

## Chapitre 7

### Ten years of quality projects and their effect on the organisational culture of the Moroccan health care system

*Dans ce chapitre, nous montrons comment le système de santé tolère l'innovation tant qu'elle se déroule à l'abri dans les projets qualité.*

*Ces projets ne transforment cependant pas fondamentalement l'organisation. Le changement de culture attendu ne se produit pas au niveau du système.*

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# Ten years of quality projects and their effect on the organisational culture of the Moroccan health care system

## Abstract

Quality circles, medical audits, problem solving cycles and other quality projects have been implemented to improve quality of care in Moroccan public health services for the last ten years. All projects emphasised participatory approaches, local problem solving and implementation of change, challenging the traditional managerial practices of public health services.

In order to investigate the extent to which the system internalised quality principles, we conducted 46 interviews of health services managers and quality projects participants in 6 hospitals, 10 health centres and 11 management offices in 5 regions. We performed a qualitative analysis using the framework method to explore the interaction between the quality projects and their host health services.

The Moroccan health system, structured as a command and control hierarchical organisation, allows innovation, creativity, local initiative and non hierarchical relationships as long as they develop within the boundaries of a project. However these key characteristics of a quality culture did not permeate routine management. The quality culture shift, expected from quality projects does not seem to have happened at organisational level. On the basis of this analysis, we discuss the potential and limitations of quality projects aiming to change organisational culture.

## Introduction

Quality improvement initiatives are now a fact of life for health care organisations in the industrialised world. This movement is now gaining momentum in developing countries. Many countries in the south embark on quality management programmes and are at various stages of development (Al-Assaf 2001b). However, the pace of this movement varies greatly. More importantly it appears that it fluctuates between periods of high enthusiasm and periods of depression where peripheral projects disappear and central quality offices enter in a state of lethargy until an internal or externally driven initiative or threat wakes them up.

In the quality movement one often hears that quality is a culture. On the other hand, organisational culture is a popular theme for research on management. For several years we are bridging concepts pertaining to the two worlds in order to better understand the interaction between quality initiatives and organisational culture (Blaise *et al.* 2003; Blaise & Kegels 2001; Blaise & Kegels 2002; Blaise & Kegels 2003; Blaise & Kegels 2004). Based in a Tropical Institute with a background of research in organisation of health care for developing countries, we are focusing our research on African health care organisations. What happens when quality management systems are introduced in African health care organisations and what is the potential to improve them: This is the question that drives our present research.

## Background and objectives of the research

### *Background of the quality movement in Morocco*

#### *The Moroccan Health System*

The cornerstone of the Moroccan health system is the '*circonscription sanitaire*' (CS), which corresponds to the primary care level. In most towns, the CS are staffed with one or several doctors and nurses. They offer general primary care services including curative and routine preventive services. They run many programmes conceived from the central level, overseen from province level and implemented in the CS by operational staff running all these programmes concurrently. The CS works under the supervision of the provincial office directed by a senior medical doctor called '*délegué*' and in charge of all health services of the province. Provincial

hospitals act as referral centres for the CS. Care is provided in these general hospitals by general practitioners and specialists. The administration holds a relative power in these institutions. The decentralisation has created another level: the regional level, which is still negotiating the power granted by the reform. University teaching hospitals (*Centre Hospitalier Universitaire*, CHU) operate in major towns. In these hospitals, medical students are trained and work under supervision of professors. There is indeed in these CHUs a more complex hierarchical structure, with non teaching medical staff beside university teachers.

### *10 years of quality assurance projects*

Quality assurance started in Morocco with quality assurance pilot projects in 1992. Central from the start, was the setting up of local quality circles running problem solving cycles facilitated by locally trained facilitators in order to improve quality of services. The pilots claim the approach stands on three pillars: quality structures & standards setting, quality monitoring, and quality improvement. However, the projects focused mainly on quality 'improvement', for 'standards' were actually set by the programme experts of the ministry, and 'monitoring' relied on the existing routine information system.

Much effort was devoted to training in the initial phase. Then activities started with an initial aim to be a demonstration site. The Tétouan region initiated the move. Enthusiastic cadres took the lead and strongly appropriated quality assurance principles as a lever to structure and streamline all activities in the province. Tétouan soon became a reference province for quality assurance and still is. From this initial experience, other projects were developed following different approaches or methodologies. The introduction of projects varied. In some places, the initiative was with the *délégué*. In other places it was proposed from above and streamlined though the usual hierarchic lines. In still other places it circumvented the hierarchy and was directly implemented in some CS without real involvement of the provincial health office.

### *Various models of quality assurance*

Different approaches have been developed. Our study identified four main approaches. The first one is the *Gestion Intégrée de la Qualité* (GIQUA) which is in essence a technique for problem solving in teams. It puts a strong emphasis on team work, facilitation and group dynamic, and rests on the systematic sequential application of specific tools and techniques. It was applied in Tétouan. The Souss Massa Draa region (SMD) applied a second version called '*Giqua amélioré*', which is less rigid in the application of the tool and proposes a flexible approach according to the context and the problem addressed. A third approach, the 'collaborative' approach, brings together many different sites around a common theme for quality improvement. The strength is in its systemic dimension. Its weakness lies in the complexity of working with many levels and teams. Another, fourth approach that we also considered as a quality improvement approach is the medical audit, mainly conducted in maternity services.

### ***Background of the research***

The aim of our research is to understand to what extent and how a health care organisation adopts and durably internalises quality principles as a result of the introduction of a quality assurance project. The subsequent objectives are to identify the factors that interfere with the process in order to identify the favorable contextual elements for the development of a quality culture.

Our focus is therefore on the phenomenon of appropriation by an organisation and its staff of the quality culture. Our research sites are therefore health care services and we remain very process oriented. The results in terms of effectiveness of these projects are only addressed to the extent that they contribute to the understanding of the process.

