

## Chapitre 3

### **A realistic approach to the evaluation of the quality management movement in health care systems : a comparison between European and African contexts based on Mintzberg's organisational models**

*Dans ce chapitre, nous comparons les évolutions suivies en Europe et en Afrique par le mouvement de la qualité.*

*Nous montrons l'influence de la culture organisationnelle dans les résistances au changement.*

*Nous générons ainsi une théorie initiale pour expliquer l'interaction entre management de la qualité et systèmes de santé.*

*Article publié*

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# **A realistic approach to the evaluation of the quality management movement in health care systems: a comparison between European and African contexts based on Mintzberg's organisational models.**

## **Abstract**

The quality movement is gaining momentum worldwide in the field of health care. Initiated in industrialised countries, it steadily grows in Africa. However, there is no evidence that approaches designed to address issues in a given organisational context have the same effect in another one where issues present differently.

Along the epistemological paradigm of realistic evaluation proposed by Pawson and Tilley, we use Mintzberg's organisational models to compare the configurations of European and African health care organisations and the trends followed by the quality management movement in both contexts. We illustrate how European health systems traditionally emphasize professional autonomy while African health systems are structured as command and control hierarchical systems. We illustrate how the quality movement in Europe emphasises standardisation of procedures, a characteristic of a mechanistic organisation, while excessive standardisation is part of the quality problem in Africa.

We suggest that instilling professionalism may be a way forward for the quality movement in Africa to improve patient focus and responsiveness of responsible professionals. We also suggest that our interpretation of broad trends and contrasts may be used as a useful departure point to study the wide contextual diversity of the African experience with quality management.

**KEYWORDS:** Health Services Research; Quality Assurance, Health Care; Organizational Culture; Europe; Africa.

## **Introduction**

All over the world, health systems are under pressure. With the exploding development of health care technology, health systems face new challenges in industrialised countries while developing countries still struggle to develop a health system able to meet the growing needs and the rising expectations of an increasing population hit by new strains of epidemics.

In Europe, health care expenditures rise and undermine its social financing. The pressure put on professionals for more accountability and effectiveness increases. Scandals such as the Shipman or the Bristol cases in UK (Coulter 2002; Dyer 2000; Frankel *et al.* 2000; Horton 1998) and the blood transfusion HIV contamination or the growth hormone scandal in France (Coignard 2002; Dumay 2002) put into question the regulation frameworks (Klein 1998). The recurrent near bankruptcy of social insurance systems in France calls for drastic cost containment measures (Dorozynski 1995b; Dorozynski 1997; Garcia 2000; Mandraud 2001). Health care reforms are presented as inevitable but provoke fears and resistance (Dorozynski 1995a; Dorozynski 1996a; Dorozynski 1996b; Dorozynski 2000; Dorozynski 2002; Fonfria 1997). Quality improvement has become the rallying point called upon to bring together proponents and opponents of subsequent waves of measures (Charvet-Protat *et al.* 1997; Guélaud 2004; Jarlier & Charvet-Protat 2000). The rising concern for quality was soon followed in Europe by a strong movement to implement various models of quality management in health care organisations, although it is not clear whether it reflects a genuine concern of health care professionals or a reaction to external pressure. Adapted from industry, the quality movement followed various approaches ranging from audit and accreditation (Klazinga 2000; Shaw 2000) to clinical governance and guidelines development (Bohigas & Heaton 2000; Buetow & Roland 1999; Campbell *et al.* 2001; Grol 2000; Scally & Donaldson 1998).

In most African countries, despite significant and successful efforts over the past twenty years to extend health care coverage, increase access and improve efficiency through

rationalisation of resources, curative services remain poorly functioning and under-utilised. Quality of care remains questionable and is questioned indeed by service users when they can voice their concerns (Haddad *et al.* 1998; Jaffré & Olivier de Sardan 2003). There is a growing awareness that increasing access to health infrastructures will serve little purpose if quality of care is not addressed (Criel & Waelkens 2003).

In this time of globalisation, it is tempting to propose the transfer of the quality management approaches developed in the North to address the quality challenges in African health services. Various quality management projects have been implemented in many countries in African health systems during the last decade (Dwyer & Jezowski 1995; Silimperi *et al.* 2002; Whittaker *et al.* 1998). However, health systems are complex organisations and there is no evidence that an approach designed to address issues in a given organisational context have the same effect in another context where issues present differently, as was already suggested by Criel (1999) about health insurance.

This paper intends to explore the reciprocal impact of quality management on health care organisations by identifying broad trends in the quality movement as well as in the organisational configuration of health care systems.

Our premise is that the interaction between the quality movement and organisational culture and structure vary from one context to another. Therefore comparisons are likely to highlight contrasting features whose interpretation will give rise to a better understanding of this interaction. We compare the organisational configurations of European and African health care organisations and the trends followed by the quality management movement in both contexts. Such a comparison represents a challenge given the complexity of both the quality management dynamics and the organisational configuration of health care systems. We deal with this complexity with a modelling approach using the organisational models developed by Mintzberg (1979). We recognise that our methodology oversimplifies heterogeneous situations. Not all health care organisations are the same, neither in Europe nor in Africa, of course. However we believe that the identification of broad trends and contrasts proposed in this paper will be useful as a departure point to later study more in detail the African experience with quality management and explore the wide contextual variation, along the epistemological paradigm of realistic evaluation proposed by Pawson and Tilley (1997).

In a first part we describe the main organisational features of European and African health systems. In a second part, we describe the main features of the quality movement in both systems and identify how it impacts organisational culture and structures. We then propose and discuss an interpretation of these trends. We argue that the organisational configuration of health care systems is not neutral to, and interacts with, the quality management movement. We illustrate how in Europe, the emphasis on clinical practice standardisation and external control to increase accountability may reflect a shift towards a mechanistic type of organisation, challenging professional autonomy, and triggering reactions from professionals to regain control or to resist, while in Africa, it reinforces the extreme standardisation and rigidity of hierarchical command and control systems where lack of responsiveness is part of the quality problem. We argue that this calls for more flexibility, patient-focus and responsiveness from responsible providers in Africa and suggest that instilling professionalism may be a way forward for the quality movement in Africa.

## **Method: a conceptual framework to compare European and African health care systems**

### ***Purpose: understanding interactions in complex health systems.***

What happens in health care organisations when they embark on quality management? Our purpose is to gain insight in the dynamic interactions between the quality movement and the organisational configurations of health care systems. Embedded in a broader research, this paper represents a first step in understanding these interactions in various contexts. It synthesises, puts

in perspective and interprets the current trends in the quality improvement movement in health care organisations. In this paper, we compare the configurations of health systems and the trends of the quality movement in Europe and in Africa and we analyse the interaction of quality management with the organisational culture and structures of these different health systems.

In order to study organisational changes - or resistance to change - in various contexts, we need an understanding of the overall trends in organisational configurations as well as in the quality management movement. In other words, we need an initial yet provisional theory as a departure point that serves as an analytical framework for further studies. This is what this paper intends to outline.

