

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 organizational models

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SUMMARY

The quality movement is gaining momentum worldwide in the field of health care. Initiated in industrialized countries, it steadily grows in Africa. However, there is no evidence that approaches designed to address issues in a given organizational 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 organizational models to compare the configurations of European and African health care organizations 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 emphasizes standardization of procedures, a characteristic of a mechanistic organization, while excessive standardization 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. Copyright © 2004 John Wiley & Sons, Ltd.

KEY WORDS: 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 industrialized countries while developing countries still struggle to develop a health system able to

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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 and 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 organizations, 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 and Heaton, 2000; Buetow and Roland, 1999; Campbell *et al.*, 2001; Grol, 2000; Scally and Donaldson, 1998).

In most African countries, despite significant and successful efforts over the past 20 years to extend health care coverage, increase access and improve efficiency through rationalization of resources, curative services remain poorly functioning and under-utilized. Quality of care remains questionable and is questioned indeed by service users when they can voice their concerns (Haddad *et al.*, 1998; Jaffré and 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 and Waelkens, 2003).

In this time of globalization, 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 past decade (Dwyer and Jezowski, 1995; Silimperi *et al.*, 2002; Whittaker *et al.*, 1998). However, health systems are complex organizations and there is no evidence that an approach designed to address issues in a given organizational context have the same effect in another context where issues present differently, as was already suggested by Criel and Van Dormael (1999) about health insurance.

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

Our premise is that the interaction between the quality movement and organizational 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 organizational configurations of European and African health care organizations 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 organizational configuration of health care systems. We deal with this complexity with a modelling approach using the organizational models developed by Mintzberg (1979). We recognize that our methodology oversimplifies heterogeneous situations. Not all health care organizations 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 study later in more 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 the first part we describe the main organizational features of European and African health systems. In the second part, we describe the main features of the quality movement in both systems and identify how it impacts organizational culture and structures. We then propose and discuss an interpretation of these trends. We argue that the organizational 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 standardization and external control to increase accountability may reflect a shift towards a mechanistic type of organization, challenging professional autonomy, and triggering reactions from professionals to regain control or to resist, while in Africa, it reinforces the extreme standardization 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 organizations when they embark on quality management? Our purpose is to gain insight in the dynamic interactions between the quality movement and the organizational configurations of health care systems. Embedded in a broader research, this paper represents a first step in understanding these interactions in various contexts. It synthesizes, puts in perspective and interprets the current trends in the quality improvement movement in health care organizations. 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 organizational culture and structures of these different health systems.

In order to study organizational changes—or resistance to change—in various contexts, we need an understanding of the overall trends in organizational

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, 2002; Pawson and 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 on how quality management interacts with organizational 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 organizational 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 organizations in the field of development, public administration and policy. A third information source is the literature over the past 10 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 scrutinized over the past 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 collecting 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 organizations

Another challenge is to characterize 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 organizational model developed by Mintzberg after extensive studies of the structure of organizations (Mintzberg, 1979). Used as an analytical framework to characterize the configuration of an organization, this model is sufficiently generic and at the same time specific enough to identify general features and trends across a wide variety of organizational 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 organizations.

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 coordination of these tasks to accomplish the activity'*. Therefore *'the structure of an organization can be defined simply as the sum total of the ways in which it divides labour into distinct tasks and then achieves coordination among them'*. From this statement, he proposes a model to describe an organization and six different coordinating mechanisms corresponding to six types of organizational structure.

According to Mintzberg, the structure of an organization has five basic parts (Figure 1).

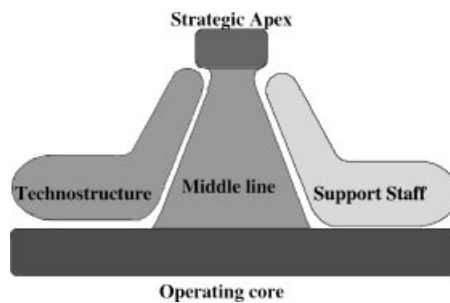


Figure 1. The five basic parts of organizations (adapted from Mintzberg, 1979)

'The **operating core** of the organization 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 organization 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 organization. [...] 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 standardization in the organization; 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 specialized, exists where **support staff** provide support to the organization outside the operating work flow.' (Mintzberg, 1979) If all these parts can be found in every organization, their relative importance varies greatly from one organization 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 organization and they coordinate their activities.

