Case studies

Factors to consider in the implementation of quality within Irish healthcare

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Keywords

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Abstract

Hospitals and healthcare institutions are today clamouring to find ways to ensure that their organisations will become more efficient and cost effective. With TQM defined as managing the entire organisation so that it excels in all dimensions of the services that are important to its customers, it appears to be the solution to the challenge that many hospitals are faced with. This article presents the findings from a quantitative research study focusing on the factors surrounding quality implementation in the Irish healthcare sector and is part of a larger research project.

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Introduction

Organisational change management is high on the agenda for hospital management in a global and national context stemming from pressure to change from both purchases and users of healthcare. Nowhere is this more evident than in the Irish healthcare sector where hospitals are striving to find ways to ensure that their organisations will become more efficient and cost effective. The impelling force for these changes has stemmed from the stifling bureaucratic management structures, ridden with alleged inefficiencies, wastefulness and remoteness from those served. Further echoes of this discontent have emerged and they include increasing pressure for cost constraint, value for money reform, demanding customer requirements and the Patients' Charter. Another driving factor is the Department of Health's document "Shaping a healthier future" produced in 1994. Underpinning this document is a drive towards a more efficient use of resources equitably distributed together with a high quality of service to maximise health and social gain for years to come (Robbins, 1997). In this context, quality management has emerged as the most significant and enduring management strategy to ensure the very survival of hospitals and to guarantee some form of overall performance improvement. This article presents the findings from a quantitative research study focusing on the factors surrounding quality implementation in the Irish healthcare sector and is part of a larger research project.

The context

Historically within healthcare, quality tended to equate with "clinical or professional quality" which bore little or no association to managerial activities; but today the importance of combining the two approaches is high on the agenda for all healthcare institutions. Furthermore, no matter how sophisticated the technical skills are of healthcare professionals or management's commitment to delivering an effective and efficient system, unless both sides share a common unified set of values an organisation will never flourish (Simpson, 1994).

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Managing Service Quality
Volume 9 · Number 5 · 1999 · 320–326

Without doubt, all healthcare professionals would agree that improving quality is a desirable objective, but they simultaneously assert different priorities in pursuit of that goal. Some would regard research and development and its subsequent implementation as their goals, while others would view an extension of enhanced service as the way to improve quality. Others would argue that changes to the traditional approach of training and education needs to be revised while yet again some would say quality improvement cannot take place until the views of the patient are heard and acted upon.

A movement, which holds great promise for improved healthcare quality and productivity, is total quality management (TQM) (Short and Rahim, 1995). While the language of TQM has its roots in the manufacturing industry, it is based on many techniques which could easily be transferred to the healthcare setting. In fact the medical field has some advantages over the manufacturing sector and these include a familiarity with statistical methods, a mentality to continuously improve care and the ability to work in teams as routine practices (Huq, 1996).

However, many healthcare managers would reject the usefulness of TQM concepts to themselves and would strongly argue that the modern philosophy of TQM is more suited to the manufacturing sector than the healthcare industry. An added problem within healthcare is that the term customer does not sit easily with professionals when the same customer/patient would often rather not have to seek hospital services (Feeney and Zairi, 1996).

Irish healthcare sector

Currently within the Irish healthcare sector there are also inherent tensions which do not sit easily alongside the concept of TQM. Firstly, the management style which has historically governed hospitals has been predominantly the conventional Taylorist management style; consequently, the theories underpinning this management style face harsh challenges from the participatory management approaches necessary to achieve TQM. A shift is essential requiring top management to relinquish power to the frontline service providers to achieve organisation-wide change. In the second instance with the various occupational subcultures operating within hospitals, the multidisciplinary team approach essential to deliver high quality care has been lacking which in turn leads to a breakdown in communications. However, it is well established that the progression to multidisciplinary teamwork is a basic prerequisite to TQM where each member of the team has a role to play in the delivery of patient care. Thirdly, hospitals by their nature are hierarchical establishments with strong interdepartmental barriers, staffed by professionals who have heretofore worked with their own traditional autonomy and have remained rigorously divided from management. A move to a cross-functional working approach where no one person or department is superior to another is an integral part of the TQM initiative. However, this is difficult to achieve in an Irish hospital context. Finally, inherent tensions exist between hospital administrators and hospital consultants, the former having traditionally been reluctant to share budgetary information and the latter acting independently of the hospital team causing uneasiness and conflict. Therefore, it is fundamental that each of these groups fully understands each other's roles and concerns, and the contributions, which they can make to the development of harmonious working relationships.