### ***Epistemological paradigm: a realistic approach of evaluation of quality management in health systems***

Our approach belongs to the realistic evaluation epistemology proposed by Pawson and Tilley (Pawson 2002b; Pawson & Tilley 1997). In a nutshell, a realistic evaluation starts from the description of the logic of an intervention, where a mechanism (M) produces an outcome (O) in a given context (C). This 'CMO configuration' works according to an initial provisional theory (T). Applied in a different context (C'), the same mechanism will produce expected and unexpected, even adverse effects (O'). The analysis of these effects and their relation to the context leads to a refined, yet still provisional, theory (T'). By multiplying contexts, we end up with a fairly good understanding of the mechanism at work, useful for further implementation. This approach differs from classical evaluation of interventions that address the question 'what intervention works best?', by extending the question to 'for whom, how and in what circumstances?' It moves away from applying a linear vision of causality towards building intermediate theories on the actual functioning of interventions, taking into account the contextual complexity of both quality management and health care delivery. Such intermediate theories do not represent universal laws to be verified or rejected by falsification in a bias controlled environment. Their falsification in a different context represents a welcome opportunity indeed for their continuous revision, update and refinement.

The aim of our broad research is to draw transferable theories indeed on how quality management interacts with organisational structures and cultures in various contexts. In this paper, to draw a first, yet still provisional theory, we describe how the implementation of quality management principles and methods (mechanism M) changes managerial and clinical practices (outcome O) to improve quality of care in two different contexts, the European health care systems (context C) and the African health care systems (context C'). To describe the mechanisms, the outcomes and the contexts, we resort to a broad range of information sources and to a modelling approach, in order to simplify the observation of complex systems and interactions.

### ***Sources of information***

Assimilating multiple observations and reports of a range of experiences in various organisational contexts represents a major challenge. Our observations draw on a wide variety of information. A first information source is represented by the experience of the authors as actors in, and consultants for various projects in health services mainly across Africa, both in Francophone and Anglophone countries. A second information source is the grey literature on quality projects made available by organisations in the field of development, public administration and policy. A third information source is the literature over the past ten years on health care reforms and quality assurance in Europe, especially France and the UK, as well as in Africa. The content of several peer reviewed journals on quality in health care were scrutinised over the last years. Together with the scientific literature, we browsed the lay press, especially for opinions and movements in the medical profession. We adopted a pragmatic approach to collect relevant information from the abundantly available material. Since our concern is to formulate a background model through reasoning rather than to validate this model by empirical measurement, we restricted ourselves to a quasi-systematic and purposeful review of the

literature. We exercised reflective praxis, with field observations continuously triggering purposeful subsequent literature searches.

**Analytical tool: Mintzberg's typology, a model to simplify complex interactions in organisations.**

Another challenge is to characterise the overall features of health systems across a variety of western as well as African countries. To draw an overall picture, and to identify general features and trends, we need a model to simplify a complex reality. We rely on the organisational model developed by Mintzberg after extensive studies of the structure of organisations (Mintzberg 1979). Used as an analytical framework to characterise the configuration of an organisation, this model is sufficiently generic and at the same time specific enough to identify general features and trends across a wide variety of organisational and managerial situations. In this section, we briefly present the framework and the typology proposed by Mintzberg to describe the structure and the coordinating mechanisms of organisations.

According to Mintzberg, "every organised human activity... gives rise to two fundamental and opposing requirements: the division of labour into various tasks to be performed and the co-ordination of these tasks to accomplish the activity". Therefore "the structure of an organisation can be defined simply as the sum total of the ways in which it divides labour into distinct tasks and then achieves co-ordination among them". From this statement, he proposes a model to describe an organisation and 6 different co-ordinating mechanisms corresponding to six types of organisational structure.

According to Mintzberg, the structure of an organisation has five basic parts (Figure 5).

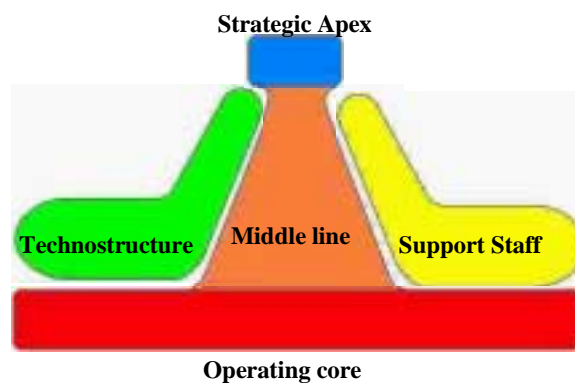


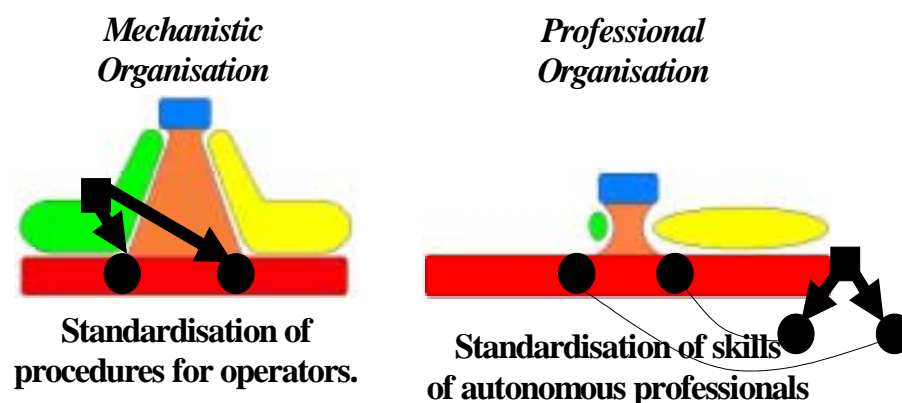
Figure 5 : The five basic parts of organisations (adapted from Mintzberg (1979))

"The **operating core** of the organisation encompasses those members -the operators- who perform the basic work related directly to the production of products and services. [...] The **strategic apex** is charged with ensuring that the organisation serve its mission in an effective way, and also that it serve the needs of those people who control or otherwise have power over the organisation. [...] The strategic apex is joined to the operating core by the chain of **middle line managers** with formal authority. [...] The control analysts of the **technostructure** serve to effect standardisation in the organisation; removed from the operating work flow, they may design it, plan it, change it or train the people to do it but do not do it themselves. Eventually [...] a great number of units, all specialised, exists where **support staff** provide support to the organisation outside the operating work flow." (Mintzberg 1979) If all these parts can be found in every organisation, their relative importance varies greatly from one organisation to another to the extent that one part may even be quasi virtual. The various parts have different roles, functions and tasks in order to achieve the purpose of the organisation and they co-ordinate their activities.

In the resulting structure, the relative importance of each part and the main co-ordinating mechanism of an organisation depends on four groups of "contingency factors" such as the *size and age* of the organisation, the *technical system* used in its operating core, the *environment* in which it evolves characterised by its level of stability, complexity, diversity and hostility, and the *power relationships* exerted within or over the organisation.

Mintzberg describes five co-ordinating mechanisms. *Mutual adjustment* with informal communication between operators; *direct supervision* when one person delegates tasks through instructions and controls the work; *standardisation of procedures* where analysts, external to the operating group design and program the tasks; *standardisation of outputs* where deliverables are fixed rather than how these should be achieved and *standardisation of skills* where the relevance, consistency and quality of the work produced relies on the high level of training and qualification of operators granted with a large degree of autonomy. Later Mintzberg (1989b) added a sixth co-ordinating mechanism, *standardisation of norms*, meaning that an organisation intentionally develops, with the contribution of analysts, a shared vision of the organisation's mission and expects the operators to comply with this vision.

Mintzberg then distinguishes six main organisational types, according to their structure and their co-ordinating mechanisms. Our analysis mainly refers to the machine type and the professional type (Figure 6).



