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CLINICAL RESEARCH

Improving Performance of Healthcare Quality through a Case Study called 'Quality Competition' in Primary Health Care Facilities in Morocco

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ABSTRACT

BACKGROUND

Since 2000, the Moroccan government has introduced several reforms in the health sector, prioritizing quality and safety of services. The number of facilities adhering to QC has increased at the primary, secondary, and tertiary levels (Ministry of Health, 2018). The Ministry of health in Morocco implemented a quality program called "Quality Competition" 'QC', focuses on the quality of management. This program was implemented from 2007 award to improve the Moroccan health care quality. The 'QC' combines several approaches self-evaluation, audits, improvement Plan, health center ranking, awards and performance disclosure. Our study aims to analyze and evaluate the Quality Contest 'QC' implemented in health care structures in Morocco between 2007 and 2018.

METHODS

We opted for a qualitative and quantitative study. A critical analysis of the data and information collected. Gathering and collection of data, analysis by a grouping and a graphic presentation of this information then the interpretation of the results. We conducted a detailed content analysis of this study and the lessons learned from it.

RESULTS

The mission of the MoH was to foster the continuous improvement of the quality and safety of healthcare facilities, services, and programs through developing accepted standards, building capacity, and awarding performance. The Ministry of Health works at the local level by building the capacity of health professionals to improve quality and patient safety. Training empowers professionals to become agents of change in primary health care (PHC) centers. A study conducted by Sahel A. et al. (2015) found that the quality competition had a significant positive impact on leadership commitment, employee involvement in quality improvement activities, and teamwork, and increased the use of continuous quality improvement strategies.

Prospects for Further Success. The MoH has evolved from an accreditation agency to an organization those partners at the micro, meso, and macro levels to improve quality and safety of healthcare services.

Transferability of the Exemplar

The ‘QC’ faces many difficulties in being taken as a model for improving the quality of health care at the national level. That is why Morocco is beginning to think about changing the ‘QC’ into a national accreditation agency.

Originality

The paper reports an original quality improvement approach in a developing country that succeeded in triggering sustainable improvement dynamics by combining support (feedback) with reward (prizes) and pressure measures (ranking, performance disclosure).

KEYWORDS

Quality competition; Contest; Quality approach; Quality improvement

INTRODUCTION

Health system reform can be defined as a process of fundamental change in policy and institutional arrangements designed by the government to improve the functioning and performance of the health sector with the aim of achieving better health outcomes. The health system is considered complex, its complexity is characterized by: 1) numerous processes; 2) multiple and constantly evolving professions; 3) a particular sociology; 4) a quality of products that is difficult for professionals and patients to grasp; 5) a difficulty in identifying and valorizing the effect of quality approaches. The WHO has defined the health system as "all activities whose primary purpose is to promote, restore or maintain health" [1]. Improving the quality of care has become a primary objective of all health authorities [2]. After more than a decade in the field of quality of care, what is the impact of the quality approaches undertaken on performance within Moroccan health care institutions?

Morocco has undertaken several attempts to reform its health care system since its creation in 1959. The objective of the reforms is to prepare it to better respond to the increase in demand for care and to act on the difficulties encountered: 1) financial; 2) organizational; 3) acute human resource deficit and demographic transition; and 4) epidemiological. A recent analysis of the Moroccan health system revealed five major dysfunctions: 1) Difficulty of access to health care for the population, especially in rural areas; 2) A very large deficit in human resources; 3) Insufficient financing; 4) A crisis of confidence in the health system; 5) A deficit in governance at all levels [3].

The provision of care is governed by eight principles [4]: 1) solidarity and empowerment of the population; 2) equal access to health care and services; 3) equity in the spatial distribution of health resources; 4) intersectoral complementarity; 5) adoption of the gender approach to health services. 6) Integration and coordination 7) Comprehensiveness 8) Graduation of care. The function approach is privileged, six functions are defined: 1) Service delivery Human resources Information Medicines, 2) Vaccines and technologies Financing General administration 3) Governance 4) Improvement of health (level and equity) 'Responsive Ness' (Responsiveness to the expectations of the population) 5) Protection against financial and social risks 6) Improvement in efficiency [5]. The health care system in Morocco is Pyramidal, Integrated, Hierarchical and based on Primary Health Care [4].

