



Impacts of Quality Improvement Strategies on the Performance of Primary Healthcare Organisations; a Case Study of the Accreditation Program in Lebanon.

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**Abstract**

In its 2008 report, the World Health Organisation called for a reform in Primary Healthcare, especially in leadership which will enforce the delivery of quality services, as per the seven elements of quality in healthcare: accessibility, appropriateness, safety, continuity of care, efficiency and effectiveness, and client-centeredness. In Lebanon, the approach of quality improvement in healthcare is still new, starting in 2000 in the hospitals and in 2009 - with the first formal award for accredited centres in 2016 - in the primary healthcare sector, led by the Ministry of Public Health in collaboration with Accreditation Canada International. This thesis aims to build a “Best Practices” Model to be applied by the leaders of primary healthcare organisations and customised to their centres in order to comply with the quality standards and integrate them sustainably in their systems.

The qualitative approach has been applied, with 15 semi-structured interviews with key-informants in addition to documentation analysis and observation, with a validation of some other methods - such as questionnaires with healthcare providers and focus groups with National Surveyors and patients - to overcome the author’s bias. The “Wimpole Street Principles” has been followed as a conceptual framework for this dissertation, due to its suitability to the studied model of care through its four domains: Policy, Organisation, Methods and Resources.

Results have shown that the Accreditation process, despite the many challenges to be implemented in a country with complex political and socio-economic situation like Lebanon, has increased the overall performance of the primary healthcare system. Indeed, Primary Healthcare Organisations

who want to become the pioneers of the international Accreditation program shall transform these challenges into opportunities and innovate into patient-centred leading initiatives.

In conclusion, quality improvement initiatives such as the Accreditation program, implemented incrementally by the Ministry of Public Health in collaboration with Accreditation Canada International in its network of primary healthcare centres, has reformed the system and improved its image via the community it serves. However, further studies must be done to ensure that this change will be integrated into the organisational DNA and be sustainable...with a continuous improvement cycle of life.

**Key Words: Primary Healthcare, Universal Healthcare Coverage, Sustainable Development Goals, Quality improvement, Accreditation, Performance of the Primary Healthcare System.**

## **CHAPTER 1: Introduction**

### **1.1. Background**

Nowadays, as many obstacles have delayed the good performance of the healthcare system - such as the increase of chronic diseases, the high costs of the health expenses, the lack of services' coordination, the aging of the population, and the significant clinical errors - the need for quality improvement initiatives is still the priority of healthcare policies in general (Gauld et al, 2015).

External competitive reforms worldwide in addition to internal changes in services' delivery focusing on customers have impelled organisations in general, and later on healthcare services in particular, to implement strategic quality improvement initiatives (Millar, 2013; Lavi et al, 2008).

In this context, quality improvement, as a strategy, was intended to re-focus the care around the patient and his/her expectations in a low costs' comprehensive system (Russell et al, 2009) and to overcome the gap between realised and recommended healthcare quality standards (Pollock et al, 2010; Millar, 2013), in an attempt to improve the performance of the health system. Indeed, quality in healthcare aims to improve the whole healthcare system's services with an optimal efficiency and effectiveness. The Accreditation Program has shown to be an efficient management tool for quality improvement, especially in terms of less wastes and better safety and efficient processes of care (El-Jardali, 2009). In Lebanon, Accreditation programs have been introduced since 2000 to

hospitals and 2009 to primary care organisations from both the private and public sectors, with the first PHCs' official licensure in 2016 (El-Jardali and Fadlallah, 2017).

## **1.2. Research Question, Aim & Objectives of the Study**

As the main Research Question of this study is: “*How can Quality Improvement Initiatives, such as the Accreditation Program, optimise the Performance of the Primary Health Care System in Lebanon?*”, the aim of this dissertation is to build a model for the most efficient strategies for quality services and patients' safety in Lebanese primary healthcare organisations, based on the lessons learned from the ACI Accreditation program, in order to enable executive leaders and healthcare providers to build patient-focused primary healthcare centres of excellence, with high performance systems. It addresses the gap of the low performance of Primary Healthcare Organisations in Lebanon due to the lack of quality services.

The core objectives are to:

- 1) Understand quality improvement in primary healthcare in general and in the Lebanese context in particular;
- 2) Identify, globally, the key success factors of quality improvement initiatives;
- 3) Analyse the case study of the Accreditation process in Lebanon using a comprehensive analytical conceptual model and applying appropriate methods of research;
- 4) Deduce the relationship between the relationship between the Lebanese Accreditation process, as a strategic quality improvement initiative, and the performance of the primary healthcare system;
- 5) Build a pragmatic model of “Best Practices” which can be easily used by Primary Healthcare Centres executive leaders.

## **CHAPTER 2: Literature Review**

### **2.1. Primary Healthcare System: Definition, Quality & Performance**

A brief historical summary is necessary to explain the concept of “Primary Healthcare”, as the cornerstone of the Health System, mainly from the World Health Organisation (WHO) perspective. Starting from the International Conference on Primary Healthcare in Alma-Ata (Kazakhstan, previous USSR) in 1978, Primary Care has been set to be the first point of citizens’ access to Health (Sharman, 2016; WHO, 2003; Hendrawan, 2013; Shi, 2012) that is equitable, efficient, and effective (Sharman, 2016).