*Figure 6 : The machine type and the professional type of organisation (adapted from Mintzberg (1979))*

The *machine organisation* co-ordinates its activities through standardisation of work processes; the "technostructure" which designs procedures is its key part. The *professional organisation* co-ordinates its activities through standardisation of skills and qualifications; the Operating core consisting of independent professionals is its key part. The *entrepreneurial organisation* co-ordinates its activities through direct supervision; the strategic apex is its key part. The *divisionalised organisation* co-ordinates its activities through standardisation of outputs; the middle line, which takes overall responsibility for a set of activities, is its key part. The *innovative organisation (adhocracy)* co-ordinates its activities through mutual adjustment; the support staff and the input and opportunities for connections it provides is its key part. The *missionary organisation* co-ordinates its activities through standardisation of norms; its key part cannot be associated with a specific group of people as "each member is trusted to decide and act for the overall good of the organisation" (Mintzberg 1989a).

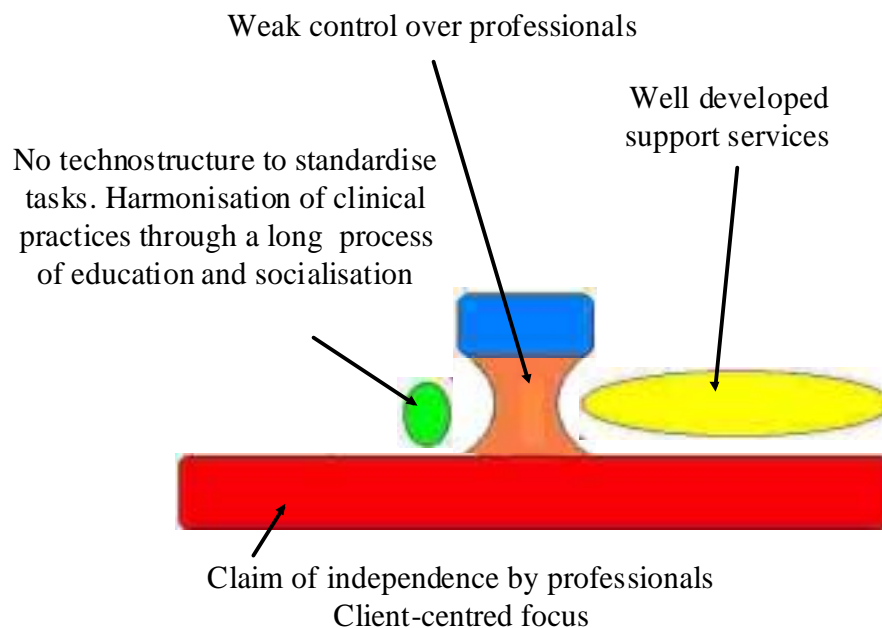
Our reasoning follows a series of subsequent steps. We start by comparing European and African health care systems, relying on the models developed by Mintzberg. We then describe quality management practices and the trends followed by the quality movement in both systems. We finally propose an interpretation of the different impact the quality movement has on the different organisational structures and cultures of European and African health systems and discuss the implication for the future orientation and evaluation of the quality movement in Africa.

## **African and European health care systems have different organisational features**

### ***Most European health care systems correspond to a "professional" type of organisation.***

The shape taken by health care systems stems from the history of health care organisations as well as from the specificity of medical care. Historically, European health care institutions have been built around powerful and independent health professionals. When the medical profession re-emerged after the middle ages, the increase of medical practitioners was a source of concern. Guilds were set up to protect the profession from quacks and to regulate the right to practice and the boundaries of the medical practice (Haskell 1997). As medical practice developed, the concentration of docile patients in hospitals was seen as a good opportunity to test scientific hypotheses and therapeutic models. Medical doctors previously essentially visiting hospitals on charitable grounds started to invest in them. After the Second World War the power of in-house professionals in hospitals further increased by the development of new health care techniques and professionals started to exert an overall control over hospitals becoming fully recognised as teaching and research institutions.

This partly explains why most European health care organisations show the characteristic features of the professional organisation according to Mintzberg, namely standardisation of skills as co-ordinating mechanism, (related to the nature of the problems i.e. complex, but yet relatively stable and predictable in features and evolution); importance of the operating core of professionals, enjoying power to control the organisation; problems with regulation and power control resulting in tension between professionals and administrators; highly motivated operators personally responsive to clients' needs (Figure 7).



*Figure 7: The European health care system: a professional type of organisation.*

In European health care organisations, the co-ordination of health care activities mainly relies on the standardisation of the skills of health services providers, which is achieved primarily through formal education of highly qualified medical professionals enjoying considerable control over their work. The characteristics of the medical activities partly explain this health organisation's configuration (Freidson 2001; Mintzberg 1979). Basically, medical care requires two basic tasks: identifying the demands and needs of the patient, which corresponds to the diagnostic procedure, and applying a therapeutic course. While the therapeutic task usually consists in the application of an appropriate standard protocol, the diagnostic phase requires the ability to deal with complexity, taking into consideration many factors together. Moreover, no matter how standardised the skills and the knowledge, this complexity requires considerable discretion. The challenge is to ensure the ability to deal with complexity and simultaneously prevent the risk of an over-creative attitude of autonomous medical professionals drifting away from the scientific rationality and reinventing their own medicine. To ensure that the personnel at the operating core perform in an appropriate and co-ordinated way, health care systems standardise professional skills through the combination of initial medical education followed by a long period of on-the-job training, i.e. internship, combined with a very strong socialisation. The result of this process allows what Mintzberg describes as "pigeonholing". Health problems are categorised as belonging to a specific cluster, be it a speciality or primary care. In this cluster, professionals are free to decide on behalf of their patient what is best to be done. As Mintzberg points out, this "pigeonholing" process is specific to the professional organisation.

The most distinctive part in European health care organisations is their powerful operating core: professionals provide medical services and concurrently exert to a large extent control over the organisation. Unlike in manufacturing organisations, where a specific department designs the tasks and procedures to be implemented, in European health care services there is no formal structure that prescribes how various clinical situations should be managed, although this is now changing. Each professional is expected to know from his extensive education what he has to do and thus to take responsibility for the clinical decision-making process. Still, doctors do not work in isolation and support services such as laboratory, ambulance services, maintenance, ancillary and catering services are also well developed. In addition to controlling their own work, professionals equally seek to control administrative decisions that affect them. They do so by either appointing peers in administrative positions or by occupying powerful positions in various decision making committees. Of course, administrative managers in professional organisations are not completely powerless but their position is much more one of a "go-between" than is the case in a machine type of organisation.