We conducted previous studies on the same issue in other countries as well as in Morocco. We anticipated that the quality culture is different and potentially clashes with the prevailing culture of health care organisations. However, we have shown that it differs from one context to another. In organisations where professionals are strong and enjoy a large autonomy, the

professional culture of autonomy is challenged by the standardisation of procedures emphasized by the quality movement, and this results in resistance and tensions between managers, commissioners and professionals. In command and control systems, however, a strong emphasis on standardisation may reinforce poor responsiveness to individual clients' expectations. On the other hand quality improvement means conformity to preset standards but also the recognition that care can be improved; thus the need to unfreeze practices, change practices and refreeze improved practices. Change is at the heart of quality improvement indeed, but change in command and control hierarchic systems is a challenge. This is the challenge we want describe in this paper.

## Method

### *Materials and methods*

Our research is a qualitative study exploring the perceptions of participants in quality assurance projects in five regions of Morocco. The data are collected in in-depth interviews, sometimes conducted individually, sometimes as a group interview. Focus groups around a specific question were also organised in each site. A guide was produced by the research team over a one week workshop to assist the sociologist of the research team who conducted the interviews. The week started by a briefing on the study aim, framework and research questions by the principal investigator (PB). The purpose of the interviews was to prompt a discussion about the experience, telling stories and expressing feelings. The questions did not directly address the research questions but rather prompted a discussion generating discursive material for qualitative analysis.

The topics (or themes) addressed in the interview guides were the (his)stories of the quality experiences and the quality cycles, comparisons with other sites, behaviour towards complaining patients, re-organisation (re-arrangements) of premises, pertinence of the quality approach in problem solving in general, support and training in quality assurance, (un)ease of implementation and essence of the quality approach

Between October and December 2003 field visits were conducted in five Moroccan regions by RA (interviewer) and AW (observer). AS attended most of the interviews, while PB attended the interviews in the two first sites.

The selection of sites to be included was made by AS, an officer of the directorate of hospitals and ambulatory care, after contacting several people from other directorates of the ministry of health and from international organisations who were involved in quality projects, and on the basis of her experience and in-depth knowledge of the situation.

	N of interviews per region			<u>Total</u>	Duration (minutes)		
	Tétouan	SMD	Fes		Mean	Min.	Max.
<b>Individual</b>	3	6	1	10	53	33	93
<b>Group</b>	2	7	7	16	55	42	120
<b><u>Total</u></b>	5	13	8	26			
<i>No audiotape, no transcript, no analysis</i>	2						

Table 2: Number and duration of interviews

Due to time constraints we restricted the analysis to 26 recorded interviews in three regions. Most of the interviews are group interviews (16), gathering at least two persons and at most eleven persons. All interviews lasted between 33 and 120 minutes (54 on average) (Table 2). A pragmatic approach was taken to recruit interview volunteers. We aimed to cover all settings (hospitals, outpatient centres and administration services), positions (regional delegate, medical

director outpatient centres, hospital director, facilitator or animator) and divisions (the different programme officers).

In December the four researchers met for a debriefing of the field visits and to discuss a first synthesis of the dominant themes made by RA, the sociologist who conducted the interviews.

The 26 tapes were transcribed. Most interviews were conducted in French; Arab quotes were translated in French and no links were made between position and setting of the originator and his quotes. Transcripts of the interviews were imported into QSR NUD\*IST software to code and compare themes.

We followed a framework approach for a thematic analysis of the data (Ritchie & Spencer 1994) In the first stage one researcher (NB) examined the transcripts for *a priori* themes, i.e. the research questions that were explored in the interviews, and emergent themes raised in the interviews.

In the next stage we reviewed the data coded according to these themes and we developed by discussion a set of more abstract, analytical themes. These analytical themes fit a framework of two axes of orientation in perceiving quality of care, according to three stakeholder perspectives, the perspective of the patient, the perspective of the hierarchic authority, and the perspective of the front line health workers themselves, considered at an individual level or the group level. This second stage coding was applied to the *a priori* themes and emergent themes, and also to the core stories of the quality experiences that were told during the interview.

## Results

### *Quality is mainly perceived as compliance to programme expectations*

Of 25 reported quality cycles, most addressed problems that fit in a health programme for which targets and performance indicators are set in terms of clinical procedures, population coverage etc. These vertical programs, described by an acronym, typically include family planning, normal antenatal consultations, maternal and child care, sexually transmitted diseases, high risk pregnancy, etc. Quality cycles on diabetes care (6) and hypertensive care (2) are recurrent in several health centres in all regions. Overcrowding of services is both addressed in hospital settings (2) and in ambulatory care centres (2).

Applying the classical "structure-process-outcome" framework of quality of care promoted by Donabedian (1966), almost all of the selected problems can be classified as problems of cost-efficiency of actual care, viewed from a process perspective and on the population level, for individual quality of care, as emphasised by Campbell (2000), does not appear as an issue. Problems of structure are present as well, as for example availability of insulin, maintenance and improvement of premises. But patient outcomes, in terms of health status or patient satisfaction are almost totally absent. A phrase like "*People are not satisfied at all*" (T1) is exceptional.

Most problems are presented as failures to meet (programme) standards defined in percentages (of population coverage).

*...;declining recruitment levels in antenatal consultations...ignorance of the program by pregnant women (T2)*

*...: the number of women seen in normal antenatal consultations that does not correspond to the number seen at the maternity (SMD6)*

*...decrease of average number of weighing for children from 12 to 23 months...Five weight records per year are necessary (T3).*

Even if the selected problem is not linked with a programme, the problem is most often reduced to the non-attainment of objectives, expressed by pre-determined percentages of population coverage, without attention for the context or the reasons why facilities and services are underused or overused.

*Why is the maternity not functioning? This means that objectives are not achieved. Indeed we had not achieved our objectives, thus we had a problem: how to make the maternity functions. (SMD10)*

But even more, population health needs are considered to coincide with targets of programs.