The 2008 WHO Report on Primary Healthcare advised four main categories of Reforms for the next three decades, mainly reforms in the following four categories: public policies, universal coverage, leadership and service delivery (WHO; 2008). Indeed, this Report holds an implicit and explicit commitment from WHO to deliver comprehensive quality healthcare services based on the needs of the targeted communities, through a participative leadership approach empowered by public policies reforms in expected high performance Primary Healthcare Systems. Indeed, some studies have demonstrated that a well consolidated Primary Healthcare System, promoting more preventative care than curative hospitalisation (Sharman, 2016; WHO, 2003 and 2004), will both improve the healthcare system and lower its costs, optimising thus both effectiveness and efficiency (Fullman et al., 2018; Sharman, 2016; ElJardali et al, 2013; WHO, 2008 and 2010; Delaune and Ewerett, 2008; Starfield, 2005). Thus, the aspirations of many health systems in the world to attain a high performance Primary Healthcare System have evolved towards the attainment of the 17 objectives of the Sustainable Development Goals and the realisation of the Universal Health Coverage services for the entire population (Fullman et al, 2018; UN, 2015; WHO, 2010).

The most known and widely used definitions of quality in the Health industry are that of Avedis Donabedian, the Institute of Medicine (IOM) and the World Health Organisation (WHO). Charming in his interpretation, Donabedian pinpointed that “the secret of quality is love” (Best, 2004: 473); for instance, when a healthcare provider loves her/his patient, she/he will deliver services with quality in the whole system. However, Donabedian’s definition of quality in the healthcare system is rather the dynamic interaction loop between the three main components of “Structure, Process, Outcomes”: Structure (inputs to the systems; such as policies and procedures), processes (all care activities delivered by the providers) and outcomes (results of care) (Donabedian, 2002; Hughes, 2008; Jardali et. al., 2008; Kolozsvari, 2014).

Performance of the system will be measured according to quality improvements within these three interactive elements of the healthcare system. In fact, quality improvement is defined as the coordinated continuous efforts of all stakeholders - legislators, healthcare professionals, patients and their families, sponsors, academics and researchers - to have better impactful changes on the performance of the system as a whole, capacity building of human resources, and patients’ outcomes (Batalden and Davidoff, 2016).

In summary, one major pragmatic goal of all these domains or dimensions of Quality assessment (Table 1) is to improve the performance of Healthcare, i.e., the efficiency and effectiveness of the system, via national and organisational policies; e.g., implementation and achievement of outcomes monitored by the Board and the executive directors – in a continuous improvement approach. Consequently, any quality initiative and strategy have to really investigate into all these areas in order to show its implications on the overall performance of the Primary Healthcare system.

Accreditation as a tool of measurement for quality improvement has shown to be efficient (till now) in some countries, such as Lebanon, increasing the performance of the healthcare system in general (El-Jardali et al, 2014), unlike the Swedish case where measurement of primary healthcare services' delivery and governance have not always attained their expected goals (Haggerty, 2011).

## **2.2. Practical Strategies of Quality Improvement**

Quality improvement has to be perceived not merely as a problem-solving methodology but as a philosophy, and its measure must be taken both before and after its implementation in order to give consistent satisfactory results (Whiteman, 2004). Indeed, quality improvement is the new paradigm of the healthcare system in general and of Primary Healthcare System in particular, shifting from a disease-based to an individual, community-based system of care with evidence-based standards and a technological basis (Sharman, 2016). In our ever changing world, financial and quality constraints have incited healthcare leaders to search for evidence-based innovations leading to safer and more effective clinical practices. As a successful strategic tool when managed properly, quality improvement has shown to decrease the inadequate variations in the organisational processes, to reduce wastes and costs (Wensing, 2006), and thus to end up with better standardisation and more efficient health impacts (ChowChua & Goh, 2000; Meurer, 2002; Bloomfield, 2003, Millar, 2013). Indeed, quality improvement is defined as a “systematic, data-guided activities designed to bring about immediate improvement in Healthcare delivery in particular settings” and quality improvement strategy as “any intervention aimed at reducing the quality gap for a group of patients representative of those encountered in routine practice” (Hughes, 2008).

After the failure of many reforms, and after assessing and comparing the performance indicators of many countries such as Australia, New-Zealand, England, Germany, the

Netherlands, Canada and the USA, evidence has found that the quality performance of the whole healthcare system will improve if policy makers empower three specific areas: primary care, information technology and quality improvement (Gauld et al, 2014). However, in the context of this study, information technology and primary care are integrated in the approach of quality improvement, which can be expected to give highly positive impacts on the performance of the healthcare system. The biggest challenge in implementing quality in healthcare is to re-focus all the healthcare providers' processes with effectiveness to satisfy promptly and safely the specific needs of each patient in order to obtain the best outcomes (Mainz, 2003).

One of the most essential key success factors of a quality improvement initiative is an appropriate human resources' training programme oriented towards a patient-focused environment of safety and quality (Tingle, 2012), training all employees on the "measures of success" and their benefits (NLC 2013 et al., 2012). Other studies have shown great variations in the effectiveness of quality improvement initiatives probably due to the different contextual frameworks of their execution rather than the technical methods used for their proliferation in addition to the non-compliance of the staff to what they perceive as "built-on" managerial interventions, with a need to conduct further epistemological studies (Millar, 2013; Kaplan et al, 2012). Hence, patients' outcomes were improved by organisational structures and integrated healthcare services' changes, comprising revision of professional roles and multidisciplinary teams (Wensing, 2006).