The description above equally applies to hospitals, one of the most visible health care organisation types, as to primary care services. One can consider the whole of primary care services in most European countries as one single virtual organisation. The apex, using Mintzberg's terminology, is represented by the National Health Service (NHS) in Beveridge health systems and virtually by the National Health Insurance (NHI) together with the government and other regulating bodies in Bismarckian health systems. A contractual relationship binds the providers with this apex by describing the rights and obligations of each party, by defining the boundaries of the care which may be provided and by monitoring quantitatively, and to some extent qualitatively, the services delivered. From this point of view, the professional status of primary care providers gives them considerable power over their own work comparable to that of professionals in hospital settings. Here as well, it is the standardisation of skills through initial and continuous education under peer control that ensures the co-ordination of tasks in order to guarantee safety and conformity to standards designed by the profession. In primary care provision, support services such as emergency and ambulance services, laboratory facilities, investigation centres and community services are equally developed. And again, there is no middle line management to co-ordinate their activities. At most, financial arrangements in the contractual agreement define what can be done under which conditions. Most regulations are outlined and controlled by professionals through their professional organisations. Within the NHS (in Beveridge systems) or the national health insurance (in Bismarckian systems), the guidelines streamlining prescriptions are equally controlled by professionals. Although the medical profession vigorously contests the cost control measures

taken by managers, they must admit that so far they haven't been subject to significantly effective sanctions. Using Mintzberg's terminology, this shows rather loose middle line management and conversely a strong operational core. Again this is a typical feature of a professional type of organisation. Another feature of such a professional configuration as pointed out by Mintzberg (1989) is that "*professionals tend to emerge as highly motivated individuals dedicated to their work and to the patient they serve.*" Indeed patient-centredness and responsiveness to their demand are key issues in health care ethos. At the same time, here lies its weakness. Such a configuration offers little possibilities for control. Today, this is the prime concern of health care policy makers facing increasing expectations. Health care is indeed undergoing a profound evolution: decades ago care was rather cheap, relatively safe yet not very effective; today it is becoming increasingly expensive, rather effective but also potentially harmful.

For Mintzberg, the conditions for a professional configuration are a complex yet stable work context, the recourse to relatively simple technical systems and the possibility for the operators to control most of the medical processes. For years, these conditions have been met in European health care but the evolution of medical practice is accelerating. Practising medicine is less and less an art and becomes more and more an engineering process (Le Pen 1999). The amount of knowledge can no longer be mastered by one professional even in his own specialisation, hence the development of sub-specialisations to keep the medical practice model going. Nevertheless there is more and more need for sharing the knowledge among professionals and develop team management of clinical problems. This evolution challenges the professional configuration of health care organisations where professionals act independently from each other. Moreover, the synthesis of experiences can no longer be disseminated among the medical profession exclusively through initial and continuous education. The influence of the emerging evidence based medicine rests on the synthesis of numerous and large studies that cannot be dealt with by any single professional (Davidoff *et al.* 1995; Straus & Sackett 1999). Hence standards are designed by analysts, often from the medical profession, but no longer practising medicine, launching their guidelines and recommendations from institutions and through channels that are no longer necessarily controlled by health care professionals. The potential danger of new technologies together with the growing concern of the public for safety, effectiveness and refusal of uncertainty raises issues of independent quality assurance, accreditation and revalidation of health care providers. The control of rising costs calls for collective action, which professionals so far have refused to endorse on the account that it would threaten their professional independence as agents for their individual clients. This refusal opens up space for managers to gain control over strategic decisions in health care. In this context, the issue of the regulation of medical care is becoming pivotal and quality management represents a powerful strategic instrument to regulate health care provision.

### ***Most African health care systems correspond to a "machine" type organisation***

Like for European health institutions, the organisational configuration of African health services partly stems from its historical background. For a long time and largely up till now, African health systems have been dominated by public services. During the first half of the 20<sup>th</sup> century, the colonial power shaped the health system around three elements (Van Lerberghe & De Brouwere 2000). Vertical services were set up in a military way often associated with mobile teams to deal with major endemic diseases ("*service des grandes endémies*" in French speaking Africa). Relatively sophisticated hospitals were built in towns to offer appropriate care to the elites and the colonial cadres. A network of small hospitals and dispensaries, staffed by the government, by missions, by the army or by commercial firms, were developed to deliver care to the rural population somehow connected with the owner institution. After independence, the further expansion and adaptation of the health system legated by the colonial era was strongly influenced by two groups of people. The medical elite perceived the hospital as central in the provision and promotion of modern health care and to answer the demand of the post-independence elite. The control of endemic diseases was considered as the most effective strategy to address the health needs of the population. This history accounts for the particular role attributed in Africa to the government vis-à-vis the health needs of the population. Today, expensive hospital-centred health care and centrally planned programmes of disease control still predominate in Africa, and

the latter entail a fertile ground for bureaucratic health care management with rigid hierarchical lines of command and control and poor responsiveness to health care demands.

Today, the health administration in most African countries remains highly centralised despite strong advocacy for decentralisation since decades. In most African countries, strategic policy decisions as well as operational instructions still are largely under the responsibility of the central administration even if they attempt to involve peripheral levels in the decision making process, usually through consensus building processes. Health care systems, embedded in the ministries of health administration, are generally organised along very hierarchical lines of command. In most instances decisions are taken in central divisions of the ministry, then conveyed top-down through the provincial (or regional) health administration to the operational services at district level (department, prefecture...): hospitals, health centres and vertical programme centres. Information on performance indicators is collected at health care level to feed central services through cumbersome vertical reporting procedures while data relevance, data accuracy and feedback is often neglected.

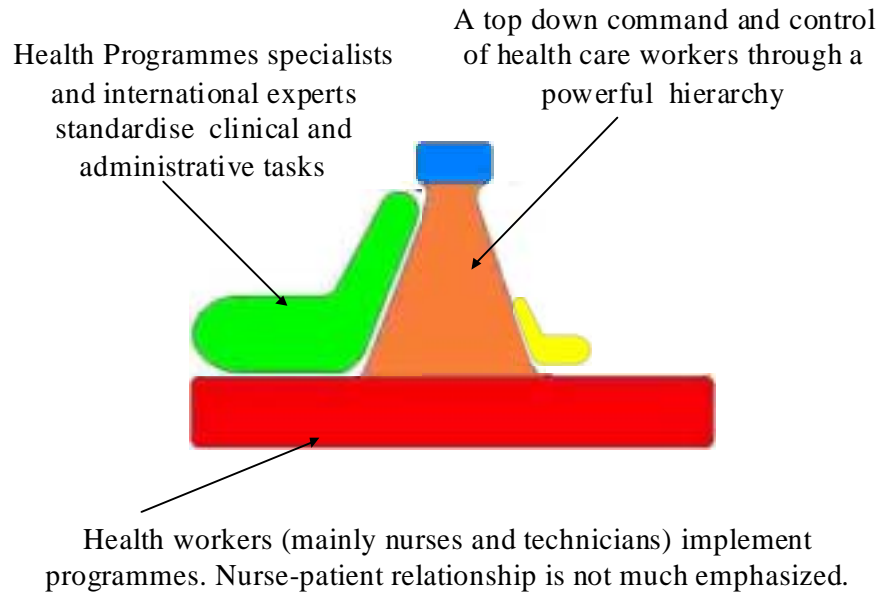
Since the mid-eighties the health sector of many African countries saw an expansion of its network of health facilities<sup>17</sup> (Levy-Bruhl *et al.* 1997; Maiga *et al.* 1999) Financial investment and resources increased thanks to international aid agencies, trying to buffer against the social impact of structural adjustment programmes, and to the launch of the "Bamako Initiative"<sup>18</sup>, which set up drug revolving funds and community financing. Yet there was a serious concern for efficient use of resources and strategies have been deployed to ensure rational use of resources, especially drugs (Knippenberg *et al.* 1997). Administrative and financial management of resources have been subjected to tight control measures. Considering the poor qualifications of available staff and the limited time available for retraining, standardisation was seen as key to allow safe delegation of tasks to low qualified staff (Van Balen & Mercenier 1989). Together with the emergence of the concept of essential drugs, supported by WHO, the availability of cheaper generic drugs on an international scale and the world-wide evidence-based medicine movement paved the way for the development of diagnostic and therapeutic protocols.