Berwick translated the Quality Chasm aims from the patient's perspective: "To have health care with no needless deaths, no needless pain or suffering, no unwanted waiting, no helplessness, and no waste" [2]. The IOM defines quality as "the ability of health services for individuals and populations to increase the likelihood of achieving desired health outcomes, consistent with current professional knowledge [6]. Quality of care has five components: medical effectiveness; compliance with scientific standards accepted by the highest authorities in the field; adequacy between the services offered and the needs of patients; safety (minimum risk to the patient); and economic efficiency, which allows for optimal use of available resources for equal quality [6]. According to the Institute of Medicine [6], and World Health Organization [7]: a health system seeks to make improvements in six areas of quality: "Effective, Efficient, Accessible, Acceptable/patient-centered, Equitable, and Safe. Morocco has opted for the same elements of definition of several organizations: Effective; Efficient; Accessible; Acceptable/patient-centered; Fair; Safe [8]. Several quality approaches have been developed over the past few decades [9]. Although there are no differences in objectives, the interventions and principles underlying these quality approaches are quite varied [10].

Demography of Morocco

The total population of Morocco is about 33.8 million inhabitants. The annual demographic growth rate is esteemed at 1.0 % (2001-2012) and the median age is of 27 years. About 30 % of the population is less than 15 years old. The life expectancy at birth was of 74.8 years in 2012 (74.3 years for the men and 76.2 years for the women). The distribution of the population by sex is balanced, the women representing 50, 5% of the population [11].

The Quality Challenge in Morocco.

In January 2005, the guiding principles of a Quality Challenge for Morocco were developed: The focus is on process, system-wide commitment, maintaining voluntary participation and improving the reward system. In Morocco, the first pilot experiments in quality improvement were implemented in health services in the 1990s (quality circles, team problem solving, clinical audits) [12]. In 2007, the Ministry of Health introduced a quality improvement program called the "Quality Competition" (QC), inspired by the systemic approach to quality improvement developed by the German Agency for Technical Cooperation [13]. The "Quality Competition" (QC) targets health facilities. It combines quality measurement, facility ranking, disclosure of results, and a reward system [3]. QC is based on the process approach. It combines several approaches: Self-assessment, external audits, personalized feedback, hospital ranking with rewards for the best, support (training and supervision) for the weakest, and results published in a global report [12]. A guide or expectations have been defined for each question to help auditors assign the score. These expectation times indicate the desired levels of quality, on a scale of 0 to 4, (0 being no action, 1 being minimum, and 4 being maximum desired).

Our study aims to analyze and evaluate the Quality Contest 'QC' implemented in health care structures in Morocco between 2007 and 2017 and explores the ways in which things can go right rather than wrong, and represents an important step in understanding what constitutes success in reform and improvement at the levels of care structures.

METHODS

We opted for a qualitative and quantitative study. A critical analysis of the data and information collected. Gathering and collection of data, analysis by a grouping and a graphic presentation of this information then the interpretation of the results. We conducted a detailed content analysis [14] of this study and the lessons learned from it. These themes represent key areas of care that have been improved or expanded and signal the ways in which success is demonstrated. The themes were extracted inductively and through a consensus approach.

The QC composed of seven steps, with six dimensions identified 'Customer satisfaction', (D1) 'Accessibility/Availability/Continuity', (D2), 'Rationalization of the resources', (D3), 'Safety and Reactivity', (D4), 'Leadership and Continuous improvement', (D5) and 'Community Partnership/Participation', (D6). Each area is subdivided into aspects that describe the expected level of quality [8]. Each aspect is divided into items, which have been transformed into questions according to the management steps of the Deming wheel: plan, do, and check, act.

Data sources included: (i) Publicly accessible information, (ii) MoPHs accreditation classification of hospitals and (iii) Survey completed by hospital administrators regarding accreditation expenses. The survey instrument comprised three questions. Two specific research methods are used for conducting this study: (1) Information synthesis to systematically identify and summarize relevant literature published on the HTP in Turkey and other relevant health reform efforts elsewhere; (2) Secondary review and analysis of existing related documents, consultant and technical reports, press releases, etc. provided by the Moroccan MoH, and various sources.