Quality improvement has also demonstrated to be more efficient when using Health Information Systems (HIS) optimally and meaningfully (NLC 2013 et al., 2012), being a good investment to get the utmost benefits of existing data (Kolozsvari, 2014). In fact, HIS have shown to improve services' delivery and patients' outcomes in Healthcare (Kolozsvari, 2014; Pine, 2012; Anifalaje, 2012; Wensing, 2006; Idowu et al; 2008), especially in collecting,



analysing, and disseminating data for better policies and decision-making processes (AbouZahr and Boerma, 2005), with a strategy of combining both administrative and clinical information to boost the cost-effectiveness of the quality reporting processes in hospitals, making quality measures more accurate and thus contributing to the enhancement of the performance of Primary Healthcare Organisations.

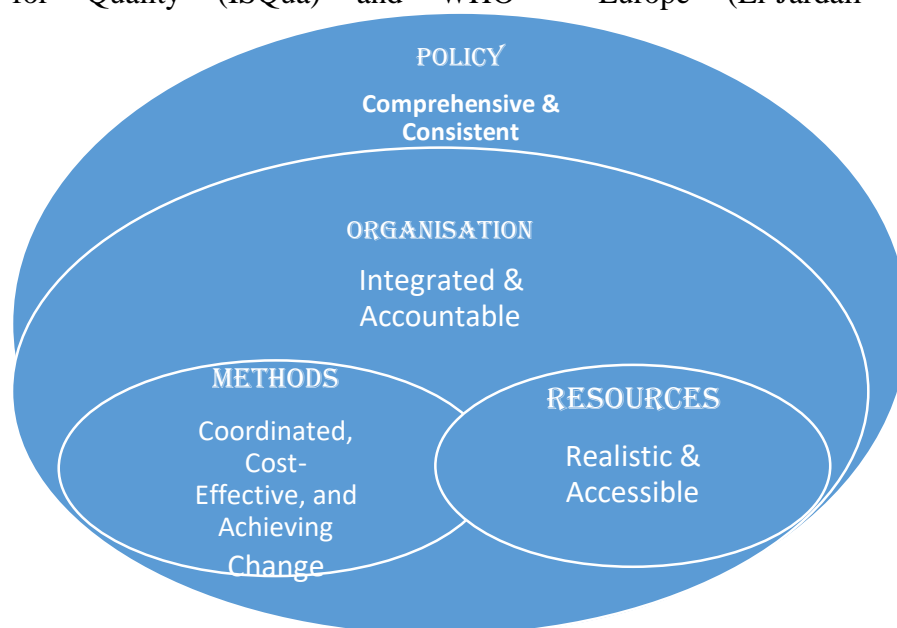
Nonetheless, the core challenges facing healthcare organisations are how to manage the costs of a proficient quality improvement program and sustain its strategic continuity in addition to the recognition of the increase of financial incentives when succeeding its implementation (Whiteman, 2004). Indeed, the ground of quality improvement is the interaction between four levels – individual, team, organisation and system – in a five dimensions world: safety, consumer-focus, access, effectiveness and efficiency; and which are prioritised according to financing allocations (Bloomfield, 2003).

### **2.3. The “Wimpole Street Principles” Conceptual Framework of the Study**

In the beginning of the Millennium, Shaw and Nichol (2000) debated the efficiency and effectiveness of public quality improvement initiatives (since the mid-80s in the U.K.) in quality of care circles, especially in terms of continuity and “lessons learnt”, to end up with the production of a framework inspired by the local experience of the National Health Services (NHS) but challenged by the following reflective question (from the authors): “*Would anyone care to try it on their own setting, and recommend improvements to give the Wimpole Street Principles” a more international application?*”... Yes, this question was responded to by Dr El-Jardali in 2017 when successfully applying this model, mixed with another one, to Lebanon and Jordan (El-Jardali and Fadlallah, 2017) and will be applied again here to orient this research.

Indeed, the *Shaw & Nichols quality improvement Framework* will be adapted to guide this dissertation and will be named: “*The Wimpole Street Principles Quality Improvement Analytical*

*Framework*” (Figure 1). The rationale of this choice is mainly because this framework is comprehensive, practicable, valid in both countries (United Kingdom and Lebanon), and directly relevant to the main research question of this study investigating on “the impacts of quality improvement on the performance of healthcare organisations” by its consistent monitoring of “performance management” (see *Principles per Domain*). Furthermore, its credibility is reflected by the fact that it has been taken as a model for the design of the quality improvement questionnaire developed by the International Society for Quality (ISQua) and WHO - Europe (El-Jardali & Fadlallah, 2017).



**Figure 1:** “Wimpole Street Principles” Quality Improvement Analytical Framework (Adapted from: Shaw & Nichols, 2000)

## CHAPTER 3: Research Methods

### 2.1. Research Design

Research Design is the blue-print of the thesis, including the methodology and methods of study, and relating the conceptual framework of a research to its empirical findings. It constitutes the core part of a research study, orienting it in a pragmatic way towards an objective and systematic solution for the *How* and *Why* of its “*Raison d’être*” (Saunders et al, 2009). Saunder’s Research Onion (Figure 2) will be followed.