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

Mintzberg describes five coordinating mechanisms. *Mutual adjustment* with informal communication between operators; *direct supervision* when one person delegates tasks through instructions and controls the work; *standardization of procedures* where analysts, external to the operating group design and program the tasks; *standardization of outputs* where deliverables are fixed rather than how these should be achieved and *standardization 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 coordinating mechanism, *standardization of norms*, meaning that an organization intentionally develops, with the contribution of analysts, a shared vision of the organization's mission and expects the operators to comply with this vision.

Mintzberg then distinguishes six main organizational types, according to their structure and their coordinating mechanisms. Our analysis mainly refers to the machine type and the professional type (Figure 2).

The *machine organization* coordinates its activities through standardization of work processes; the 'technostructure' which designs procedures is its key part. The *professional organization* coordinates its activities through standardization of skills and qualifications; the Operating core consisting of independent professionals is its key part. The *entrepreneurial organization* coordinates its activities through direct supervision; the strategic apex is its key part. The *divisionalized organization* coordinates its activities through standardization of outputs; the middle line, which takes overall responsibility for a set of activities, is its key part. The *innovative organization (adhocracy)* coordinates its activities through mutual adjustment; the support staff and the input and opportunities for connections it provides is its key part.

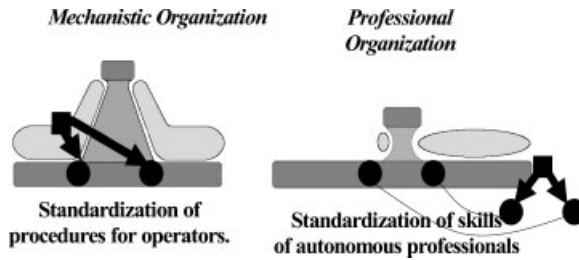


Figure 2. The machine type and the professional type of organization (adapted from Mintzberg, 1979)

The *missionary organization* coordinates its activities through standardization 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 organization’ (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 organizational 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 ORGANIZATIONAL FEATURES

Most European health care systems correspond to a ‘professional’ type of organization

The shape taken by health care systems stems from the history of health care organizations 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 recognized as teaching and research institutions.

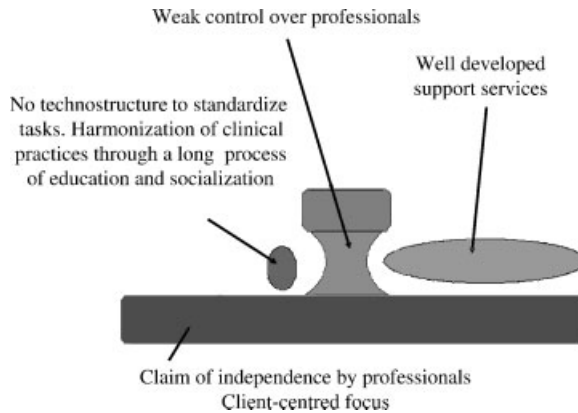


Figure 3. The European health care system: a professional type of organization

This partly explains why most European health care organizations show the characteristic features of the professional organization according to Mintzberg, namely standardization of skills as coordinating 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 organization; problems with regulation and power control resulting in tension between professionals and administrators; highly motivated operators personally responsive to clients' needs (Figure 3).

In European health care organizations, the coordination of health care activities mainly relies on the standardization 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 organization'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 coordinated way, health care systems standardize 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 socialization. The result of this process allows what Mintzberg describes as 'pigeonholing'. Health problems are categorized as belonging to a specific cluster, be it a specialty 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 organization.

The most distinctive part in European health care organizations is their powerful operating core: professionals provide medical services and concurrently exert, to a large extent, control over the organization. Unlike in manufacturing organizations, 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 organizations are not completely powerless but their position is much more one of a 'go-between' than is the case in a machine type of organization.

The description above equally applies to hospitals, one of the most visible health care organization types, as to primary care services. One can consider the whole of primary care services in most European countries as one single virtual organization. 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 standardization of skills through initial and continuous education under peer control that ensures the coordination 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 coordinate 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 organizations. 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 have not 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 feature typical of a professional type of organization. Another feature of such a professional configuration as pointed out by

Mintzberg (1989b) 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 specialization, hence the development of sub-specializations 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 organizations 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 and 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 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 organization

As for European health institutions, the organizational configuration of African health services partly stems from its historical background. For a long time and largely up until now, African health systems have been dominated by public services. During the first half of the 20th century, the colonial power shaped the health system around three elements (Van Lerberghe and 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 centralized despite strong advocacy for decentralization for 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 organized 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-1980s the health sector of many African countries has seen an expansion of its network of health facilities[†] (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',[‡] 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, standardization was seen as key to allow safe delegation of tasks to low qualified

[†]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.