*Q: .. Have you already tried, at least in your health centre to address a problem which does not correspond to a programme with the quality approach? Can you think of an example?*

*R : No*

*Q : Does it mean that it never happened?*

*R : No, it didn't (T5)*

*With regard to programmes ... The only problem that the medical officer mentioned was the low utilisation of the maternity, I mean the women seen in the antenatal clinic and who do not come for delivery ... This is to me the only problem that I see relevant for quality intervention at the level of our health district. (SMD6)*

Pragmatic arguments are given to explain why quality cycles usually tackle programmes.

*Problems (arising outside programmes) are beyond your capacity. Outside programmes, [...] it is difficult. There are no indicators to measure. You need solutions and there are no indicators either. (F2)*

*There is a guideline for TB, for bilharzia, for what have you. There are 22 to 25 guidelines, 22 to 25 programmes. People don't think anymore but these guidelines are outdated. With communication, we found that we must move towards professionalism in communication. The time when you only tell people what to do is gone. (SMD11)*

This also reflects the emphasis given to locally vulnerable problems.

*...If I say that diabetic patients are not adequately supplied with insulin. I cannot do anything, that is a reality [...] I mean [lack of insulin is] a problem without a solution for the moment. (SMD10)*

*For example we solved the problem of overcrowding to ease the work, and the organisation, like for instance the mother and child room,... We organised a screen to make the patient feel at ease. It helped us in our job... because good job was disturbed ... Now the work is organised, thus there is an improvement... (F7)*

The cause of problems is restricted to the non-compliance of staff or patients with procedures. In that respect, putting things in writing takes precedence to the reality of an action.

*Another one checked the health education as an hypothesis; He found that health education is not done and that we do not have a register to record health education sessions. We checked all the records and found that indeed we were not giving appointments to the patients as it was not written in the records. (SMD3)*

*Thus at the beginning it was 25% of insulin which was not recorded, It was given but not recorded. (smd6)*

The need to shape services around the needs and preferences of individual users and populations (patients, their families and their caretakers) is almost absent. The reasons why services fail in reaching their targets is because patients fail to respond to the logic of the service delivery.

*The problems were the decrease in antenatal consultation intake, the ignorance of antenatal care by pregnant women... (T2)*

Accessibility (equity) is no issue. If problems are stated in terms of access to patients and more consultation time, patients are almost seen as the enemy. Equally, communication is seen as a means to convince patients to behave in a staff-friendly way.

*...following this [quality]cycle, we can afford them 7 to 8 minutes of consultation...For ourselves, we selected the most feasible solution, this is the reception at the entrance...we must get the work organised, this is why we put people outside with numbers and sick patients...they must stay outside and we let them enter bit by bit... this iron bars that you can see, we did not want to, but we had to put them, It is a pity but we thought it was necessary*

*when you deal with 600 people at once. They queue, we let 40 enter, we orient them to the consultation room or family planning, when they come out we let the next 40 enter. With these problem we thought we cannot fight this population without communication; If we communicate well, maybe a time will come when we can fight them... You have to talk to them whether they like it or not because if you do not communicate and explain, nothing will work... You need to orient them to diminish the flow otherwise you will never get things sorted out. And this training in health education...we need it to tame this population. (F3)*

Communication is a discovery, not only on the team level but also in addressing the patient population. Yet it is often meant to organise, to control, to 'domesticate' the patient population.

*You have to talk to them whether they like it or not because if you do not communicate and explain, nothing will work... we need it to tame this population. (F3)*

Rather unreasonable and patient-unfriendly actions are taken to enhance programme compliance. For example, hypertensive patients are asked to notify when they consult a private physician.

*...we find patients who go to the private sector but we ask them to let us know each time and to come here to check their blood pressure even if they go to private doctors ... (T3)*

If organisational issues are addressed, these are described mainly from a staff perspective.

*The facility was not adequate: patients queue outside. They are not happy, the doctor is stressed and the patient too. This is an uncomfortable situation, even for the patient (Fx).*

The actions or solutions chosen are equally conventional interventions such as continuous training of the staff members and patient education sessions. Self-criticism is virtually absent, except for the successful region of Tétouan, where several comments are made on the limits of conventional approaches to patient education and on the absence of innovative approaches.

*...Solutions that have been retained are education of the staff on ANC informing and educating women on the importance of ANC and revision of the antenatal women circuit in the unit...(T2)*

*With regard to the programmes, the solution is always health education. Outside the programmes there would be other problems and thus other solutions. (T6)*

Innovative or informal approaches exist but illustrate the dilemma faced by the health workers confronted with conflicting objectives and facing a shortage of means to perform adequately. To cope with an insufficient supply of insulin and non-compliance of diabetic patients, a centre adopted the strategy to give half of the needed doses free of charge and to deliver a payable prescription for the complement. In the meantime, they convinced diabetic patients to attend consultations by stressing the extra time and attention they will receive (F8)

In terms of performance indicators meeting standards, quality cycles in the region of Tétouan have been rather successful, whereas results are mixed in the region of SMD and rather negative in the region of Fes, due to discontinuation of the quality assurance process.

### ***Implementing quality improvement meets organizational constraints***

Stopping of cycles is attributed to several factors. Time constraints are prominent, especially in hospital settings where working in shifts makes it more difficult to attend to meetings. But also high staff turnover, poor premises and facilities are mentioned.

*The first cycle, it blocked... The paediatric ward works in shifts thus it was difficult for the team to meet ... (F6)*

*We had decided on fixed meetings nearly every 3 weeks despite our commitments: either we are on call or in the operating theater, or else in the consultation. (SMD11)*

Resistance of providers, especially physicians, seems not to be the major problem except in university settings, where it is mentioned.

*We have no problem with specialists... Unfortunately, at the end of the second cycle, the teaching hospital started... The head of department changed, now there is a professor with his*

*assistants. We asked the professors [to continue] but they did not react positively thus we stopped because even with the team we thought commitment was getting loose...(F6)*

Lack of involvement, participation of and recognition from local authorities is explicit in the Fez region.