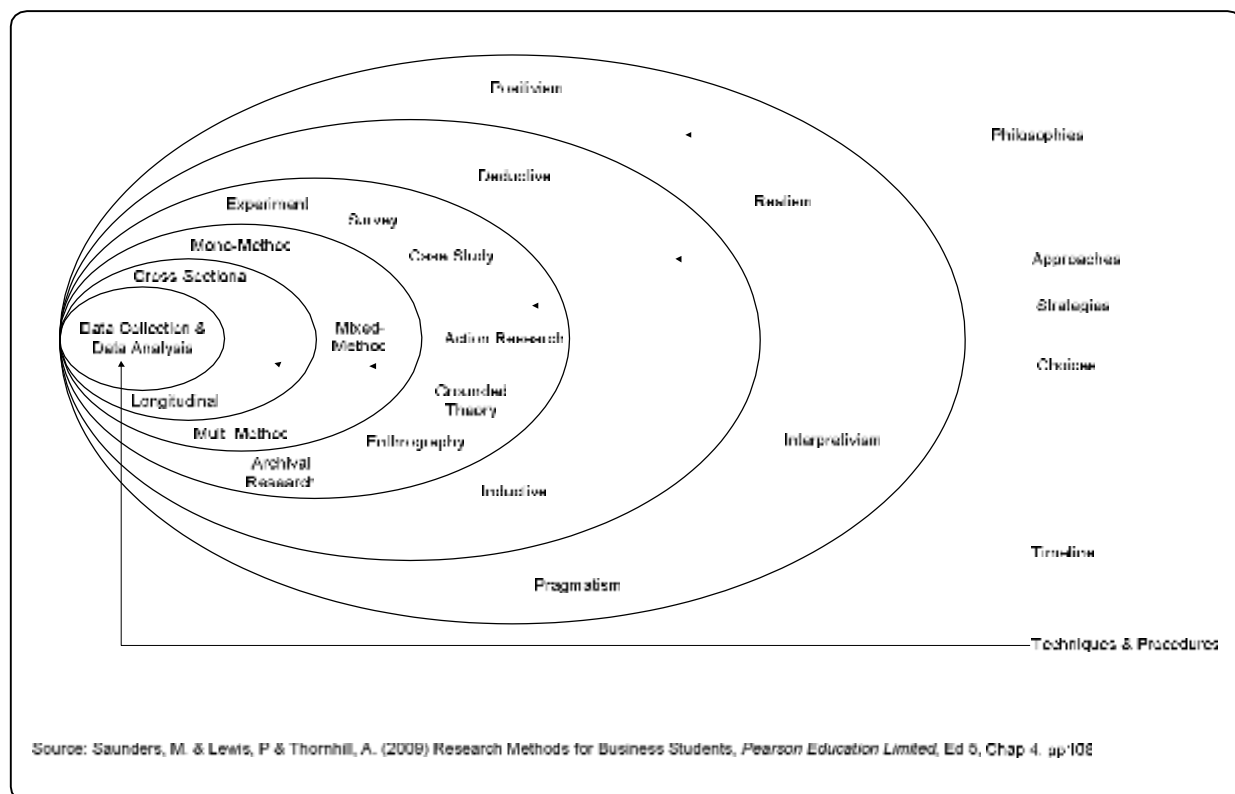


Figure 2: The Research Onion (Adapted from Saunders et al., 2009)

## 2.2. Rationale of Choice

As per the above Research Onion model, the philosophy of this study is *Interpretivism*, following an *inductive* approach, with the *case study* of the Accreditation Program in Lebanon as a choice in a *cross-sectional* timeline, with *semi-structured interviews* involving 13 key informants in addition to *Focus Group Discussions* with 15 patients, administered as the main data collection & analysis (thematic fields) techniques. Indeed, the “case study” strategy has been chosen because it is a flexible suitable holistic research method in many fields, especially in health science researches in order to develop both theoretical and pragmatic interventions (Baxter & Jack, 2008; Yin, 2014).

## 2.3. Ethics

In this study, Staffordshire University “Fast-Track Ethical Form” in addition to the “Information Sheet” and “Informed Consent” have been used after final approval by the University Ethical Committee. For instance, the researcher has clarified to the respondents the purpose and the

objectives of the investigation, their voluntary participation (or withdrawal) and their right to omit answering to undesirable questions. Anonymity of participants and confidentiality of data have been respected in all the phases of this case study. Finally, some limitations of the study were, like most qualitative studies, the generalization of the data to all contexts, respecting the uncertainty of human nature and the constant changes of the internal and external factors leading to the success of the accreditation process as a core quality improvement strategy leading to a higher performance of Primary Healthcare Organisations.

## **CHAPTER 4: Results & Discussion**

### **4.1. Policy**

Key-informants in Group 1 are generally proud to import the Accreditation process to Lebanon, giving the rationale of choosing this model because it is the one which is “...*the most appropriate...*” to the Primary Healthcare system in the country after being customised by PHCs. In fact, the ACI standards were piloted, tested and customized to the needs of Lebanon, before being officially launched in Beirut in front of the representatives of the MoPH network of PHCs, many of whom have already participated in the first phase of the ACI pilot project too.

As mentioned by the Director of Primary Healthcare in Lebanon (Dr R.H., Group 1a):“... *the interest for the concept of quality began in Lebanon in 2007 with the “Quality Assurance and Performance Improvement” (Kanaan et al.; 2007) as a study presented by Balamand University and afterwards, the MoPH developed this concept into an agreement with ACI in order to implement the Accreditation process in Lebanon as a main reform for the Primary Healthcare Sector in particular, and now [in 2017], the results have shown the big positive evolutions in the centres that have underwent the Accreditation with success...*”

Indeed, the results show that the Accreditation Program implementation in PHCs reflect the MoPH first success in its QI national policy in Lebanon for the first batch of surveyed centres. For instance, Mr I.H. (Group1) mentioned that, amongst the MoPH network of 212 public and private

PHCs, from which 92 mock and 31 actual Accreditation surveys have been done (until January 2018), the main things that have changed are: the concept of quality, the dissemination of quality standards, and the unified policies and procedures, assuring that the performance of these centres has improved in general, according to the feedback of the MoPH health coordinators during their monitoring field visits to the PHCs in all Lebanon. Briefly, Accreditation was a real QI reform at the level of all the Lebanese PHS, as Dr F.J. (Group 1) emphasised:

*“The Accreditation policy is one of the most effective tools for a better regulation of the health system ... This was a driving force and a change of management ... a reform as a key driver for the reform of PHCs...”* in addition to its main impacts on the whole PHS: *“... a better satisfaction of staff and clients, optimal utilisation of resources, diversification of services, attraction and retention (of Human Resources), with more actual impacts related to patients’ outcomes”*.