[‡]The 'Bamako Initiative' was launched in 1987 by WHO and UNICEF to revitalize primary care services and was implemented in most African countries during the past decade.

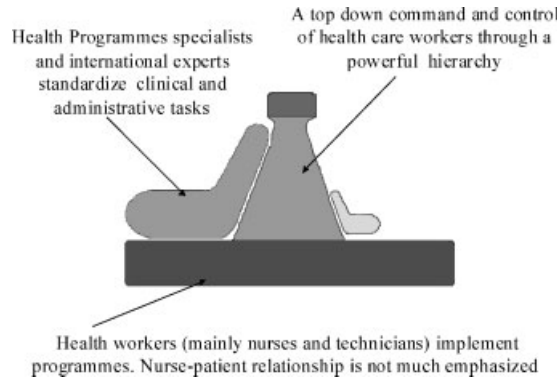


Figure 4. The African health care system: a machine type of organization

staff (Van Balen and 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 organizations present features predominantly of a 'machine type' (and in part of a 'divisionalized' type), in Mintzberg's terminology. Indeed, these features are standardization of procedures as a coordinating mechanism together with standardization of outputs from disease control programmes; importance of a technostructure elaborating standardized instructions; the pre-eminence of a strong hierarchical middle line; control by direct supervision; and low focus on the direct patient-provider interaction (Figure 4).

Standardization, 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 standardized 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 standardized clinical management decision issued from the 'ordinogramme'. The latter synthesizes 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 emphasize a tight stock control of drugs and medical equipment. Authorized 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 Immunization, Mother and Child Health programmes, Family Planning programmes are equally strongly regulated by protocols and standard procedures and largely use standardized data collection tools.

All these approaches to rationalize the efficient use of resources and to ensure an acceptable level of quality of care correspond to what Mintzberg refers to as 'standardization of procedure'. It ensures coordination 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 immunization programmes,[§] or in Mintzberg's terminology 'standardization 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 organized 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 immunization status and if necessary immunized. 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 standardizing 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 familiarize 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 characterized by a strong hierarchical structure. The ministries are usually organized in divisions in charge of specific

[§]Eighty percent is a mythical number for immunization programmes. It is indeed the immunization coverage rate which permitted the successful eradication of smallpox, the only communicable disease so far eradicated in the world.

programmes or services like hospitals, primary care services, immunization, 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 divisionalized 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 coordination of the health services delivery by the health centres, the hospital and the programme specific services if any (mobile team for immunization, family planning unit and so on). Within the divisionalized 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 organization with strong hierarchical lines. However, among these services, the hospitals run by physicians, share similarities with the professional type of organization 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 decentralization of decision making power is also a characteristic of the 'machine' type of organization, still according to Mintzberg typology.

The organizational 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.

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 technostructure 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 10 years of such a revitalization 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 and 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 standardization 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 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 organization.

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 such as 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 STANDARDIZES PROCEDURES. IN AFRICA, EXCESSIVE STANDARDIZATION IS PART OF THE QUALITY PROBLEM

In Europe, the quality management movement emphasizes the standardization of procedures, which is characteristic of a 'machine' type of organization

For years, the industry has developed a 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 and Marshall, 1999; Houdart *et al.*, 1998; Houdart *et al.*, 2001; Houdart *et al.*, 2003; Malye *et al.*, 1997; Nutley and Smith, 1998). In France, the publication by the magazine *Science et 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 and 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 formalization 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 and 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 and Sweeney, 2001; Grol, 2000; Hibble *et al.*, 1998). In the 1990s, 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 noncompliance, 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 and 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 standardization of procedures, a typical feature of a 'machine' type of organization. The managers' role in guidelines development brought them closer to clinical decision making and subsequently increased their influence. External organizations such as the Cochrane collaboration play an increasing role in the design of evidence based recommendation and serve as a reference for designing guidelines. This externalization 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 organization 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 emphasizes a comprehensive approach to quality and views it mainly as a dynamic process, involving a whole organization 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 rationalization 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 an increase of resources rather than rationalization.[¶] Eventually they see the quality movement as an intolerable shift of regulating power from professionals to managers, which threatens their professional autonomy (Sutherland and Dawson, 1998). The reaction, however, was different on both sides of the Channel (Laplace *et al.*, 2002). In France the health profession is represented by three kinds of institutions: the *Ordre des Médecins*, the trade-union organizations 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 3 to 5 years and they now lobby for the development of formal quality management procedures (Chabrol, 1999). However, this shift is contested within the organization 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 *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 organizations 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 and Stretch, 2003; Rothman, 2000; Southon and 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 organization), 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 and 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 organization towards a machine type of organization. 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