*...The management we do is not quality management. If you consider the bosses we have. We are still dealing with traditional manners and shouting etc. Thus the whole team make efforts and expect the boss to listen to the team and see how far they moved. But the answer is simply that he does not have time and this and that.(F6)*

Lack of local involvement is attributed to a lack of training. Especially in one region, lack of a quality culture is seen as a matter of insufficient knowledge.

*The problem started right from the beginning because only the ambulatory care staff had had training... The paediatrician had the feeling the job was imposed on him. (SMD7)*

*Unfortunately also that did not materialise because people know nothing about the methodology. Of course they had chosen some topics and we had explained them how to proceed. But they were missing basic knowledge, they did not know the tools. As a result, it took a long time to progress and only a few sites, let's say 2 could make progress.(SMD4)*

*The other thing is that unfortunately there are many transfers of senior officials and they do not follow. They do not speak the same language. You speak about teams and team problem solving... but when the team has made a decision he comes and cancels everything in a minute. He does not follow-up, it is worse, he destroys.(F6)*

### ***The discovery of team work: a positive experience***

Irrespective of the results of quality experiences in terms of objectives, the majority of interviewees is positive and enthusiastic about their experiences, both on the personal and the team level. Even if teams failed in closing a cycle, they draw positive conclusions from the experience.

*... It is true that we did not solve everything but there is team spirit. We are together we talk about problems and we look for solution. It is already something... (F3)*

*...Mainly the team spirit came about: only by meeting every Wednesday afternoon around a table and drinking a cup of tea together, problems are seen the same way by all the personnel (F7)*

*We feel our work becomes of good quality...Just only for yourself, it gives you motivation to work ... also regarding the patient, he feels more at ease. When you do your examination, he feels relieved, you reassure him and you convince him to be compliant, and he becomes compliant. Before the patient knew he would not be examined anyway thus he used to send somebody to collect insulin. By giving value to these close contacts, it contributes to the credibility of the doctor ... (F8)*

*This approach must be encouraged at local level because trained staff like to work as teams. (SMD7)*

Happiness, satisfaction with the results is expressed both on the team and the personal level, almost in a passionate way. It is a common expression that quality can be applied anywhere, also in the family and personal context. On a personal level, the pleasure and excitement of acquiring new knowledge is emphasised. People talk the same language.

*What is positive about it is that it is a rich experience. We had the opportunity to meet with many consultants in various fields...Thanks to [the project] we managed to disseminate a quality culture at regional level. Before, if you talk about quality to a cadre, he would have answered, please talk about something else. Now everybody talks about quality (SMD4)*

Quality assurance is seen as an interesting novelty, an eye opener, a learning experience. Teams have only emerged after training, particularly in communication (TET1). Before quality experiences, meetings were run by the physician, who did the talking and the other participants listened (Tet2). It seems like changes only (especially?) occurred on a technical plan (TET6), people learned to confer, to consult all implicated staff members. Staff discovered team working.

Mutual respect, tolerance, transparency, solidarity (T1) are key words. The problem solving techniques make them less dependent from the hierarchy.

*When we ask them which problem they had, they speak about it and everybody feels at ease. Each time I facilitate a continuous training session, I keep time for discussion. They are free to discuss and it is a pleasure (F4).*

*... When we knew more about this quality, we found out that it was a unique approach. Before, when there was a problem, you would let the boss deal with it. Now at least we meet and look for a solution. ... We like Tuesday afternoons. (F7)*

The emergence of teams has (might have) indirect beneficial effects on patient care since team working enhances the appropriation of health care problems. According to Grol (2003) implementation is a process, in which behavioural changes are preceded by attitudinal changes. The following quote is a perfect example of being in the second phase, insight and awareness of own performance, in which a problem is seen as "my" or "our" problem.

*... But after quality, everybody adhered. Regarding the problem with insulin, before they would think it is a problem for the medical officer ... (SMD6)*

Team development is not seen as a threat to the system but rather as a positive experience that also relieves the day-to-day worries of the provincial delegate.

*It contributed to develop team spirit and to have analytical capacity. It helped to solve problems without having to call upon the hierarchy for just any problem. It helped to be innovative. People start to look actively for solutions at their level. I have less problems with these two centres compared with the others for things like electricity, or lighting, for example. (SMD9)*

Several people claim that the quality of care itself did not change, but Quality Assurance made it possible to demonstrate, to prove the quality of their work.

*With this quality system, if I send a women for an ultrasound, I wait for 2 weeks and if she does not come, we call her again and visit her at her door to know what happened. Before we even did not know she would have not come back. It does not mean we did not work, but... (SMD3)*

*Q: Since you started and beside this team spirit, did other change take place?*

*A: Many things. For instance, the light, before I would never have thought of putting in a bulb. Another example: we did not have a table for meetings. We took that one we repaired it, varnished it and use it for other administration meetings, for programmes meeting, and of course for quality meetings ... (SMD10)*

### ***Genuine ownership of the quality approach remains doubtful***

Involvement of health care practitioners in the definition and development of tools and targets to monitor quality of health care is seen as a key criterion for its success. The idea that an organisation is more likely to be committed to a project if it has been involved in its development is expressed by the term ownership.

Several indications suggest that only in the Tétouan region local ownership of the quality process is credible. Tétouan is perceived as being in the phase of consolidation of quality achievements while other regions are still in an experimental phase. Even if the quality programme stops, staff members claim they will continue to use quality principles. Several sites stress it is unjustified to compare their results with Tétouan. The Tétouan region has a long quality tradition since they were the first to start in 1992. The relative wealth of the region, financial opportunities, the availability of project funding, the vicinity of Spanish quality sites, staff stability, and local leadership provided a fertile breeding ground for quality. The role of the latter is seen as pivotal and it is felt that if the present leadership would fade, the present focus on quality would be seriously threatened.