The resulting health service organisations present features predominantly of a "machine type" (and in part of a "divisionalised" type), in Mintzberg's terminology. Indeed, these features are standardisation of procedures as co-ordinating mechanism together with standardisation of outputs from disease control programmes; importance of a technostructure elaborating standardised instructions; the pre-eminence of a strong hierarchical middle line; control by direct supervision; and low focus on the direct patient- provider interaction (Figure 8).

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<sup>17</sup> In Guinea more than 256 sub-district health centres have been renovated, equipped and staffed between 1989 and 1993. In Mali about 200 community health centres have been created or renovated between 1993 and 1996.

<sup>18</sup> The "Bamako Initiative" was launched in 1987 by WHO and UNICEF to revitalise primary care services and was implemented in most African countries during the last decade.



*Figure 8: The African health care system: a machine type of organisation.*

Standardisation, a precondition for tasks delegation, is the strategy often chosen to deal with the scarcity of medical doctors, concentrated in hospitals and reluctant to work in remote rural areas or in primary care services in many African countries. The delegation of clinical tasks and responsibilities to health workers other than physicians is seen as a method to improve health care. If well designed, the clinical and therapeutic decision making process can be sufficiently standardised to reduce uncertainty and allow lower qualified health personnel to address many complex clinical situations and cover most of the need. (Equipe du Projet Kasongo 1982). Clinical aids such as decision trees, flow charts, algorithms, "ordinogrammes" or more simply protocols are regularly used in many health programmes and services. In Guinea and Benin, all the health centres routinely refer to such algorithms, called "ordinogrammes", for all their diagnostic and therapeutic acts (Knippenberg *et al.* 1997). Those tools are even connected with the information system and the payment system. Indeed, the fee for a service can only be determined against a standardised clinical management decision issued from the "ordinogramme". The latter synthesises in a linear relation the complaint, the clinical decision taken, the epidemiological record, the drug prescription, and the financial income of the facility. Such an approach has reduced dangerous, inappropriate or abusive prescription dramatically. At the same time, it improved the management of resources, especially drugs, since drug consumption became much more predictable. But it also drastically reduces the boundaries for negotiation with the patient and thus the typically professional autonomy and responsiveness to a patient's needs and demand.

Additionally, most development programmes in Africa emphasise a tight stock control of drugs and medical equipment. Authorised lists of drugs and equipment are established for each facility level, manuals and guidelines provide detailed procedures and tools for ordering drugs and recording stock movements and financial and book keeping procedures are tightened. As a result, the availability of essential drugs has dramatically improved where these procedures have been effectively applied, even on a large scale as evidenced in Guinea, in Benin or in Mali (Knippenberg *et al.* 1997). Moreover, Disease Control programmes, the Extended Programme of Immunisation, Mother and Child Health programmes, Family Planning programmes are equally strongly regulated by protocols and standard procedures and largely use standardised data collection tools.

All these approaches to rationalise the efficient use of resources and to ensure an acceptable level of quality of care correspond to what Mintzberg refers to as "standardisation of procedure".

It ensures co-ordination within the clinical activities and between the resources management activities and the clinical activities.

Furthermore, these programmes set coverage targets, usually conforming to international standards such as the common 80% coverage rate set as target for most immunisation programmes<sup>19</sup>, or in Mintzberg's terminology "standardisation of output". In these programmes, as well as in the curative consultation, there is often a division of labour among staff for each clinical case. Take for example the case of the well-baby clinic organised as a chain. First the baby is registered by a person able to read and write. Secondly, the baby is weighed and then pushed forward for the control of its immunisation status and if necessary immunised. Then a discussion will follow, usually with the nurse about nutrition, risks factors or medical complaints. Eventually the child is discharged with an appointment for the next visit. It is not exceptional that a problem noticed at one stage of the chain will remain unnoticed at the stage where it should be dealt with. It is up to the mother to decide if an appropriate action is required.

The process of standardising procedures and output does not stem from the needs of the operators in the front line. It reflects a strategy of the ministry of health striving for efficiency of its service provision, often under strong influence of international agencies involved in the financing of the services. The service providers are only marginally involved, usually in national or regional workshops designed to familiarise the staff with standards rather than to set them up. These standards are indeed often pre-designed by experts from specialised divisions in charge of specific programmes. Since they are involved with the design of standards and more generally the technical follow-up of the activities, they constitute a powerful "technostructure" in Mintzberg's terminology.

Public health services in Africa are characterised by a strong hierarchical structure. The ministries are usually organised in divisions in charge of specific programmes or services like hospitals, primary care services, immunisation, mother and child services or family planning services. They usually operate under the responsibility of a national director of health, whose strategic decisions are then conveyed to the operating services through the provincial or regional offices. These middle line offices normally reflect the divisions of the ministries albeit more lightly staffed. Structured around programmes, they stress output achievements to the operating staff of peripheral health services. The structuring of the ministry along these specific divisions with a strong hierarchy but relatively independent from each other, corresponds to a divisionalised configuration in Mintzberg's terminology. In the periphery, the district services, operating core of the ministry, are composed of a district hospital and a set of primary care health centres. The district office, sometimes embedded in the hospital services, has administrative responsibilities and is equally structured along vertical lines of command and control. The health centres and often the hospital are supervised by the district office, which plays a major role as it is responsible for co-ordination of the health services delivery by the health centres, the hospital and the programme specific services if any (mobile team for immunisation, family planning unit and so on). Within the divisionalised structure of the ministry, the district services with the district office and the set of two tiered clinical services (the hospital and the health centres) represent a machine type of organisation with strong hierarchical lines. However, among these services, the hospitals run by physicians, share similarities with the professional type of organisation in Mintzberg's terminology, comparable to European hospitals by their historical origin. The predominance in all these subsystems of a powerful hierarchical line of command and control with little effective decentralisation of decision making power is also a characteristic of the "machine" type of organisation, still according to Mintzberg typology.

The organisational control strongly emphasizes supervision of auxiliary personnel along hierarchical lines. Theoretically enhancing problem solving, and staff development, supervision most often consists, in reality, of a systematic control of conformity to standards and instructions with a strong focus on written records rather than on the actual observation of the activities. This mode of control is again very typical for a "machine" type of structure.

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<sup>19</sup> 80% is a mythical number for immunisation programs. It is indeed the immunisation coverage rate which permitted the successful eradication of smallpox, the only communicable disease so far eradicated in the world.

Client satisfaction is only recently emerging as a concern in African public health services (Baltussen *et al.* 2002). So far accessibility, equity and efficiency were targeted with a strong focus on priority health problems. These concerns were central in the design of strategies by the apex and the technostucture as they were thought to guarantee meeting the population's needs. Patient-staff interaction was largely neglected. Responsiveness to the population needs and demands was supposed to be addressed through the community participation in health committees and the like. Unfortunately their power in the decision making process has remained marginal. Some problems clearly arise after more than ten years of such a revitalisation of public health services in some African countries. Studies now reveal a strong dissatisfaction of the population with health services. Especially the patient-staff interaction is rather problematic (Haddad *et al.* 1998; Jaffré & Olivier de Sardan 2003; Jewkes *et al.* 1998). The public complains of the little attention to their individual health problem and they reject the extreme standardisation of the diagnostic and treatment process offered. Providers often develop strategies on their own to circumvent the rigid procedures in order to negotiate more personal care off-the-record (Olivier de Sardan 2003). If this may sometimes benefit to the patient, it is mainly a coping strategy to increase health workers revenue (Ferrinho *et al.* 2004; Macq *et al.* 2002; Van Lerberghe *et al.* 2002). This weak attention to client-operators interaction is also mentioned by Mintzberg as a typical feature of a machine-like organisation.