Nevertheless, the MoPH has to change its negative authority image perceived by some NGOs and rebuild with NGOs a mutual partnership instead of an autocratic conflict of powers, as referred to by an NGO’s CEO:

*“Another challenge (of the Accreditation process) is the “Police culture” detained by MoPH as a controller of healthcare services instead of building partnerships with NGOs...hence, the culture must be shifted towards a culture of cooperation and improvement with respect and trust and help...”* (Group 3; Dr K.M.).

Here below, the results of the study will be exposed according to the policy-related themes of *good governance, financial management and performance* in addition to *the sustainability of the system*.

### ***Good Governance***

In fact, the standards of the Accreditation (see Appendix D) contain an essential part dealing with good governance, mainly the integration of the Board and top management on the new Accreditation reform, in addition to the management of the human and financial resources. The results show that the Accreditation Program has improved the good governance processes

in general as mentioned by one Canadian Accreditation Surveyor (Group 1; Mrs M.B.):*“The Accreditation program has assisted sites to improve, or to initiate, their governance processes...”*

As in the below quote, the trend in Lebanon is that powerful political parties detaining high financial resources manage big social centres and PHCs that will compete by far the ones with no political support, especially on the absence of a powerful governmental authority: *“There is a lot of political power and the Lebanese Health System is weak (effectiveness versus efficiency)... Small centres have to be empowered.”* (Group 2, Dr H.A.), knowing that: *“There is a big discrepancy among PHCs according to the existence of money or not.”* (Group 2, Dr H.A.).

### ***Financial Management***

Results have shown that funding is uncertain in most NGOs and that *“... PHCs have a big financial burden in order to meet the requirements [of the compliance with the Accreditation standards]...as the costs of quality are high”* (Group 2, Dr G.H.), especially in some rural or semi- urban places where: *“... Money is a big problem in poor areas...”* (Group 1; Mr A.B.), especially that MoPH cannot cover all the expenses - as it is already covering in kind costs such the essential medications, the basic equipment (such as echography and minilab machine). However, *“Pay for Performance”* will be a solution for this financial gap (Group 1; Dr F.J.) as it has already been implemented in Lebanese hospitals because *“...it is easier to implement in hospitals, giving more business, such as physicians’ payment.”* (Group 2, Dr G.H.). In reality, NGOs are less business oriented than private hospitals and clinics and rely more on charity donations and projects funded by international NGOs. Consequently, the financial process shall be more formal, with a better emphasis on accountability and transparency.

### ***Performance and Sustainability of the System***

All groups of key-informants unanimously agree about *“... the positive difference the Accreditation process has made”* (Group 1; Mrs M.B.) indicating its positive impacts on the PHS in general and

how “*Accreditation has restructured the PHCs’ network in Lebanon. It modernizes and scales them up to our [NGOs...] expectations of services*” (Group 3; Mr K.K.). However, the perception of “performance” can differ from one group to another; for instance, from a national policy perspective of improving the overall PHS (Group 1), through an academic and learning development approach (Group 2), to an internal organisational improvement of processes and outcomes (Group 3) as connoted below:

*“The Accreditation process has improved the performance of PHCs: [mainly through the...] empowerment of human resources, enhancement of the quality of services, standardisation of the physical settings, the management of medical wastes and the optimal repartition of services in addition to the emphasis on a well-established monitoring system”* (Group 3; Dr K.M.).

However, as “*many sites are facing sustainability issues*” (Group 1; Mrs M.B.), sustainability is an essential factor in the long-term success of the Accreditation program and its institutionalisation in the whole PHS to become a part of the daily operational activities of each component of the national system, at both the MoPH and PHCs’ levels. As the accreditation certification is valid for 3 years, and even though the process is monitored through the MoPH regional coordinators - with a very little number of auditors per PHC - the PHS shall be regularly and constantly monitored for the implementation of the ACI quality standards, as mentioned by a well-known and highly experienced key-informant: “*System-related interventions have to continue ... Improved performance and sustainability [will result] if MoPH consistently monitors PHCs. Each 3 years [of the accreditation certification validity] is not enough ...*” as explained by Dr F.J. (Group 1) who added that the Accreditation Program is a “*systematic way which the government uses to improve the system*” (Group 1; Dr F.J.).

## ***Discussion***

The efficacy and efficiency of the Accreditation as a QI initiative enhancing the PHS has been confirmed by a lot of studies (WHO, 2008; Ammar, 2009; El-Jardali et al., 2013 & 2014 & 2017; ACI, 2010; MoPH, 2014; MoPH, 2018, Chow-Chua & Goh, 2000; Meurer, 2002; Bloomfield, 2003; Wensing, 2006; Millar, 2013) with few others doubting about its real sustainable benefits (Health Foundation, 2013) in comparison with the personal interests of some healthcare providers, such as doctors (Chamberlain et al., 2018). Even though many policy reforms have failed worldwide, but comparison of performance indicators in 7 main countries has found that the quality of the whole healthcare system will improve when policy makers will enhance: primary care, information technology and QI (Gauld et al, 2014). In the case of Lebanon, QI began in hospitals and it is only recently that it has been launched in the primary care sector where information technology has been already installed. Finally, the main improvement request is the creation of a “National Council” for clinical governance which will monitor the good application of the evidence-based guidelines and will afford the QI and patients’ safety education for the healthcare providers (El-Jardali & Fadlallah, 2017). To be more holistic, it is recommended that this council will oversee the managerial part of the Accreditation system in addition to the clinical one; it must be trustful and representative too.