Several interviewees (not all) express more critical opinions on quality experiences, more reflexivity on quality achievements. Only in the Tétouan interviews a critical awareness is shown that quality interventions are restricted to programmes and traditional actions like "health

education". They see this reflexivity as a result of their quality experiences. Interviewees express more awareness of the dangers to focus on specific programme objectives.

Lack of ownership and long term commitment and absence of criticism and reflexivity on the quality experiences cast doubts on the expectation that the quality process could be continuously applied. Frontline health care workers look at the quality interventions as just another programme and not as a new way of running services.

*When I arrived here I had suggested to the doctor to organise a training among us. We had started with tuberculosis. The one who knows teaches the others. It was nice. It was adopted.*

*Q : Why did you stop?*

*A : Because quality assurance came in (F1)*

*Q : Since that time you did not start a new cycle? Why?*

*A : Instructions. (F1)*

*Q : Do you intend to start again new cycles?*

*A : New sites ?*

*Q : new cycles in new sites?*

*A : Quality assurance cycles ?*

*Q : Yes*

*A : Why not.*

*Q : You seem not very...*

*A : Well, I understood, but it is difficult to convince others. If we only continue like this they will lose trust, all that is only talks.(F4)*

Dependency towards the central level is still high. The importance given to approval by the hierarchy is stressed. Yet, by working in teams, staff relations, staff culture and practices have started to move. The potential of non hierarchical relationships is acknowledged. Staff experienced the effectiveness of local decision making and local leadership. The following quotes show this ambiguity.

*Quality approaches have not been well explained... we do not accept things imposed on us ...The facilitator had to call central services to make sure people accept. (SMD7)*

*I wonder why we should always wait [until] we are called upon to meet. Why not meeting together ... As a head of department I cannot gather doctors, I do not have the authority. It is not for the administration to decide what we have to do but if we decide all together something, the recommendations will never be applied ... (SMD5)*

*The start was difficult .... Because it was not very official, it was an initiative from the department and thus it cannot commit all the staff, we cannot impose it. (SMD11)*

The interference of the central level with the emerging quality culture of innovation is often raised as an issue. For example, to address the problem of non-completion of hospital intake forms, a staff survey was done and staff education was undertaken to inform them on the importance of medical data. A new form was designed by the team but unfortunately, in the experimental phase of the form, a circular was received from the Ministry of Health, ordering the use of a new form, containing a field for diagnosis at entry but not at hospital discharge.

*A document for use at local service level, it should be reviewed by field staff. They should be gathered and told that to finalise this document they must bring their experience. But when things come from the top we have no option ... (F4)*

Failures of quality experiences and absence of local ownership are attributed to bureaucratic inertia and rigidity and absence of a longer term strategy for quality assurance. Starting at the root level, some evoke strategic mistakes that were made in restricting training in quality methods to a few health workers and cadres. Local staff complain that central level interfered in the selection of participants to some activities or special events related to quality and considered it a lost opportunity to express recognition for the work done. Moreover people that were put aside happened to also be considered as opinion formers within the health services. The launching of quality programmes without a long term strategic plan, resources, infrastructure and feedback undermines the credibility of the central level and the continuous character of the efforts for quality.

*We were also volunteers to be trained and take part in the training workshops. Unfortunately these workshops were not brought to attention to all the same way. For some seminars, we had been contacted but for [others] the staff which will be directly responsible for implementation had been forgotten. Then demotivation started. Central level got involved in choosing participants or imposing a quota... We also would like not only facilitators to participate in trainings, but also the cadres. They did not go for training, as a result they are not sensitised. (F5)*

*There is no feed back, we do not know whether it was achieved or not. There were also events that were organised but we had not been informed. (F5).*

Several interviewees in the region of Fes are openly negative on the local administration.

*...I do not want to speak about administration. In 90% of cases you cannot count on them. It tells you these are the means available and the ambulance is broken, don't ask me ... (F1)*

*...The whole team knows where the problem is. Everybody wants to be the first; the problem is that not all can be seen as emergency. This is a problem we cannot solve. It is a problem for the administration ... (F1)*

*No, neither the local authorities, nor the delegation. They don't do anything, they are useless... we chose a problem that we can address locally without external help. (F2)*

The profile of SMD interviewees is one of victims of a lack of vision and strategy, having missed the first essential phase in acquiring a quality culture, which is the (technical) knowledge. Changes in the SMD region are seen as too basic and restricted to the level of premises. The variety of quality approaches that have been followed in Morocco is perceived as a lack of consistency and vision.

*...: Soon we start with a method, we are injected another one. (SMD4)*

### ***The managerial perspective of quality is dominant. However, a professional perspective also emerges***

A recurrent question in (almost) every interview is about the essence of quality. The prevailing perspective on quality is a managerial one, as promoted by local and central authorities, emphasising local problem solving with limited resources to meet centrally defined objectives and targets. As a consequence, quality of care is related to organisational aspects, often staff-centred, and pertaining to working conditions and work environment as was shown above. However, as a result of their exposure to quality principles, health workers begin to express a wider vision of quality, revealing positive and also negative attitudes towards quality of care that are more typical of the medical profession. Medical doctors stress the care for the individual patient supported by up-to-date competence and equipment: a professional characteristic.

*...[quality is about] doing the right thing at the right place and in the right way. For instance for an injection it has to be done a certain way: it refers to competence....of the doctor. It is not the same as cooking potatoes. (F1)*

*For the records how are we going to do...There are say 30 patients, you must take the register and fill it in. How are we going to do a quality consultation if we must record in writing at the same time? (F2).*

*... Follow-up, good follow-up of ill patients . Staff must solve the problems. He should not care for any other problems ... (F7) If we manage properly what we have it is already quality management (SMD8)*

*Our wish is to improve doctor-patient relationships. When you operate on a patient, you visit him to know how he feels etc. But this is not medicine. (SMD5)*

*A1: ...Quality is about concerns for the patient, the benefit must be for the patient and for the staff. You need work in a good environment so as to be effective for the patient. The end point is the patient*

*A2: ... For me it is about doing one's job the way it should be done....(F2)*

*For surgeons, science is the scalpel, for the radiographers, it is the scanner. When you speak to them about organisation, optimisation, problem solving, they think it is only philosophy. (SMD9)*

### ***Synthesis of the results***

Quality management is perceived -and induced- from a managerial point of view. At stake is the attainment of coverage targets defined by central programmes, and quality relates primarily to the correct execution of the tasks and procedures. The interventions are essentially quality improvement activities through the implementation of quality cycles, engaged in problem solving using locally available resources.