RESULT

The objective of the Quality competition is twofold: a) to improve the health care service and b) to put in place a dynamic for institutional change. It is important to measure and evaluate the quality of prevention strategies to better understand how they work and their potential benefits and risks, to assess their impact and appropriateness, and to assess their usefulness in reducing health inequalities [15]**.** We note an improvement in the number of establishments that participate in the different editions from one year to the next see Table 1.

	1 Edition (2007)	**2 Edition (2008)**	**3 Edition (2010)**	**4 Edition (2011)**	**5 Edition (2013)**	**6 Edition (2015)**	**7 Edition (2018)**
Number of PHCF participants	102	126	152	151	255	333	421
% of Increase	125	151	150	254	332	420	

Table 1: Evolution of the participation of primary health care facilities during the different editions.

Despite the increase in the number of establishments participating in the CQ editions, the performance, either overall or by dimension, has not increased or has even decreased for some dimensions see Figure 1 and Figure 2.

Among the 16 institutions that were ranked in the top three, only one was ranked twice. This is due to the fact that the PHCF are becoming reluctant to participate in the following editions due to the increasing workload that participation entails see more information in Table 2.

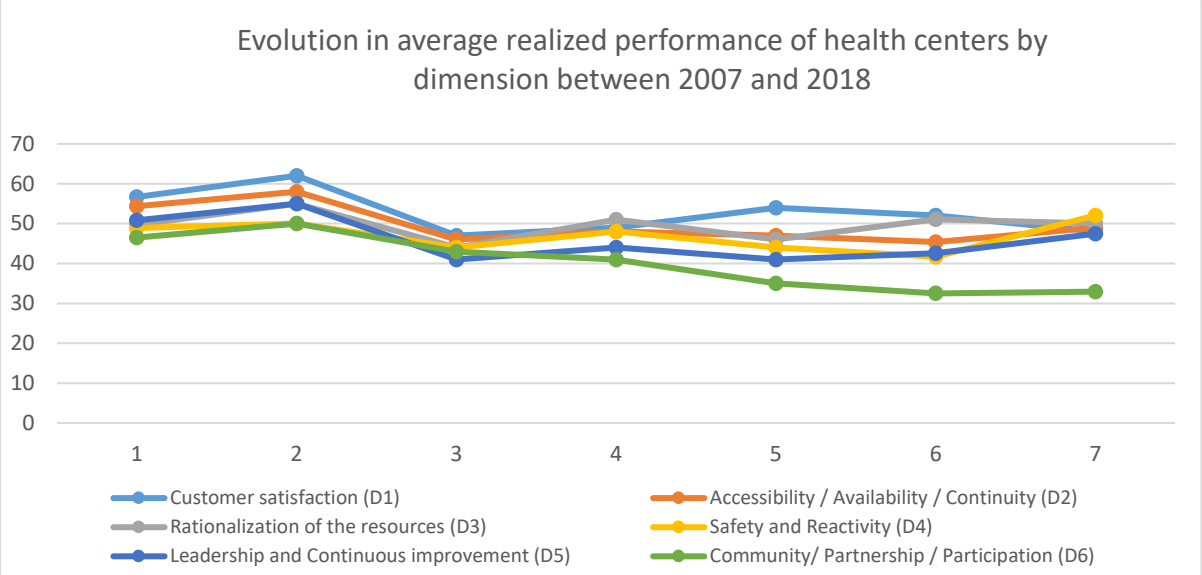

Figure 1*:* Evolution in average realized performance of health centres by dimension between 2007 and 2018 [16].