## ***4.2. Organisation***

### ***Culture***

At the organisational level, it is found that the visibility of PHCs has improved after the Accreditation program reforms in comparison to the previous negative image and stigma on the minds of the population. In reality, as quoted below, the real positive change was on the quality of services, offered to more demanding vulnerable communities and expanding to new categories: “... *The image of PHCs is more apparent now, with better quality of products, in response to the high demand from poor populations and Syrian Refugees...*” (Group 2, Mr M.H.); and:



*“Accreditation improved PHCs, [...] with a better quality engagement and a better coverage of the population”* (Group 1; Dr F.J.). It has been found that the culture of quality has not been achieved yet in this first phase of the Accreditation reform, as internal people are targeting in general the day of the Accreditation survey as a final destination without realising that *“quality improvement is a journey; we are always changing, improving, adapting, discovering...”* (Group 1; Mrs M.B.), and thus to conclude that *“PHCs’ thinking about quality needs maturity and time to become a culture...”* (Group 2, Mr M.H.). Indeed, it has been remarked too that the beneficiaries from PHCs’ services are not aware yet of the QI concept, as explained by the consultant Dr A.O. (Group 2): *“However, the Accreditation process impacts have not affected the end-users (patients and their families) because it has not yet been integrated into the culture of the organisation and its people, which is a prerequisite for the quality process in order to reach clients effectively”*.

### ***Patient Satisfaction***

It has been shown on the amended version of the WSP framework, people’s satisfaction is an essential component of QI. The Community Focus Group Discussion has reflected the perception of patients’ and community’s representatives of what do “better quality services” mean to them by presenting the following answers: *“...less waiting time...”; “...better information about my health...”; “...more timing dedicated by the physician for explanation...”; “...to participate and make decisions related to my health...”; “...obtain positive outcomes for my treatment ....”*

### ***Discussion***

In some PHCs, radical QI organisational modifications have been noticed which have reflected on the productivity of the offered services and on the impacts of community outreach activities; this style of change matches the Business Processes Re-engineering followed by some senior executives to obtain highly valued processes for a great and rapid productivity of performance (Chow-Chua et al., 2000). Indeed, a sustainable - to reconsider Klazinga’s (2000) criticism to the “Wimpole’s Street Principles” - quality system adapts all the available strategies and functional

systems to the actual context while enhancing a transparent evidence-based culture of continuous improvement in which strategic management is consistent with performance evaluation (Hinchcliff, 2012). It is highly recommended then to install a culture of safety and continuous improvement at the organisational level (El-Jardali & Fadlallah, 2017) and to promote it in order to celebrate the realized safety measures (Elmonstri et al, 2017). For instance, healthcare organisational characteristics can influence quality improvements and major variations can be due to different situational factors (Glasgow, 2013). This is why it is recommended to customize the quality standards to the local context and to adapt them to it, and then to let the healthcare providers obtain the ownership of the relevant processes they are performing.

#### **4.3. Methods**

##### ***Evidence-Based Processes***

All groups recognised the great shift the Accreditation program has induced, from informal routine daily operations to evidence-based thinking, still needing more time to become totally integrated in all the PHCs' practices. The following testimonies from some Group 1 policy makers clarify that *“the accreditation process has assisted sites to formalize processes through the implementation of policies and procedures, develop programs such as preventative maintenance programs, performance management and care plans with patients”* (Mrs M.B.). Moreover, Mr I.H added that the main impacts of the Accreditation process were that: *“... it has induced many changes on PHCs in Lebanon such as: Medication reconciliation, Pharmacist' audit and (the concept of) safety in general, medical files, strategic planning and indicators.”* However, academics and experts in Group 2 suggested that knowing that *“...the purpose is to standardize up-to-date evidence practices with better quality services [offered in PHCs]...”* (Dr G.H.), then *“...there is a need to enlarge the network of Benchmarking indicators”* (Mr M.H.). Indeed, Group 3 acknowledged the importance and transformation done in their centres regarding the implementation of managerial procedures, policies and procedures, updated capacity building,

safety systems and infection control procedures but are still facing some obstacles for the implementation of significant Key Performance Indicators and unified interdisciplinary clinical guidelines.

### ***Coordination and Partnership***

Analysis of the data indicates that the PHCs who have undergone the accreditation process have built new formal partnerships - such as the referral system - and networking between other similar settings or complementary ones on the same region or catchment area of the PHC. Both keyinformants from Group 1 and 2 are satisfied about these results: *“I have seen much growth in the clinics... I believe the sites are doing more `cross- pollinating` now than they used to – that is, they are sharing more and helping one another out.”* (Group 1; Mrs M.B.); *“Referral systems have created partnerships with the community and municipalities [and hospitals]”* (Group 3; Mr K.K.).

### ***Discussion***

Although during the accreditation process, PHCs in Lebanon were not well-prepared, especially on the use of some tools like Quality Improvement Plans, clinical guidelines and the monitoring system of outcome indicators (Jardali et al, 2013); e.g., for the first time, PHCs are setting short and long-terms plans such as the ones for strategy, operations, Safety and Risk Management. . Undeniably, Quality Improvement is an analytic problem-based strategic tool for change in healthcare towards better systems and towards ultimate patient’s outcomes through a more efficient performance of processes by people with continuous professional development (Millar, 2013).