The results are mixed and the continuation over time is doubtful. Reflection on the quality movement, on its aims and objectives is only expressed by a few individuals. Although the relevance of national health programme coverage objectives is not questioned, criticism is expressed towards the commitment and support of local and central health authorities in quality matters.

The importance given to the leadership, typically endorsed by the hierarchy, is prominent in all the sites. It is perceived either positively as a major factor for success and continuity, or negatively as an obstacle to local innovativeness. Any quality improvement initiative appears extremely dependent on the involvement of the hierarchy to provide support, recognition and, more importantly, legitimacy.

However there is general agreement that impressive progress has been made in team development. At local level, health workers, doctors and nurses discovered that they were able to tackle and solve some problems. Engaging in quality improvement had positive effects on quality of care by improving structural aspects of quality such as material working conditions and a more satisfying work environment. Quality experiences are thus seen as a learning discovery on the individual and team level, especially the acquaintance of communication skills and the benefits of teamwork. Teamwork was not only a more effective way of dealing with problems but was also a source of pleasure.

However quality of 'care' for patients is almost out of focus. The patients are viewed more as a means to an end rather than as the main focus of quality improvement. Responsibility towards patients only emerges as an issue in professional resistance towards the central level officials' agenda. Interestingly, the tension between programme outcome at population level and responsiveness to individual expectations is acknowledged and may represent an entry point to reconsider patient-doctor relationships. Only a few interviewees, and typically medical doctors, see quality as the use of competence for individual patient care.

## **Discussion**

### ***Validity of the results***

The site selection is a purposeful sample of sites followed by a purposeful sample of personnel interviewed. Given the time, resources and logistic constraints of our study, we did not opt for a random selection of all health staff working in the sites selected. We concentrated our interviews on the staff who were directly involved in quality activities. When an interesting divergence of opinion was expressed, we systematically sought for cross-checks in order to increase the variety of view points.

The time and resource constraints of our study did not allow a refined and systematic analysis according to variables such as sex, age, or more importantly, position or professional background. Likewise, our sample is a mix of group interviews and single interviews. However, the interpretation could correct for this reduced information thanks to the familiarity of some of the researchers with the field who could provide complementary information when unexplained discrepancies in the data were found.

In order to enlarge as much as possible our perspective, the work was done as a team. Diverse backgrounds were represented in this team, with two sociologists having different backgrounds, and three medical doctors with various background and experience. They hold different positions in research settings in Europe and Morocco, as officials in the ministry, or close to field operations. Multiple discussions have been held at all stages of the research and all along the field activities. In particular, the interview guide was elaborated during a week gathering all the research and invited resource persons.

The findings have been partially validated during a workshop attended by a series of key resource persons. Some were officials working in the health system, some were directly, others indirectly involved in quality assurance projects, some were part of the interviewees and others not. A feedback of the preliminary results was presented to them and they were invited to react. The results presented did not differ significantly from what the in-depth analysis later confirmed. The reactions confirmed the consistency of our findings with their personal experience. Moreover they could identify with the interpretation proposed. Interestingly, some of them viewed the feedback workshop as a welcome opportunity to revive the dynamic of quality assurance. They also viewed it as a form of recognition of their experience.

We did not seek a patient perspective from the patients themselves. This would have required resources we could not afford. The reading of our results and interpretation must consider this limitation in scope.

Our study sample cannot claim to represent a balanced picture of 10 years of quality assurance. However, as we relied on the memory of the officials working at the time of the study, and as the time span of our review intended to cover several years, we remained very open to interventions mentioned by local authorities and service providers and managers during the site visits. In each site, the provisional list of persons to interview and activities to study was reviewed in order to add relevant interventions in a snowballing process. Not all quality interventions, nor all public health centres or hospitals involved in quality management were scrutinised in each site. However, project reports or the review of the available documentation pertaining to interventions not included in our analysis do not suggest that they might have followed a divergent course of action. Moreover, given the centralisation of the system, it is very unlikely that our informant ministry would have not been aware of significant project. We are therefore confident that our selection is diverse enough to cover a wide enough range of perceptions to allow an interpretation useful to better understand the interaction between quality management and organisational culture.

However, our objective was not to evaluate in a systematic review the level of achievement of a quality programme; we rather intended better to understand the nature of the shifts in organisational culture that may have resulted from implementing quality assurance, and the potential of quality assurance approaches in creating a quality culture within the health system. We selected sites where it was known that specific quality activities or projects had taken place and had a meaningful impact, irrespective of their actual results. We were indeed mostly interested by negative experiences, mixed feelings or possible conflict areas.

### ***Interpretation of the results***

We can now discuss our results, going one level further in abstraction in an attempt to draw lessons. To do so we resort to several organisational models and theories that may enlighten and give meaning to our observations. In a nutshell, the Moroccan health system appears -and has been built- as a command and control hierarchical system, well adapted to the main initial objective of disease control, but conflicting with the dynamic, organic and innovative model proposed by the pilot projects for quality improvement.

#### *The Moroccan health system exhibits features of a command and control, rule based hierarchical organisation*

Our interviews have highlighted a poor client orientation, the patient being more a means to an end (i.e. programme achievements) than the real focus of the services. The interviews also

show a lack of outcome orientation in terms of health status or of service experience. Nearly only programme outputs are considered in terms of results, output expressed in terms of coverage and procedural compliance.