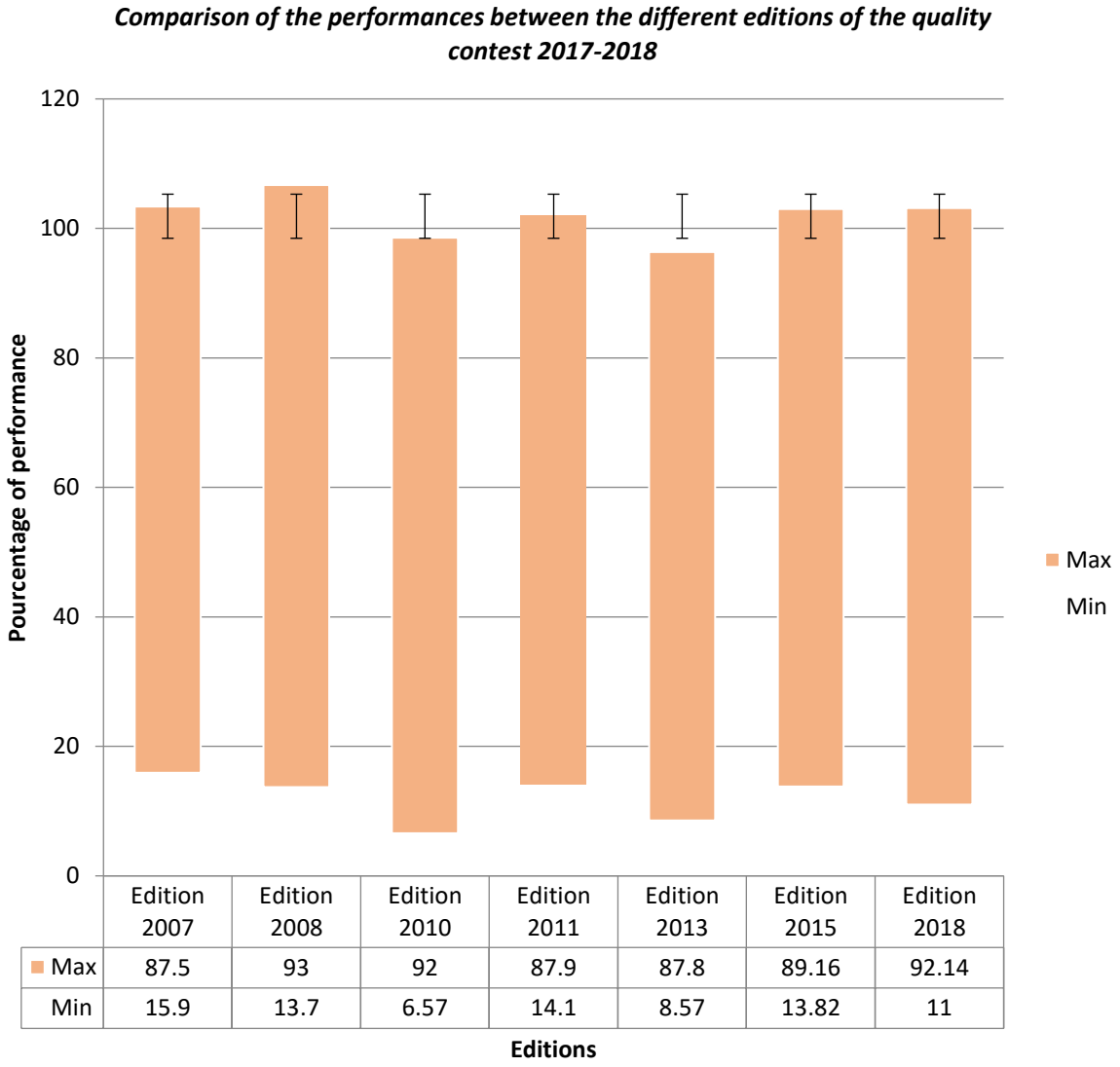

Figure 2: Comparison of the performances between the different editions of the quality contest edition 2007-2018.

Ranking	2007	2010	2011	2013	2015	2018
1 er	Benkarich (Tetouan)	Touarga (Meknes)	Mers Sultan (Casablanca)	Oudayas (Marrakech)	Biada (Safi)	Ben M'sik (Casablanca)
2 eme	My Al Hassan (Tetouan)	Riad (Meknes)	My Al Hassan (Tetouan)	Badr (Casablanca)	Mediouna (Casablanca)	Ras Aghil (Meknès)
3 eme	Alqods (Taza)	Ait harzallah (Elhajeb)	El Fajr (Casa)	Biada (Safi)	Bir Tamtam (sefrou)	Sidi Kacem (Sidi kacem)

Table 2: Table showing the three PHCF awarded during the different editions.

The CQ had some positive effects on the behaviour of the health care personnel, especially with regard to the quality of the health care service itself, the relational aspect was less cited, and the attitudes towards oneself were not the object of perceptible improvements see in Table 3.

