227: QUALITY MANAGEMENT AND HOSPITAL ORGANIZATIONAL PATTERNS: EXPLORATORY RESEARCH IN TWO UNIVERSITY HOSPITALS, IN FRANCE AND SWEDEN.

Authors :
Moret L., Halgand N., Pascal J., Lombrail P.

Objectives :
The French regulation reforms in health care have introduced a care quality assessment exercise in University Hospitals (UH) for several years. This incentive has urged UH to develop quality management practices and to eventually integrate these key elements into the organizational strategy of the site. While this requirement leads to a more decentralized structure, UH prove to behave like professional bureaucracies, as labelled by Mintzberg, which are characterized by high levels of centralization and do not facilitate the bottom-up approach of TQM systems.

In order to explore two hypotheses: 1 - quality management is favoured by a decentralized organization ; 2 - quality management tends to redesign the hospital organization around the patient, we studied two cases. The first one is located in Nantes (France) and is a pilot site, which has been developing a delegated management initiative for three years, aiming at decentralising power down to supra-departments. This reform had been initiated before the even more recent introduction of quality management. The second case is the Swedish University Hospital of Linköping (LUH), which has been developing for more than ten years a voluntary policy in quality development, and was rewarded at the national level for its quality practices. This has led to the redesign of the organisation resulting in raising a new management structure.

Methods :
A qualitative methodology, based on interviews, unit visits and on analysis of public documents was pursued on these two cases. Semi-structured recorded interviews of clinicians, nurses and hospital managers have been conducted. Documentation included activity and quality reports, and documentation providing contextual information.

Results :
The comparison between Swedish and French contexts shows several different points. First of all, Sweden profits by a rigid regulatory framework, and by strong political support from the county council. LUH displayed incentives such as setting contracts and accountability, in order to speed up for high-cost efficiency. Horizontal integration of activities in LUH with a delegated management and autonomy of centres, supported by the headquarters of the hospital, contrasts with director's concern related to a possible loss of autonomy in NUH. Parallel evolution of the organisational culture at the central level towards a bottom-up management in LUH contrasts with some ambiguous managerial approaches in NUH, offering resistance to change.

In LUH we observed a comprehensive training policy and timely consistent implementation, involving all actors, setting standard practices for a common language, with a reengineering of processes. A bottom-up approach focusing on the patient's needs has been developing for several years. At NUH, this approach is still perceived as a bureaucratic duty, showing that changing opinions and attitudes requires long-term involvement.

Furthermore, in LUH, the monitoring of indicators is decentralized and participative when NUH is still characterized by centralized monitoring and too few indicators. Another condition is a high performing information system, already existing in LUH, using monthly balanced scorecards.

Conclusions :
The comparative analysis of the Swedish and French cases shows that some of the reform drivers are present in the development of quality management. The pressure of stakeholders can be highlighted. The quality implementation strategy appears to be central in the success of the process, and is the pre-requisite of a new organization structure. The relationship between a decentralized organization, and quality management as a process, has been identified as a key factor helps explain the success of the initiative.

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