There is indeed a strong emphasis on procedures and tasks, transmitted through guidelines and instructions, mostly externally designed by programme experts at central level. The hierarchy, structured along vertical lines of accountability, is given paramount importance. To some extent this reflects a self-orientation of the organisation. The hierarchy conveys, enforces and controls procedures. It also plays an important role as a provider of recognition and a source of legitimacy, giving authority –or permission- to introduce change or innovation. All these features are typical of what is often referred to as a bureaucratic organisation.

The confrontation of our findings with organisational theory provides a useful framework to understand the phenomenon at work with the development of quality assurance. Weber's work on the legitimacy of authority considers the bureaucratic administrative type as an ideal-type of rational-legal authority: In the ideal-type of rational-legal authority, featured by the administrative bureaucracy, the employee is tied to the organisational purpose and achievement through a contractual relationship protecting the employee from the arbitrary control of the employer. The employee voluntarily submits himself to the explicit rules and procedures set by the organisation and controlled by a hierarchical chain of command whose employees' activities are also regulated by a formal contract (Weber 1947) cited in (Weber 1997). Weber's work explains the rationale of the organisational behaviour reported in our interviews. The absence of personalisation of function supports the rationale for the high turn-over of cadres. The importance conferred to the rules and procedures is the means by which bureaucracies attain their goals whatever the commitment of their employees who so remain free and may distance themselves from the ultimate goals of the organisation.

Crozier, studying power control in big organisations describes what he calls the 'bureaucratic phenomenon' (Crozier 1963). He postulates that individuals seek power to keep control over their lives. In big organisations, the mechanism individuals use for power control is to enlarge the area of uncertainty attached to their work. One of the mechanisms to do so is to play with the necessary interpretation of rules, regulations and procedures so as to reduce the control supervisors have over them and, in their turn, to increase the power they have over their own subordinates. This corresponds to what he calls the bureaucratic phenomenon, which results, he claims, from the way the organisation is structured. As a result, goals are 'displaced' and the prime mission of the organisation may be grossly distorted. Further elaborating with Friedberg, Crozier states (Crozier & Friedberg 1977a) (p386) that employees "*unconsciously oppose initiatives that threaten their autonomy and reorient change in order to maintain or reinforce the area of uncertainty which they control.*" In our observations, this is exemplified in the way staff consider patients, sometimes portrayed almost as enemies to be fought. It also enlightens the reluctance of senior officials to surrender the power attached to rules and procedures to a quality process that functions out of hierarchical control, emphasizing horizontal organic relationships. One way for the hierarchy to keep control is to reduce the room for decision making and action to what is only actionable at strictly local level. This of course reduces the scope of quality improvement. Although the tension between conflicting goals is sometimes mentioned, the quality assurance process was indeed not meant to put into question national strategies and lines of command.

Mintzberg, studying organisations, established a typology of organisations. He identifies the mechanisms of coordination as a discriminative element. He describes the characteristics of what he categorises as a 'machine type of organisation' as follows: coordination of tasks through standardisation of procedures, externally designed by a 'technostructure', conveyed and controlled by a strong hierarchic line of command and control and executed by an operating core of workers. By contrast a 'professional type of organisation' coordinates its activities through the standardisation of the skills of a core of professionals enjoying a large autonomy (Mintzberg 1989b). The standardisation of skills resorts to a long process of training and socialisation, which ensures that professionals exercise their discretion in clinical decision making in the interest of the patient and conform to what their peers recognise as good practice. This model is consistent with features of the ideal type of professionalism described by Freidson (Freidson 2001). The

way the Moroccan health system is perceived by some of its actors to function shows consistency with the machine type of organisation described by Mintzberg. Procedures are designed by programme managers and central level officers -the 'technostructure'- conveyed through a hierarchic line -the 'middle line'- for implementation by health centres and hospital health workers -the 'operating core'- with a strong focus on compliance to procedures. Although health workers are trained as 'professionals' the work does not do justice to their potential for autonomy. Yet when discretion is granted in decision making, as happened within the quality assurance projects, then this is positively appreciated.

The organisational characteristics that come out of our interviews is not a surprise. The Moroccan modern public health system has been built as a bureaucracy, rightly considered as the most effective way to implement a series of disease control programmes. The health system is pyramidal with a strong hierarchical chain from central level 'directorates' to health '*circonscriptions*' (primary care level health centres) through regional and provincial offices. The health centres implement the procedures designed by the programmes' experts. This design is logical according to Mintzberg's theory of contingency. At the time when the system was built, the environment was rather stable, the goal was the control of well identified diseases affecting populations, rather than individual response to complex needs and suffering of individuals. Disease control objectives were achievable through well identified strategies amenable to standardisation. This possibility of standardisation of procedures and subsequent delegation of tasks was most welcome given the initial scarcity of highly qualified medical staff. This design, however, is less adequate when the epidemiological transition shifts emphasis to chronic degenerative diseases, which require more responsiveness to individual expectations and long term relationships in order to enable individuals to cope and achieve a meaningful life.