The Strong Points	The Weakness Points
An increase in the satisfaction of professionals when performance is improved.	Not all auditors are qualified to conduct a proper audit.
In general, we note an improvement of the working space of the PHCF	Lack of support for follow-up and continuity of improvements.
An improvement of the working equipment in PHCF	Lack of support from senior management
Opening up to the outside world (partners) and improving benchmarking.	The elements of motivation are insufficient.
The commitment of the staff to the success of the experience.	The flagrant lack of human resources (medical and paramedical)
	Insufficient commitment from other partners.
	Resources are insufficient.

Table 3: The strong and the weak points [17].

DISCUSSION

Accreditation/Certification/QC are complex interventions within a complex health system environment. The conceptual framework for QC assessment is the result of a synthesis of several frameworks: The Donabedian quality of care framework, the WHO performance assessment framework and the German SQI framework. The process approach is a real management tool for improving the quality and safety of patient care as well as the improvement functions. The review of literature on the effectiveness of health-care accreditation reveals a complex picture, with mixed views and inconclusive findings. Researchers, nonetheless, agree on the fact that the preparations for accreditation give hospitals a valuable opportunity to reflect on the treatment of patients and on its operational modalities [18]. This experience has only been able to provide "process results" rather than the results of rigorous assessments of their impacts on country health systems. A positive outcome of the process has been the rapid expansion to cover more and more health facilities, becoming the country's primary mechanism for continuous monitoring, evaluation and improvement of its health care system and institutions. Qualitative evidence from different institutions and different levels of the Moroccan health system indicates that the Quality Competition has been successful in embedding the culture of quality improvement in the institutions.

The Quality Competition approach aims to mobilize the entire system and achieve a critical mass for change by encouraging all organizations in the system to work together to define and continuously adjust standards and goals, measure results, learn, introduce changes and improve performance. It involves self-assessment by each organization, peer review, and the participation of all organizations in writing and approving improvement plans. An institution's choice of quality improvement model must take into account both its expected effectiveness and its acceptance by healthcare professionals [19]. The study concludes that the preparation for accreditation offered professionals the opportunity to rethink treatment and operational modes in a collegial rather than hierarchical

manner [20]. Although the effects of auditing and feedback are generally considered to be weak to moderate [21], a well-conducted feedback has been recognized to be a fundamental element for improving practices [22]. A qualitative study [23], conducted among professionals and managers identified some conditions necessary for feedback to promote change, notably, the perception by professionals regarding the validity of the information communicated, the credibility of those identifying problems and giving feedback and the manner of presenting the feedback (supportive or punitive, aimed at the person or system) Recognizing and valuing efforts were reported to be motivating factors affecting performance sustainability among healthcare professionals [24]. comparing performances among hospitals appeared to be associated with an improvement in care procedures [25]. In the same way, participation in contests with the aim of winning a prize may represent an incentive for professionals to improve their procedures and services [26].

This experience provides a model of what constitutes successful health systems change, offering a storehouse of knowledge about how to achieve goals. Despite the fact that most countries have in fact experienced some success in reform [27], it seems that it would be more interesting to explore the failures and pitfalls of reform initiatives, rather than the triumphs. The benchmarking approach seems to help structures to learn from each other and overcome internally referenced behaviour [28]. A majority of hospitals consider accreditation to be a worthwhile investment, and acknowledge that accreditation has benefits, mainly in terms of improved quality and patient satisfaction [29]. Several factors contributed to achieve these results: First, the participatory approach taken to developing the evaluation instrument provided a tool that was tailored to the country, thus avoiding the risk of it being contested by staff [29]. Second, the QC provided a learning opportunity through a clear description of the domains, subdomains, and aspects of the assessment. Third, QC became a lever for improvement. The focus has been on improving the management process and the use of resources, a component on which it is important to act in developing countries where resource scarcity is particularly problematic [30]. A decision was made about large-scale dissemination of results within the health-care system but not beyond. Although the dissemination to the public at large may seem an attractive option to reinforce the culture of transparency and accountability [31], there are several reasons why this option was not favored. Ranking institutions without recourse to any punitive measures has laid the basis for an organizational culture that makes professionals accountable. The set-up of such a culture without resorting to blame or punishment is one of the difficulties encountered on the pathway to quality improvement in health services of LMIC [32]. In all countries, rich and poor alike, effective, independent evaluation of reform initiatives is currently lacking [27]. Improvements require better integration and coordination between all those departments and agencies which affect population health [27]. The lack of recognition for professionals who strive to implement best practices can demotivate them, as well as the difficulty of finding the best appreciation system to maintain a sense of justice and motivation [33]. According to Buetow and Wellingham [34], the impact of quality approaches can be summarized as: improved quality control by achieving an optimum level of service quality, improved regulation by meeting legal and safety standards, the establishment of a positive image of practice and service standards in primary care facilities, the provision of information to patients, which confers confidence in the services provided and enables them to make informed decisions, and stable, measurable, and sustainable improvements in the quality of care provided to patients despite financial constraints [35]. Hospital accreditation has a positive impact on improving the quality of services provided in hospitals, more research is needed to understand the impact of accreditation on the quality of care from the perspective of professionals [36].