[¶]The need to increase resources for the NHS is now recognized in the UK.

a professional type of organization 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 organization: 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 standardization 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 industrialized countries. Patient focus and more specifically patient-centredness is pivotal for the quality movement (Fehrsen and Henbest, 1993; Henbest and Fehrsen, 1992; Mead and Bower, 2000). However, it is ironical to see that in Africa the extreme rationalization of the consultation process, another asset of quality management, is part of the quality problem. The standardization of procedure in Guinean health centres was introduced on probably the largest scale ever. For more than 10 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, immunization coverage increased from less than 5% in 1986 to 61% in 1993, 51% of pregnant women have three 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 utilization 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 recognized by the guidelines (the ordinogrammes), and that the same treatment, 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 organization (Crozier, 1963).

It is worthwhile to note that in the first experiences of standardization 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 the 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 allowing 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 professionalization of auxiliary personnel, subsequently implying more independent performance and more responsiveness to patients' needs (Van Balen and 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-professionalization in the absence of enabling factors such as the specific characteristics of supervisors (Blaise and Kegels, 2002). Such an evolution is precisely what is feared by professionals when standardized 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 solve problems locally (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 emphasizing 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 2 years producing a league table of performance of health centres yet without any intervention to address the highlighted problems.^{||} 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, 2000). Indeed, especially in a bureaucratic

^{||}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.

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 change profoundly the working relationships and hierarchic lines of command and control.

UNDIFFERENTIATED APPLICATION OF QUALITY MANAGEMENT TECHNIQUES IS NOT A MAGIC BULLET

Standardization and responsiveness: searching for a balance

The challenge of the quality movement is to find a balance between the perverse effects of the over-standardization 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 organization on the other hand. The comparison between the quality movement in Africa and in Europe shows two distinct systems of logic (Figure 5).

Whilst in European health care systems the concern is to rationalize the work, externalize its control and to increase accountability to the public, in African health systems it should rather be to improve the capacity to deal with complex situations, internalize 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 standardization, 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

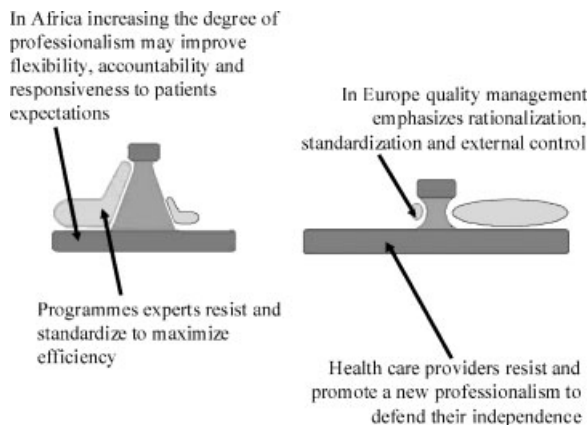


Figure 5. European and African health care organizations: the relationships between the quality management movement and the structure of the organization (based on Mintzberg)

possible and to what extent it would profoundly and durably influence professional behaviour and change the organizational configuration. This raises questions and comments.

Changing organizational culture and structure, a relevant task for the quality movement?

We can question the feasibility of curbing 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 organization 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 organization towards a professional type of organization 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 out with the bathwater. This paper should not be interpreted as an advocacy for re-engineering health care systems as professional organizations. 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 and 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 conceptualized professionalism in an ideal-type which '*can both organize 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 assume wrongly that organizational 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 organizational structures and types of health care professionals. However, elements of the professional model are emerging in parts of Africa (Dugas and

Van Dormael, 2003). 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 the 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 organization 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 organization 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 organization (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 organizations, recognized 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 organizations behave as they do, face the constraints they face and deal with them as they do. We argue that the organizational 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 organization dominates, the emphasis on clinical practice standardization and external control to increase accountability reflects a shift towards a mechanistic type of organization, challenging professional autonomy and triggering reactions from professionals to regain control or to resist, while in Africa it reinforces the extreme standardization 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 organizational 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 organizational context. High 'professionalism' is required in quality management itself; professionalism in the sense of capacity to operate in particularly complex, i.e. not standardized-situations. Quality management itself cannot be a 'Standard Operating Procedure'.

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

In health care systems structured as professional organizations, quality management approaches emphasizing standardization of clinical processes and reinforcing control to increase accountability, reflect a shift towards a mechanistic organization, 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 emphasizing standardization and control of processes often reinforce the mechanistic characteristics of the organization, 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 organizations indeed (Iles and Sutherland, 2001).

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