However, these models of hierarchical command and control rule based organisations do not perfectly explain the wide gap between the actual behaviour -and misbehaviour- of frontline workers and the expected behaviour -given the mission of the organisation- supposedly streamlined by the rules and procedures. Lipsky studied the critical role played by front line personnel in public service policy implementation (Lipsky 1980). He postulates that the public health workers who interact directly with citizens have actually a wide area of discretion in carrying out their work. This discretion stems from the nature of their job which requires the application of supposedly impersonal procedures to individual singular cases. The conditions in which they work are typically characterised by inadequate resources to perform their tasks; a demand exceeding supply; ambiguous and conflicting goals within the organisation; intangibility of outputs that are difficult to measure; and the non-voluntary characteristic of the clients (patients have little discretion in the decision to be ill or to belong to a programme target population), left with little or no alternative to seek service. According to the 'street level bureaucracy' theory of Lipsky, these characteristics explain why frontline workers are forced to ration services so as to reduce excessive demand and deal with scarcity of resources. They cope with this tension by 'creaming off' those who will deserve service. Several of our interviews show this coping mechanism, which forces workers to depart from their professional ethics or state of the art procedures. They deal with this dilemma by redefining their role and mission in a way that reduces the role conflict. Because performance is hard to measure and people have nowhere else to go nor the choice not to be sick, health workers have no incentive to put patient satisfaction at the centre of their work. Lipsky goes on explaining that attempts to improve accountability through new performance measurement and control devices are likely to fail because of the plasticity of coping mechanisms in the case of street bureaucrats. He rather suggests, on the one hand, to change the structure and the context of the work opting for the enhancement of professionalism (for the control of professional groups must come from within the group of members), and on the other hand to empower the citizens in order to make them a reference group rather than clients to be processed (Hudson 1997; Lipsky 1980).

*However, all quality projects emphasise non hierarchical relationships, team work, and innovation.*

All the projects that were reviewed emphasise team collaboration. They break hierarchical lines at service level. Staff start to talk to each other instead of communicating from one office to the one next door through three hierarchical layers going through the regional capital city. All

projects encourage the implementation of innovative solutions. However, the very strong emphasis given to seeking locally vulnerable solutions also significantly narrows the boundaries of quality assurance's field of usefulness. Despite this limitation the flexibility and openness to innovation was greatly appreciated, showing an encouraging receptivity on the part of the public health services staff. Local actors felt empowered and some seized the opportunity to grow -in a professional sense of the term.

However, despite an obvious potential, the pilot projects did not really question the system. The shift towards the patient remains very timid and does not reflect a profound change in the perception by the staff of the role citizens and civil society could play. Likewise, conflicts between individual and collective objectives of some programmes are acknowledged. The staff sometimes acknowledges that the system claims that what counts is the patients' demand, but at the same time exerts pressure on the staff to achieve significant coverage with health projects even if this means enforcing procedures on patients. Still the quality assurance projects have not been taken as opportunities to address these contradictions and tensions, prominent in all of the project settings. A subtle equilibrium has been reached between the health system's tradition and the project culture so as to avoid areas of confrontation. One may view it as a missed opportunity to shake the health system and force it to move towards more flexibility and responsiveness. One may also view it as a first step for the quality culture to gain recognition.

In addition the greatly appreciated horizontal relationships developed in the quality projects, suspending hierarchical lines, go paradoxically together with a very strong need of recognition from the hierarchical line. Even when the hierarchy encourages autonomy and promotes empowerment, the staff seek recognition for the good work done and legitimacy for its action from the hierarchical line, always mentioned, while two other important providers of recognition, peers and patients, are almost never mentioned.

Eventually, the importance of the patients starts to be acknowledged. However the patients remain a target for interventions. They are not really considered as partners, nor is the defence of the patients' interest, above that of the organisation really emphasised. The quality approaches sensitised the staff to a more responsive and autonomous attitude, accountable to peers (not only the hierarchy), but other dimensions of professionalism such as patient-centredness (Fehrsen & Henbest 1993; Henbest 1989; Mead & Bower 2000) are still poorly addressed.

*Quality assurance pilot projects apparently failed to effect a profound transformation of the health system towards a more flexible and responsive organisation.*

The permanence of a strong command and control hierarchical culture in the health system after ten years of pilot project, even in sites where it was vigorously implemented, suggests that a major transformation of the system did not occur as a result of the quality projects. However this does not mean that a positive preparedness in some areas toward major shifts in the system would be excluded. Only future developments will provide an answer.

The quality culture emphasizing local initiative, innovation, systematic documentation, team work and non hierarchical relationships could flourish within the system as exemplified in many interviews. There are, however, signs that it may not survive the projects' end. The international support to the Tétouan quality project ended the very day of the start of our interviews. The confidence in the relevance, and to a lesser degree in the future of quality was remarkable among the personnel at all levels. A close monitoring of what will happen to quality assurance in Tétouan in the coming months and years will be crucial to better understand the complex dynamic between projects, quality improvement initiatives and organisational culture.

The findings of our study are consistent with the view of Kolb (Kolb 2002b) that quality management is a subtle articulation of successive phases: eliciting actual processes; challenging them to change existing practices; consolidating new practices. It refers to the dialectic between rigour and creativity: "Too much of the former, sterile rigidity dominates; too much of the latter, sterile chaos follows". We previously acknowledged this tension in several case studies (Blaise & Kegels 2001; Blaise & Kegels 2002) and argued that the challenge of quality management is less

mastering tools and techniques and more managing the tension between on the one hand conformity to standards and on the other promotion of change and creative innovation.

However, we also raised the question of the potential of quality management to transform the culture of an organization (Blaise & Kegels 2002). Our study does not permit to be very confident that this will happen. From the findings of this study, we can formulate an hypothesis as an intermediate and provisional theory to explain the paradox of cohabitation between the quality culture paradigm and the command and control paradigm:

It appears as if the Moroccan health system, structured as a command and control hierarchical organisation, allowed innovation, creativity, local initiative and non hierarchical relationships as long as they developed within the boundaries of a 'project'. However these key characteristics of a quality culture did not permeate routine management. The quality culture shift, expected from quality projects did not happen at organisational level.

If that is the case, then there are consequences for the strategy of pilot testing quality projects with the aim of scaling up successful approaches. If, as our findings tend to show, a bureaucratic system only tolerates innovation creativity and horizontal lines of accountability within the boundaries of a project, but naturally kills the initiative as soon as it is left out of its shell, then the research priority is to understand better how a bureaucratic system can be transformed and how quality culture can be developed in such a system *outside a project context*. In that case the multiplication of successful pilots would not increase relevant knowledge. The answer to this challenge may well be that a bureaucratic system can only be 'bureaucratically' 'de-bureaucratized'.