## ***4.4. Resources***

### ***Number of Staff and Competency***

Results have shown that the number of healthcare providers, nurses and practical nurses in particular, is low in relation to the number of PHCs’ visitors. Furthermore, most of them are ancient and well experienced but lack updated knowledge and innovation. However, a better human

resources' policy has been implemented, such as recruitment and career development. For instance, as Mr M.H. (Group 2) noticed: "...[there is a] *lack of highly qualified people to implement the quality process*", and he added: "...*more clever employment and recruitment, I do not mean that more Human Resources are employed but rather that PHCs know now how to invest more efficiently on them*" (Group 2, Mr M.H.). Nevertheless, some gaps have been emphasised by some Group 2 scholars, such as the differences between newly recruited and/or university trainees in PHCs and the ancient full-time employees, as testified by (Dr H.A.): "*New staff and fresh graduates are eager to improve but there is a discrepancy in performance... The main criteria are: age, security of the job and management of the Centre.*" On the other hand, some internal or external auditors are privileging the compliance process to the quality standards more than the interaction with the people implementing them in order to detect their encountered obstacles, as Dr Dr A.O. (Group 2) angrily objected: "*Some auditors are kicking people out of the process if they do not tell them that the Accreditation standards are a holy truth; instead, go with the people and listen to their problems and you will arrive more easily to abide by the standards*".

### ***Capacity-Building and Teamwork***

Results acknowledge that "*the Accreditation is a successful educating and learning process*" (Group 2, Dr M.O). In fact, the MoPH has investigated into capacity building and solid training sessions on the different domains of the Accreditation, at the different management levels of the organisation, especially the middle and executive managements in addition to the front line healthcare providers, mainly nurses. For instance, one of the main Key-Success factors was the "*continuous education and on-job trainings*" offered by the MoPH to all PHCs healthcare providers (Group 1, MoPH, Mr I.H.), especially for nurses which "*... has changed the traditional model of doctors as "big bosses"*" (Group 1; Mr A.B.). Indeed, physicians' resistance to change is high, whether in terms of very low participation to MoPH capacity building or

interdisciplinary teamwork, as noted: “*Availability of Human Resources versus overload (because of their scarcity) in order to apply all the (Accreditation) requirements...a better cooperation of Doctors (is required)...*” (Group2, Dr M.O.).

### ***Discussion***

Indeed, training is essential for the success of Accreditation (Buetow & Wellingham, 2003) and a specific human resources empowerment program focusing on patients and their safe environment is a key-success factor for QI initiatives (Esain et al, 2012; Tingle, 2012), in addition to the initiation of people to use “outcome measures” and to understand their advantages (NLC, 2013). For instance, it has been shown that staff from accredited centres in general were more engaged in initiatives related to safety and risk management and QI (O’Beirne et al., 2013) and in better career development (Greenfield & Braithwaite, 2008). In the case of Lebanon, this involvement has motivated people to speak out their opinions with satisfaction, which is thought to increase with Accreditation (Paccioni et al, 2008), and therefore, to help improve the results of quality compliance and sustainability of the QI initiative (Jardali et al, 2014).