QC has improved the practices and organization of primary health care facilities, but Morocco lacks a systemic approach to support quality improvement in PHC see more information in Table 4. Links to the different domains of quality: access to care, continuity, coordination, efficiency, governance, and population health are already established. Continuity of care must occur within each facility and between facilities of different hierarchical levels ('PHC' and hospitals) [7], but continuity is often conceptualized and measured in different ways [37]; et [38]. Alignment of hospital standards with ESSP improves continuity of care [39]. According to Reisi et al. [40], benefits of accreditation had the highest average score, followed by strategic quality planning, education and training, and staff engagement. While leadership, commitment and support, education and training, rewards and recognition, and staff engagement are factors that influence quality outcomes. Barriers encountered included financial and human resources. Hospital accreditation has a positive impact on quality of care. According to Wensing et al. coordination of care improved health outcomes [41]. but insufficient coordination with hospitals and inconsistent coordination with other departments remains the concern of staff and caregivers [42]. Measuring effectiveness and efficiency is indeed a complex task and poses a number of conceptual and methodological challenges. Weighting for indicators within a sub-dimension appears to be biased. Lack of comprehensiveness with respect to existing assessment tools and no formal assessment of reliability, validity and limited comparability of results with data from other "PHSS" in other countries. The most valid frameworks remain limited in their ability to reflect the complexity of the health system.

LIMITATIONS OF THIS STUDY

Lack of comprehensiveness compared to current assessment tools and lack of formal assessment of reliability and validity. risk that facilities will focus only on those aspects assessed by QC at the expense of others that are equally important but not assessed [43]. It appears that better use of resources may improve efficiency but does not necessarily impact quality of care [30]. The challenge is compounded if clinicians are not fully engaged in the process. Finally, the costs associated with implementing quality approaches in developing countries are part of the difficulty of sustaining them [44]. Additional resources, even moderate ones, to implement these schemes must compete with investments in other equally important areas [45].

CONCLUSION

The main findings showed that the results are contradictory. The current approach to quality performance measurement is far from an effective national performance measurement system for the following reasons: Objectives are not well defined and not accessible, measurement outputs are inconsistent and unstable, skepticism among health professionals about the positive impact of these programs on the quality of health services, different and conflicting views of performance and different approaches to measuring it, variable data collection techniques for performance dimensions, as well as limitations in existing indicators, insufficient coherence between the operational and strategic levels, and lack of ownership of quality management tools by all staff. Despite this, QC has contributed to a better understanding of what quality of care is and how to measure its performance, and has helped to understand the extent to which PHC undertakes a quality-of-care policy and the extent to which this has an impact on the quality of care and services. QC is a quality improvement approach that has been successful in triggering a sustainable improvement dynamic by combining performance measures, feedback with reward (prizes). The continuity in participation in QC had significantly improved their performance levels in terms of

management quality. QC needs to be integrated into an approach that encompasses other certification and quality assurance mechanisms to eliminate duplication and waste.

FUTURE

Some of the issues encountered: broadening the scope of research in the area of performance measurement by working on: Developing performance indicator systems, formalizing performance measurement, developing and defining valid and reliable measures for monitoring specific components of quality of care, developing methods for measuring the patient and provider satisfaction dimension.

LESSONS LEARNED

Experience suggests that a team approach to quality improvement can be very effective in any health care setting, and that a culture of quality improvement can take root. However, accelerating quality improvement toward ambitious goals may require substantial upfront investment in health institutions, especially those serving low-income, rural, and particularly vulnerable populations. Finally, experience shows that competition, certification, and other rewards should never discourage weak institutions from doing their best to improve.

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