Despite these structural constraints, there is an emerging concern for the quality of services provision, and attempts to address poor quality of care are high on the agenda. Approaches like quality assurance, total quality management, continuous quality improvement and the like are very appealing to the decision makers of the African public health services.

**In Europe, the quality management movement increasingly standardises procedures. In Africa, excessive standardisation is part of the quality problem**

***In Europe, the quality management movement emphasises the standardisation of procedures, which is characteristic of a "machine" type of organisation***

For years, the industry has developed sophisticated means to control the quality of their products. In European countries, though quality has always been claimed, it is only recently that a systematic approach to quality assurance emerged in the health sector through the implementation of accreditation procedures and the emphasis on evidence-based medicine and clinical guidelines (Laplace *et al.* 2002; Le Pen 1999; Schyve 1998). Two factors may have contributed to this. First, the pre-eminence of market regulation increasingly tends to consider health as a commodity and health care as a commercial service. In such a paradigm, reducing asymmetry of information is crucial; thus transparency to allow fair competition is necessary. The public disclosure of performance is on the rise and pushes for the development of accurate indicators and models for quality assessment and management in health institutions (Davies & Marshall 1999; Houdart *et al.* 1998; Houdart *et al.* 2001; Houdart *et al.* 2003; Malye *et al.* 1997; Nutley & Smith 1998). In France, the publication by the magazine "Science & Avenir" of a league table of French hospitals revealed that the French paradigm of equality in health care was an illusion. The considerable differences between hospitals in terms of outcomes means that there is room for quality improvement (Malye & Houdart 1997). Secondly, in Europe, scandals revealed by the press raised questions on the appropriateness of leaving the regulation of health care in the hands of professional institutions such as the General Medical Council (GMC) in the UK or the *Conseil de l'Ordre* in France. In the UK, the uproar following what was called the "Bristol case" revealed the weakness of the professional control and urged the NHS to accelerate the formalisation of its performance assessment and quality management mechanisms. Several institutions were created such as the National Institute for Clinical Excellence (NICE) and the concept of "clinical governance" emerged (Baker *et al.* 1999). Under this concept, managers enforce the setting up of formal quality management activities in all health care institutions coordinated by a quality manager (Buetow & Roland 1999). Tools, method and indicators are provided while professionals decide on the content of quality management activities (Campbell *et al.* 2001).

Quality management in European health care stresses the formulation of explicit standards of care to reduce uncertainty and variation in medical practice of health professionals. Standards are derived from clinical and managerial evidence translated into guidelines. Much effort goes to the development of input, process or outcome indicators including patient satisfaction, to encompass all aspects of health care provision. In the UK this trend results in the production of numerous guidelines inundating overworked professionals and piling up while their management and implementation remains problematic (Cranney *et al.* 2001; Feder 1994; Freeman & Sweeney 2001; Grol 2000; Hibble *et al.* 1998). In the nineties, protocols called *Références Médicales Opposables* (RMO) have been produced in France (Durand-Zaleski *et al.* 1997). On the basis of available scientific evidence, RMOs state what professionals cannot do in given clinical situations. In case of non compliance, the National Health Insurance can "oppose" these protocols to doctor's prescription and apply financial sanctions. These RMOs had an impact on prescriptions and their subsequent bill (Le Pape & Sermet 1998). However the inapplicability of sanctions resulting from two decisions issued by the *Conseil d'Etat* in April and July 1999 will probably reduce this impact.

If we refer to Mintzberg, one can view the European quality management movement in Europe with its focus on guidelines, indicators, setting up local quality management teams, and training in-house quality managers, as a trend towards standardisation of procedures, a typical feature of a "machine" type of organisation. The managers' role in guidelines development brought them closer to clinical decision making and subsequently increased their influence. External organisations like the Cochrane collaboration play an increasing role in the design of evidence based recommendation and serve as a reference for designing guidelines. This externalisation of the control of clinical processes, moving away from clinicians, can be seen as the emergence of a technostructure focusing on the design of good medical procedures. The importance of such a technostructure is a key element of a machine type of organisation in Mintzberg's terminology.

Of course, this view contrasts with the modern vision of quality assurance labelled Continuous Quality Improvement/Total Quality Management. The quality management movement today emphasises a comprehensive approach to quality and views it mainly as a dynamic process, involving a whole organisation and focusing on client satisfaction rather than a mere collection of standards and measurement of results (Minvielle 1997). Still, in its application such a comprehensive and dynamic approach is not the most commonly perceived.

This process of quality management and rationalisation gave rise to a very hot debate (Gupta 2003; Loughlin 2002; Miles *et al.* 2002). Health professionals question the validity of the indicators chosen arguing that the complexity and the individual character of medical acts cannot be encompassed by a set of proxy indicators or procedures (Campbell *et al.* 1998; Casalino 1999; Edwards *et al.* 2003; Leung 2000; Malmesbury 2000; Shekelle 2002). They discuss whether it truly aims at clinical excellence or whether it is an instrument of managers to identify poor performers (Hall 1998). Moreover, they are suspicious that the hidden agenda of managers is merely the control of health expenditures rather than a genuine commitment to improve quality, which would require increase of resources rather than rationalisation<sup>20</sup>. Eventually they see the quality movement as an intolerable shift of regulating power from professionals to managers, which threatens their professional autonomy (Sutherland & Dawson 1998). The reaction however was different in both side of the Channel (Laplace *et al.* 2002). In France the health profession is represented by three kind of institutions: the *Ordre des Médecins*, the trade-union organisations and the scientific societies. The discourse of the French "*Conseil National de l'Ordre des Médecins*" (the French equivalent of the "Health Professions Council") in their journal has changed dramatically over the past three to five years and they now lobby for the development of formal quality management procedures (Chabrol 1999). However, this shift is contested within the organisation and one can query whether their troops will follow. On the other hand, the health professional trade unions opposed the movement although the appreciation of the situation varies across professional groups. Professional scientific societies exist but are weak in France, especially at primary care level, and are not vocal in the policy debate. They contribute to the design of good practice recommendations but rather as followers than as leaders. In France the

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<sup>20</sup> The need to increase resources for the NHS is now recognised in the UK

*Agence Nationale pour l'Accréditation et l'Evaluation en Santé, ANAES*, leads the quality movement. Although set up as an independent institution, ANAES is a government creation (Boissier Rambaud *et al.* 1998). In the UK, as in northern Europe, the reaction was different. Medical scientific societies and professional associations are traditionally very strong. Health professional organisations try to get back in the driving seat to control the threat over professional autonomy. They do not question upfront the need for reform and call for a new professionalism (Husser 2003; Irvine 1999; Irvine 2001; Kirk-Smith & Stretch 2003; Rothman 2000; Southon & Braithwaite 1998). The GMC is deeply involved in the process of revalidation of doctors (General Medical Council 2000) and GPs negotiated a new contract and are supported by the British Medical Association (2000; Beecham 2001; BMA 2002; Shekelle 2003). Clinicians participate actively in the design of guidelines, mostly locally designed. However professional journals reflect hot discussions about the best way to go about these changes (Hellbruck 1997; Miles *et al.* 2002; Shekelle 2002; Wakeford 2000). Delvosalle, describing the same attempt in higher education (equally a professional type of organisation), suggests that it may be seen as an attempt by professionals to keep control over renewal of the modalities for standardizing skills. Looking at it from a less cynical point of view, it could also be that professionals *discover the virtue of quality management* (Delvosalle & Lorent 1999).