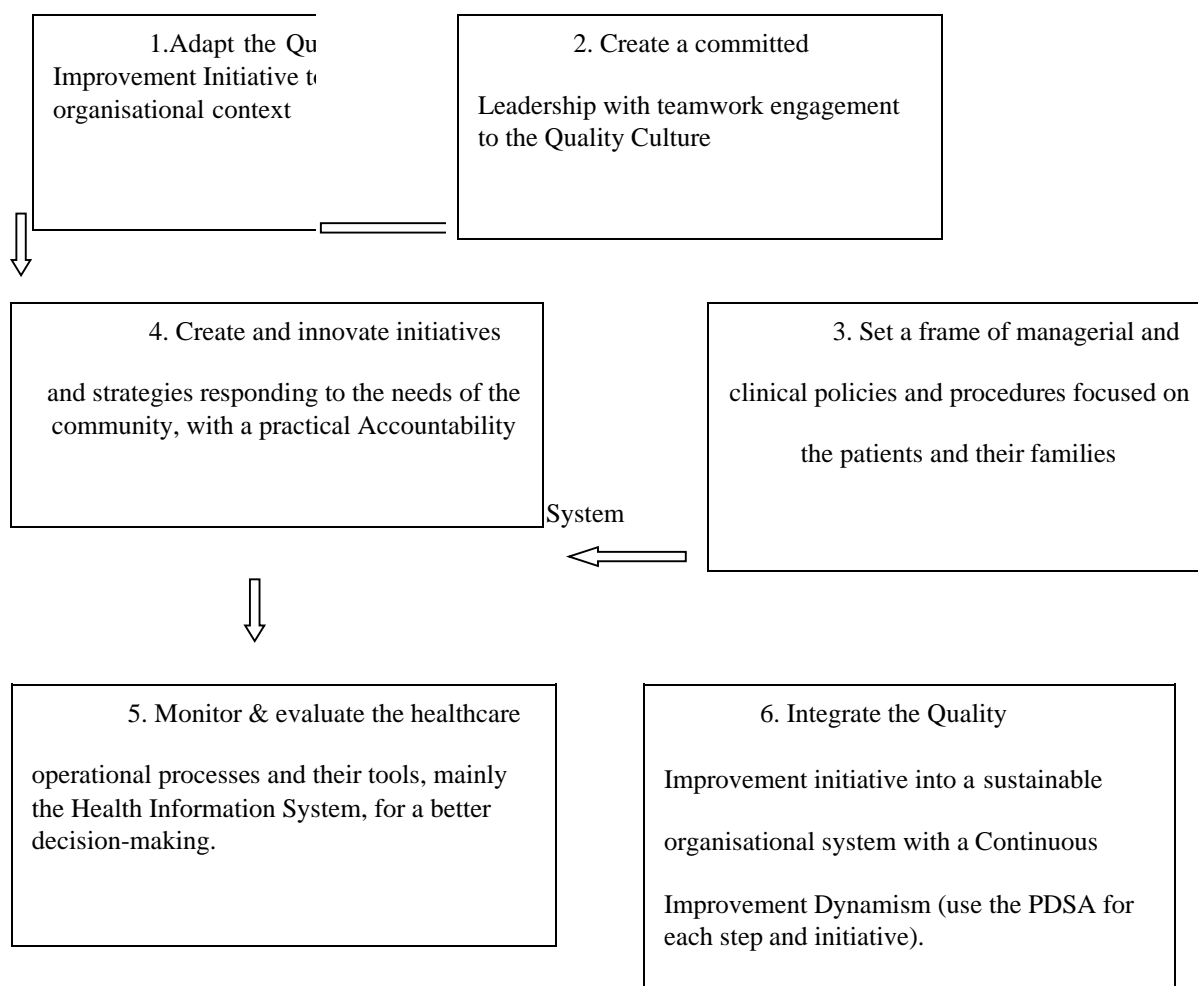
As per the financial resources, the “pay for performance” mechanism exists only in hospitals but not in PHCs where only partial in-kind allocation support is afforded, such as the Essential Medications Program, vaccinations, equipment, and free of charge trainings. Also, it must listen and respond to PHCs’ claims to have better financial support for the most vulnerable ones, which has no political or stable economic coverage, in order to enhance the performance of the PHS, seeking a harmony between equality and equity. Indeed, the allocation of resources for QI initiatives is still weak at the national level, especially in the public sector, whereas it varies in the private sector, from previously allocated budgets to non-existent ones, needing to be more systematic (El-Jardali & Fadlallah, 2017). However, better governmental investments in healthcare are demanded with the expected future reform of the PHS towards Universal Health Coverage of

all vulnerable populations, as health is a basic human right and not a consumable service or good (The Lancet, 2018; WHO, 2018)

#### 4.5. *The Best-Practices Model*

As a summary, the main key success factors – in theory & practice - of Quality Improvement to improve the performance of the primary care system, the following Conceptual Framework can be useful for decision-makers to implement a sustainable effective Quality Improvement initiative at the Policy level:

**Figure 3:** *Best Practices Framework for a high performance PHS*



This six-step “Best-Practices Model” is an analytical result of all the comprehensive strategies used

in this dissertation. When implemented at the Policy level, it will enable the Primary Healthcare

System to implement efficiently the quality standards through its incremental implementation into the MoPH network of PHCs by their executive leaders.

#### **Chapter 4: Conclusion & Recommendations**

In conclusion, there has been many major reforms in Primary Health Care internationally since Alma Ata in 1978 and, even though it has not achieved its intended goals of attaining “Health for All”, it has realised a paradigm shift of a healthcare system that has become a comprehensive people’s centred system, with a harmonious synergy between evidence-based and humanitarianism. Indeed, the “Wimpole Street Principles” as a framework for QI needs to be more flexible and interactive between its four domains of quality, with a virtual circular shape bridging all the existing frontiers. In this case study on the impacts of the Accreditation program in Lebanon on the performance of the PHS, a lot of progress in all the domains of quality has been shown since 2012 till now, but it is still an emerging pilot QI initiative which needs continuous improvement. The main recommendations are to have a standardised valid and reliable QI system at both the national and organisational levels, with a sustainable integration of the standards on the operational processes of engaged people and leaders focusing on patients and their families’ well-being. Finally, the key-message for the change management process of the Accreditation of the Primary Healthcare Sector in Lebanon is that the implementation of quality improvement standards by engaged leaders and delivered by empowered teams, lead to a better comprehensive people-centred evidence-based health system with high performance and safe patients’ outcomes. Indeed, the key success factors for a sustainable transformation and high performance are: engaged Leadership (top and executive), integrating quality into the organisational culture, learning and empowering people, partnership with the targeted population (and community volunteers) in addition to the prompt responsiveness to its needs, team spirit, engagement of physicians, partnerships with local stakeholders, financial stability and system’s sustainability ...

### *Recommendations*

In practice, and as an outcome of this thesis, the researcher's main key-messages for Primary Healthcare Organisations to achieve high performance in Quality Improvement reforms in general and in the Accreditation program in particular, are the following:

- Leaders from the top to the bottom management shall be strongly involved, in addition to physician managers, in order to possess the ownership of the change management of the quality improvement initiative. Good governance and financial stability are needed;
- A strong capacity building program engaging people has to be monitored and sustained; - A culture of quality, safety and continuous improvement shall be installed in an incremental way, with clear small objectives to be attained in a defined time;
- Health Information Systems shall be reinforced for an efficient evidence-based health and staff shall be well-trained on its utilisation and its data management;
- Clear and intelligent documentation shall be implemented and practical "Policies and Procedures" simplified to be used easily by the front line healthcare providers;
- Participation of healthcare providers (interdisciplinary teamwork) and involvement of the community (prospective visitors and patients and their families) and other levels of care shall be implemented through coordination and collaboration.

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