Drawing on the foregoing observations, and in an effort to redress the current imbalance in the literature, the authors sought to examine quality practices in Irish healthcare institutions. Specifically, the research study was guided by the following objectives, which were to:

- examine the nature and extent of quality initiatives in Irish healthcare institutions;
- investigate senior managerial commitment to the quality process;
- appraise the extent of employee involvement in quality management programmes;
- elaborate upon quality implementation approaches adopted by participating healthcare institutions;
- determine the nature and degree of responsibility given for managing quality management initiatives;
- outline the drivers of quality management programmes in healthcare institutions; and
- examine the ways in which quality is evaluated within the healthcare sector.

Managing Service Quality
Volume 9 · Number 5 · 1999 · 320–326

Methodology

A survey was conducted in April 1998 of Department of Health listed healthcare organisations and focused on the extent and nature of quality management within healthcare in the Irish context. This study was seen as exploratory and a quota sampling method was utilised to ensure that the views of both small and large hospitals were taken into account. The survey method was applied because of its effectiveness as a tool for gathering a "snapshot" of information about the subject under research. Following an initial pilot study a personalised self-completion questionnaire, together with a stamped addressed envelope, including a cover letter explaining the nature and purpose of the research was mailed to 182 chief executive officers/hospital administrators. Follow-up telephone calls were made to encourage non-respondents to reply. A total of 122 (67 per cent) responded, yielding a useable response rate of 120. This compares favourably with rates quoted for mail surveys within the literature (Churchill, 1996).

The questionnaire was designed so as to elicit information on the key issues identified within the literature review and was as a result divided into four sections containing questions relating to each area of concern.

Research findings

From the findings it appears that quality management has not fully permeated the sector with only 25 per cent of responding organisations indicating participation in a quality programme. Furthermore, the quality approach is very new as 87 per cent of organisations had only adopted this approach within the past twelve months. However, this situation is set to change as 50 per cent of hospitals indicated that they do intend to embark on a quality programme in the near future. Several factors emerged from the findings that have the potential to undermine the successful implementation of quality initiatives. The reported findings will seek to explore these elements which will have important implications for the development of healthcare quality implementation. The results also carry implications for the practicalities of implementing quality within Irish healthcare institutions.

Organisational culture resistance to change

In 47 per cent of hospitals surveyed organisational resistance to change was indicated as a barrier. With the functional nature of hospitals often breeding a negative culture in which people guard and defend their own patch, this finding is not surprising. In addition, large healthcare institutions are typically organised on a hierarchical basis, exemplifying bureaucratic cultures, which are resistant to employee empowerment thereby aiding and abetting resistance. Quality management requires a fundamental shift beyond what has gone on before and the key lies in the development of a culture dedicated to the delivery of quality services to customers. Other authors go further to claim that hospital structures must change to adopt participative configurations before the implementation of quality management can occur (Godfrey *et al.*, 1992; Badrick, 1996). However, changing culture is not an easy task and will only develop over time and a major reason for failure is that the strength of culture is often ignored. Organisational change will not occur through new mission statements, speeches, newsletters or new fads but will only occur by altering the everyday policies, practices, procedures impacting the beliefs and values that guide employee actions (Simpson, 1994) . Human attitudes are far more difficult to change and manage than are the harder quality elements, which focus on the transparent and tangible procedures associated with formal quality documentation. Another factor impeding culture change is that healthcare organisations are by their nature inward looking tending to focus more on the needs of the caregivers and professionals rather than on the needs of the patients. Change efforts within organisations are doomed to fail if they do not succeed in changing employee perceptions. Therefore, there can be no sustainable change if the psychology of these people remains the same. To change a corporate culture so that it values its employees and their views requires fundamental change that often requires individuals to relinquish cherished beliefs (Dutton, 1997). Change strategies are often introduced without consideration of the overall impact that they have on an organisation and, instead of achieving the desired change, the end results may be resistance, conflict and

confusion (Devine and Dimock, 1998). Planned change efforts must include strategies for systematic organisational renewal rather than group or individual renewal. Thus, for Irish hospitals to achieve the transition to TQM there must be a change in attitudes, communication, employee involvement – in other words, entire organisational change (Hayes, 1995). To make change stick, the everyday policies and practices that create the "feel" of the organisation needs to be explored with change occurring only when new climates and cultures are created and maintained. What people experience as the climate and believe is the culture ultimately determines whether sustained change is accomplished (Schneider, 1996).