From this analysis and on the basis of Mintzberg's models, one can wonder to what extent the European quality movement reflects a shift from a professional type of organisation towards a machine type of organisation. If this holds true, the question remains as to whether the quality management trend reveals and accompanies an underlying shift of paradigm for the European health systems moving away from a professional type of organisation towards a machine type of health care industry or whether the quality movement itself shapes the evolution of the European health systems, fostered by an international concern for quality in all domains. And again if this holds true one can anticipate problems arising from a machine type of organisation: poor flexibility to adapt in an ever complex and changing environment, poor patient-centredness and poor responsiveness to patient needs. This fear may explain the reaction of many health professionals, ready to give up if this trend is confirmed.

***In most African health systems, the extreme standardisation of procedures hampers patient-centred care, an important characteristic of quality of care.***

Client focus and increased responsiveness are important assets brought into the public services by quality management models as applied in industrialised countries. Patient focus and more specifically patient-centredness is pivotal for the quality movement (Fehrsen & Henbest 1993; Henbest & Fehrsen 1992; Mead & Bower 2000). However, it is ironical to see that in Africa the extreme rationalisation of the consultation process, another asset of quality management, is part of the quality problem. The standardisation of procedure in Guinean health centres was introduced at probably the largest scale ever. For more than ten years, roughly the same procedures, whether administrative, financial or clinical, are applied in a strict way and are controlled by regular supervision. The results have been impressive (Levy-Bruhl *et al.* 1997): In Guinea, 43 % of the population had access to a health centre in 1993, immunisation coverage increased from less than 5% in 1986 to 61% in 1993, 51% of pregnant women have 3 antenatal consultations, essential drugs are generally available, and despite initial scepticism, there has not been financial bankruptcy of the community financing schemes and some health centres are even in a position to invest. Still, the utilisation of curative services remains low and studies show great disappointment from service users in particular and the population in general (Gilson *et al.* 1994; Haddad *et al.* 1998; Sauerborn *et al.* 1989). Patients complain that they are not being heard nor understood, that there is no space for discussing their problems nor the proposed treatment, that the patient-provider interaction often deals only with symptoms recognised by the guidelines (the ordinogrammes), and that the same treatment, they often already bought at a cheaper price in the market place, is applied to almost all cases (Olivier de Sardan 2003). In a nutshell, they complain of the poor client orientation and the poor responsiveness to individual problems. Such a poor user orientation is not surprising. It is a well documented weakness of a machine type of service organisation (Crozier 1963).

It is worthwhile to note that in the first experiences of standardisation of procedures using algorithms in African primary care services, beyond the ability to delegate complex clinical tasks, the objective was explicitly twofold. First, the use of algorithms was supposed to free the mind of the health worker from clinical reasoning which was hazardous as his competencies were limited, and to free consultation time in order to concentrate on the quality of the relationship with the patient. Indeed less qualified staff was expected to be in a better position to engage in an empathic relationship, being socially closer to his rural patient than would be a medical doctor. Secondly, the delegation of complex tasks to less qualified personnel was considered as a personnel developmental approach and perceived as a motivation factor for the staff (Equipe du Projet Kasongo 1976). The flexible, training oriented supervision, led by a senior professional health practitioner primarily responsible for the activities delegated and involved in the design of algorithms, was key to allow flexibility in their use. Trust based relations with a supervisor taking care of the difficulties met by the staff in applying rigid standards and in a position to adjust procedures, was supposed to lead gradually to the professionalisation of auxiliary personnel, subsequently implying more independent performance and more responsiveness to patients needs (Van Balen & Mercenier 1989). However, scaled up at a large level, as was the case in Guinea, the approach was far less comprehensive and led rather to a de-professionalisation in the absence of enabling factors like specific characteristics of supervisors (Blaise & Kegels 2002). Such an evolution is precisely what is feared by professionals when standardised protocols are at stake.

The same applies to quality management techniques such as quality circles. They break up hierarchical lines of command, gathering staff from different positions and promote bottom-up initiatives to locally solve problems (Huberac 2001). However, their implementation in mechanistic African health systems shows serious drawbacks. First, these approaches are often perceived as another 'programme', additional to the routine activity and not as a tool to improve it. They are often introduced as other vertical programmes emphasising training workshops, standards and targets as was the case in Niger in the quality assurance project. Assessing this project, Dugas and De Brouwere (2001) report that the quality management activities and the problems they address are taken in isolation and lack connection with the daily tasks of the staff. The strategies designed to address the problems identified through the project are labelled "quality activity" as if quality was not central to any other activity of the health services. Secondly, these approaches emphasize standards measured by indicators. Gaps with standards point to quality problems tackled by local quality circles. The process is often very long and fastidious (Legros *et al.* 2000). Problem solving cycles take on average a year to implement changes which often are considered trivial. The collection and management of data and indicators is often cumbersome. In Tanzania a quality assurance project spent two years to produce a league table of performance of health centres yet without any intervention to address highlighted problems<sup>21</sup>. Moreover, the problems identified do not necessarily coincide with daily problems facing management teams (van Bergen 1995). As a result, the commitment of managers is often weak whereas their involvement is crucial in quality management (Silimperi *et al.* 2002). Finally, quality teams set up to address a specific problem often lack power to enforce the proposed strategy.

Nevertheless, such quality management initiatives are, frequently, extremely valued by the staff involved (Dugas & De Brouwere 2001). Indeed, especially in a bureaucratic environment, it gives the staff a strong feeling of having a hold on their work, and gives rise to genuine team work by breaking up hierarchical lines. However it is not clear whether this survives the quality project's life (Bouchet *et al.* 2002b). In Niger there was a steep and constant decline in the practice of problem solving cycles after the project's completion (Bouchet *et al.* 2002a). This raises the question as to whether such quality management contributes to profoundly change working relationships and hierarchic lines of command and control.

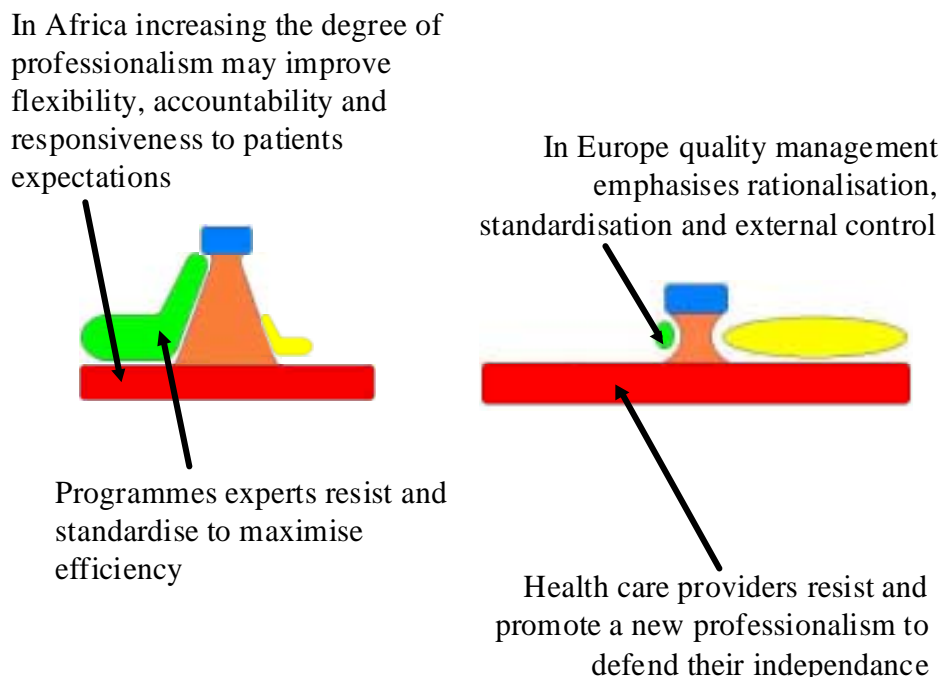
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<sup>21</sup> Personal communication from Kulke R during the short course 'quality management in International Health', GTZ & Dept of tropical Health & Public Hygiene, Heidelberg, 26 march-6 April 2001.

