stifles innovation.

5. The risk of serious harm is a stronger rationale for accreditation than the prospect of indifferent or variable performance. Where risks to health or well-being are modest, there is less reason to exclude people from a market or to insist on standardized approaches to service delivery. Similarly, where performance or quality is transparently reported, where people are capable judges of products or services, and where real choice is available, accreditation may not be worth the effort and cost.

6. The theoretical benefits of accreditation exceed its demonstrated performance; this is not the first or only instance of reality falling short of the ideal. Accrediting organizations have to varying degrees taken the gap seriously and moved to modernize their approaches.

7. In the best of all possible worlds, accreditation and the other approaches to performance measurement, quality assurance, and quality improvement would come closer together. Accreditation is ultimately a judgment: pass/fail, 1 year or 3, full or provisional. It is vitally important that the judgments correlate with real performance, and rely on valid measures. It can and should rely on exactly the same information used to generate other types of performance scores, ratings, and rankings, and to stimulate quality improvement.

8. A major foreseeable issue for accreditation is its capacity to transform itself from a periodic review process to a more continuous activity based on real-time information monitoring. As organizations adopt a culture of CQI and enhance their IT capacities, they will be in a position to act on today's data today. The likelihood that periodic accreditation surveys will reveal very much of significance that the organizations do not already know will decline. Either accreditation surveys and visits will have to find new ways to add value, or they will have to evolve into more continuous processes that take advantage of real-time information.

9. In that sense, accreditation can be seen as a final layer or another step in the assessment process. The question then becomes, what is the added value of this formal and summative judgment, assuming that other, valid performance measurements will take place continuously? In other words, suppose there were well-accepted, valid and reliable measures of performance on all the rele-

vant major dimensions in a sector, reported in both aggregate and disaggregated form (like the Ontario hospital report card). What would accreditation a) look for and b) judge that that is absent from these measures?

10. Perhaps the strongest rationale for accreditation is that it ensures that organizations have a common set of characteristics that reliably either guarantee a certain standard of performance. Again, the rationale strengthens where poor performance has serious adverse consequences. Even here, though, there are other ways to guarantee these characteristics, e.g., legislation that specifies hospital and school standards (physical structure, personnel, etc.).

11. One of the risks of accreditation is that it can become too incestuous. Leaders in a sector may agree on what is important and how to measure it, but if the whole sector has become inward looking and self-serving, that is cold comfort to the unsuspecting public. The revelation of huge safety problems resulting in literally thousands of avoidable deaths in health care in fully accredited facilities is a cautionary lesson.

VIII. Implications for the Social Housing Sector

Accreditation is no panacea, but it can be helpful. If the social housing sector decides to pursue this path, it may be worth thinking about a number of issues that will arise in the course of determining the core purposes, the nature and breadth of the services to be accredited, and the indicators to be measured. Among these are:

1. Depending on location and mandate, social housing involves physical plant, financial management, financial assistance, social services, vulnerable populations, and related programs. Obviously, the housing itself is the core, but the other elements are central to its purposes and influence its successes. Some are directly under the control of the housing organization or provider, while others are not. Defining the scope of what might be accredited and to whom or which organization performance can be attributed will be an important task.

2. Defining success is also potentially complex. Does a successful housing project have permanent, long-term residents, or is there an expectation that some people will move on to other housing as a result of improved financial circumstances? Is a high turnover rate necessarily a bad thing? There will be more problems and adverse events in a facility with high-needs populations, and rating systems have to be sensitive to these circumstances and resist making unfair comparisons.

3. The sector is diverse, and developing performance measures and accreditation standards that reflect this diversity may be difficult. One solution would be to cluster social housing into categories; another would be for providers to choose the dimensions of service they seek to provide and to be accredited.

4. Ideally, accreditation identifies issues and opportunities over which the organization has total or major control. If the success of a housing project, however defined, depends on partnerships, accreditation would presumably have to assess the structures and processes in place to ensure they are successful.

5. The relationship between accreditation and credentials needs to be carefully considered. In health and education, accreditation is multi-layered and inter-

dependent: program accreditation requires personnel who are certified by accredited educational or licensing bodies, etc. If social housing contemplates requiring formal credentials for management and staff, it will be important to verify that there is a plausible relationship between these requirements and actual performance. Otherwise, the sector could encounter problems experienced in health care, where many personnel do not work to their full capacity because of rigid rules surrounding scope of practice.

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