Lack of financial resources

The lack of financial resources for quality implementation was a significant factor in 47 per cent of hospitals. The very tight financial constraints are set to continue, in the hope of improving efficiency and effectiveness within the sector. All operations within a hospital have to be improved in an effort to enhance efficiency and effectiveness and it is only then that financial resources will be freed for utilisation within quality improvement programmes. Hospitals have been responsible for almost 50 per cent of the finances invested in the Irish healthcare sector in recent years. However, this has not always been accompanied by a sufficient questioning of the efficiency of the administrative organisations and procedures involved (Robbins, 1997). Techniques such as business process re-engineering do not appear to have permeated the sector with just 13 per cent of hospitals indicating that this approach was being used. Given the significant impact and promise this technique holds for the service sector the low uptake is disappointing. Additionally, hospitals require detailed work process analysis to determine who is performing what kind of work, what type of work adds value to the organisation and how work can be redistributed to eliminate non-value added and inefficient processes and systems (Murphy and Murphy, 1996).

Employee resistance

Installing a quality programme within any organisation involves movement and change (Hayes, 1995), and a significant factor hampering change plans is employee resistance to change (Dowd *et al.*, 1998). The picture emerging from this study is that 33 per cent of hospitals are encountering problems with employee resistance. However, people do not resist all change, only change that they do not understand or that they see as psychologically or economically threatening (Hayes, 1995). Resistance arises in reaction to a particular situation rather than emanating from a built-in response to change; therefore, an understanding of the sources of resistance is important. Specific sources of resistance have been highlighted by many scholars (Kanter, 1983; Humphreys, 1996; Hayes, 1995) and include among others self-interest, fear, group pressures and inertia. Employees typically resist a change they believe will take something of value away from them, which may be related to economic well-being, or a loss of status. Uncertainty is an outcome of change and can lead to fear of failure as people are faced with learning new ways. The strong influence of group norms results in strong pressure to resist change from peers and in many large organisations inertia is a potent factor for resistance. To lessen the impact of these specific sources of resistance hospitals need to respond to the various issues. In particular, areas of response include communications with its aim to make employees aware of all aspects of the proposed changes and to convince them that the changes are necessary. Also, there is a requirement to involve workers in decisions relating to change initiatives, thus allowing any potential resistors to partake in designing change and thereby enable them to become more committed to the process.

Middle management resistance to change

Coping with change is especially difficult for managers who must plan change in the workplace as well as adjust to it themselves (Dowd *et al.*, 1998). In many instances middle managers are the executors of top management decisions; therefore, it is important that their vision and perspective of

Managing Service Quality
Volume 9 · Number 5 · 1999 · 320–326

quality is consistent with senior managerial attitudes Nevertheless this vision is often at odds with middle managerial views which often do not perceive employee satisfaction as the most important factor in improving organisation performance. When views deviate from each other there is a significant risk of failure to develop and successfully implement quality management programmes (Madhu and Kuei, 1995). Research has shown that many middle managers openly resist change and from the reported results it would also appear to be occurring within the healthcare sector in Ireland with 33 per cent of hospitals indicating it as a barrier to quality implementation. This resistance according to Anand,(1996) is a deliberate strategy and can take many forms, which can stem from lack of motivation, autocratic management styles, lack of trust and poor communications or a combination of these. Many middle managers today feel neglected and do not consider themselves as managers but as scapegoats of top management and workers alike. In fact the contention is that the middle managerial role in facilitating the articulation of a quality ethos is fundamentally undervalued and misunderstood in a great many organisational settings (Harrington and Akehurst, 1996). However, their active involvement is fundamental for the success of any quality programme and it is essential that middle management receive training in problem-solving processes, in the need for continuous quality improvement and cost reduction methods. Several other strategies can also be adopted by hospitals – for example, a change of management style and the development of a reward scheme to win the support of this group. However for Feinburg (1996) the best way to overcome resistance is to seek out resistant managers and demand their full participation from the beginning.