## Undifferentiated application of quality management techniques is not a magic bullet

### *Standardisation and responsiveness: searching for a balance*

The challenge of the quality movement is to find a balance between the perverse effects of the over-standardisation of procedures by an inflated technostructure on the one hand, and the potential of the quality movement to foster dynamic, flexible and participatory changes in an organisation on the other hand. The comparison between the quality movement in Africa and in Europe shows two distinct systems of logic (Figure 9).



*Figure 9: European and African health care organisations: the relationships between the quality management movement and the structure of the organisation (based on Mintzberg)*

Whilst in European health care systems the concern is to rationalise the work, externalise its control, to increase accountability to the public, in African health systems it should rather be to improve the capacity to deal with complex situations, internalise the quest for excellence and increase commitment to the work. The simple transfer of quality management approaches from Europe to Africa assuming both systems are alike reinforces extreme standardisation, hampers patient-centredness and further increases the de-motivation of those still dedicated to the ethos of caring. Instilling elements of professionalism in such a context is appealing (Haddad *et al.* 1998; Unger *et al.* 2002). However, it remains to be tested whether it is possible and to what extent it would profoundly and durably influence professional behaviour and change the organisational configuration. This raises questions and comments.

### ***Changing organisational culture and structure, a relevant task for the quality movement ?***

We can question the feasibility to curb the present trend of the quality movement in Africa. It may well be that it reflects more a passive influence of a powerful international trend rather than a genuine concern. One may query to what extent the quality movement in Africa has the strengths to put into question and change the present organisation of public health care systems as it does in Europe. By the same token one may question whether the quality movement itself has the potential for instilling professionalism to the benefit of African health care services, or if a shift from the machine type of organisation towards a professional type of organisation is a

prerequisite for quality management to effectively increase professional accountability and patient-focus.

### ***Shifting to a professional model of health care as a blue print is not an option***

However one should not forget the rationale for the current mode of control of resources management: the baby should not be thrown with the bathwater. This paper should not be interpreted as an advocacy for re-engineering health care systems as professional organisations. Our message is that cut and paste approaches to change are not appropriate. Moreover the pure professional model has many limitations highlighted by Unger who qualifies both the professional model and the mechanistic model as inappropriate for Africa (Unger *et al.* 2000). The call for a renewed professionalism in the UK also acknowledges the limitations of the present professional model (Irvine 1999; Irvine 2001; Southon & Braithwaite 1998). Freidson, a sociologist studying professions for decades considers a pure professional model of regulation as a pipe-dream. As Weber did decades ago for bureaucracy with the rational-legal ideal-type, Freidson conceptualised professionalism in an ideal-type which '*can both organise the abstract theoretical issues and the practical issues confronting social policy*', and with which he can then *specify what can but may never fully be* (Freidson 2001).

### ***Instilling elements of the professional model: is it feasible ?***

There is no evidence that intentional instillation of professionalism in Africa would repeat what was historically built in Europe. A danger would be to wrongly assume that organisational barriers and quality issues are the same around the world, that active planning can repeat what was historically built and that the same quality management approaches would produce the same effects on what we have shown to be very different organisational structures and types of health care professionals. However, elements of the professional model are emerging in parts of Africa (Dugas & Van Dormael 2003b). It will be crucial to study whether and how these experiences will diffuse in health systems and how far they will keep their strengths and avoid adverse effects while going to significant scale.

### ***Does oversimplified modelling betray the rich and complex reality of the quality movement ?***

Mintzberg's models helped us to describe and understand the interactions between quality management and various health system configurations and to compare trends in these two different contexts. The virtues of models is to simplify reality. Our analysis therefore appears as a caricature: oversimplified. Of course there is neither one African nor one European health care organisation as there is neither an African nor an European way of managing quality. Proponents and actors involved in quality management projects may not identify themselves or their organisation or their project with our description. This is not surprising as quality management is often implemented as pilot projects, nested within health systems, with their own project culture, which may well differ from the general configuration of their host organisation (a hypothesis for further research). Moreover, our approach considers broad trends in order to gain a general insight and generating a broad theory, subject to refinement. This being done, it is now possible to focus on more specific quality management approaches or health care organisations, recognised as different contexts in which this provisional theory can be confronted. We believe that, however oversimplified, our reasoning helps to understand the past and the present, and possibly to be in better control of the future.

### **Conclusion**

Comparing European and African health care systems and quality management trends with the models developed by Mintzberg, we better understand why health care organisations behave as they do, face the constraints they face and deal with them as they do. We argue that the organisational configuration of health care systems is not neutral to, and interacts with, the

quality management movement. We illustrate how in Europe, where the professional type of organisation dominates, the emphasis on clinical practice standardisation and external control to increase accountability reflects a shift towards a mechanistic type of organisation, challenging professional autonomy, and triggering reactions from professionals to regain control or to resist, while in Africa, it reinforces the extreme standardisation and rigidity of hierarchical command and control systems where lack of responsiveness is part of the quality problem. We argue that this calls for more flexibility, patient-focus and responsiveness from responsible providers in Africa and suggest that instilling professionalism may be a way forward for the quality movement in Africa.

We can draw lessons from this analysis. The quality movement interacts with health care organisational culture and system configuration and may induce unexpected adverse effects. Quality issues differ in Europe and in Africa and one should be aware that the approaches to quality management implemented in one context are not necessarily applicable to another context. When embarking on quality management it is therefore important to make sure to take account of the organisational context. High "professionalism" is required in quality management itself; professionalism in the sense of capacity to operate in particularly complex, -i.e. not standardised- situations. Quality management itself cannot be a "Standard Operating Procedure".

At this stage, we can now synthesise our analysis and derive a first, yet provisional, theory :

**In health care systems structured as professional organisations, quality management approaches emphasising standardisation of clinical processes and reinforcing control to increase accountability, reflect a shift towards a mechanistic organisation, challenging professional autonomy, and triggering reactions from professionals to regain control or to resist.**

**In public health care systems of resource-poor countries, quality management approaches emphasising standardisation and control of processes often reinforce the mechanistic characteristics of the organisation, undermining patient focus and restraining health personnel initiative to address problems while the lack of responsiveness is precisely part of the quality problem.**

From this departure point, the life of quality projects in African settings can be put under scrutiny confronting this initial theory to many different contexts, looking for discrepancies, treated as treasures for deepening and refining the theory. As usual, more research is needed, endlessly needed. Health care systems should be learning organisations indeed (Iles & Sutherland 2001).

## **Acknowledgement**

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