Interdepartmental barriers

Another significant factor posing problems for Irish healthcare institutions was that of interdepartmental rivalry (30 per cent). As stated earlier hospitals by their nature are functional hierarchical establishments and contain strong interdepartmental barriers. In this sense they are much more complex than the typical business and have a more diffuse authority structure (Zabada, 1998). The more complex the nature of the work and the higher the qualifications of the worker, the larger and more elaborate the hierarchy (Badrick, 1996). In the past few decades much change has occurred in social, educational and technological areas, making functional organisations obsolete. Successful quality improvement programmes require a structure that minimises the layers of management, empowers employees, tears down the communication barriers and fosters the creativity of the workplace (Short and Rahim, 1995). As Deming remarked there is a strong requirement to "break down barriers between departments". While many hospitals are being restructured, many elements of the old functional hierarchical structure still persist today.

Measurement of quality

In 23 per cent of healthcare organisations, the measurement of quality was noted as a barrier. With the many intangible facets inherent in quality programmes, measurement is not always easy; however this is not to say that measurement of quality cannot be achieved but it does require extra effort to find a way of adequately converting the impact of the changes into tangible results. Of significant interest was the finding that the cost of quality was not used as a measurement tool in participating hospitals. This is something of a paradox given that a substantial number of hospitals indicated this as an aim for the introduction of quality initiatives. Clearly, there may be problems in actually apportioning a financial saving to quality initiatives; nevertheless quality programmes must not only indicate reducing waste and errors as objectives but also include measures of the costs of quality and resource utilisation. Many healthcare practitioners believe healthcare systems are uniquely complex and consequently are not good candidates for statistical process control application. However, many of the differences that can complicate data analysis in healthcare also exist in other industries. Measurement must be seen as a critical component of any quality initiative and a useful starting point at an early stage to assess the impact of likely changes associated with the introduction of quality programmes.

Managing Service Quality
Volume 9 · Number 5 · 1999 · 320–326

Quality not seen as an issue

Of concern was the study finding indicating that quality appeared to be viewed as a separate and secondary issue for many healthcare employees (17 per cent). The reasons for this may stem from the fact that activities are not directed to producing improvement to clinical care or to making changes which staff and managers see as critical to their work. Likewise an overly "documentation-driven" system can restrain staff from adopting the process as they may see little value added to their work by adhering to the system. Therefore, in an effort to overcome this problem, managers within healthcare institutions need to strengthen accountability; however at the same time they also need to pay attention to the ways in which they can lead and direct quality actions such as empowering staff and devolving authority to making changes to improve quality. In short, responsibility for leading the quality effort must be shared equally between professionals and management.

The findings from this study are somewhat limited by the very nature of the quantitative methodology utilised. However, despite the limitations, important information has been gleaned regarding the approaches utilised for the implementation of quality management in the Irish healthcare sector. Moreover, the findings uncovered vital elements associated with the implementation process, which have the potential to render many of the initiatives unsuccessful; therefore important areas of further research have been established. In particular there is a need to determine what are the concerns of healthcare employees surrounding quality management implementation in the Irish context and to determine what tensions and challenges employees themselves perceive to be problematic in the process.

Conclusions

Evidence emerging from this study is that the culture within Irish hospitals is not changing fast enough to embrace the quality management philosophy. Any change effort must recognise the diversity of the many subcultures that exist within hospitals and therefore transform themselves from traditional bureaucratic institutions to more participative enabling organisations. Employees must be convinced of the need for change in their work practices and must be involved at all stages of the process, which calls for strong leadership and widespread communication. Middle management must be supported and trained in specific techniques to enable them to steer employees through the change process. At present, there are serious deficiencies in these areas within the healthcare sector in Ireland.

However, the study findings indicate that change is occurring, albeit slowly. Despite the many difficulties encountered from quality management implementation, a significant number of hospitals (67 per cent) have reported that their efforts had been reasonably successful and in addition an awareness of quality and patient satisfaction had improved. It is fair to say that the findings are somewhat limited given the quantitative nature of the research. However, further in-depth qualitative research is currently underway which seeks to capture employee views and identify possible challenges and tensions inherent in the quality management implementation process.

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