



TQM IMPLEMENTATION FOR THE HEALTHCARE SECTOR. THE RELEVANCE OF LEADERSHIP AND POSSIBLE CAUSES OF ITS LACK

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Purpose

The main purpose of this paper is to enlarge the debate on Total Quality Management (TQM) implementation in the healthcare sector and to evaluate how and whether leadership can affect TQM implementation.

Design/methodology/approach

This paper is based on findings from a literature review of TQM and leadership. We analysed our findings in order to categorise causes of a lack of leadership in TQM programme implementations.

Findings

We propose three categories of causes of a lack of leadership in TQM programme implementation. The first cause is well known: a lack of senior managers' involvement and commitment. Our second category is the 'combined leadership' that occurs in large healthcare organisations; our third category is the influence of an external 'political leadership' on public healthcare.

Research limitations/Implications

This paper presents researchers with three categories of causes of failure of leadership in TQM implementation that can be investigated. It also encourages reflections from practitioners concerning TQM leadership in the healthcare sector

Practical implications

We request that practitioners reflect on ways to create or sustain a 'monolithic' leadership, especially in large organisations, to ensure a common vision, values and attitude for unitary TQM governance.

Originality/value

In an original way this paper analyses and proposes three categories of causes linked to a lack of TQM leadership in the healthcare sector.

Introduction

Total Quality Management (TQM) has its roots in Japanese Total Quality Control (JTQC) as well as in the teachings of quality management gurus such as Deming, Feigenbaum, Ishikawa and Juran (Chiarini, 2013). TQM has characteristics linked to customer satisfaction, continuous improvement, process management, employee fulfilment and learning, management commitment as well as visionary leadership (Deming, 1986). TQM was popular during the 1980s and 1990s but its popularity declined in the 2000s. In the 1990s, excellence awards such as The Malcolm Baldrige Award in the USA and European Foundation for Quality Management (EFQM) in Europe (Gómez et al., 2015) contributed to the popularity of TQM. Moreover, ISO

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3 9001 certification boosted TQM implementation; it encouraged the embedding of a more performant
4 quality management system (Psomas and Pantouvakis, 2015).

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6 TQM programmes have affected the healthcare sector, including the public healthcare sector, as
7 revealed by several interesting and successful case studies (Øvretveit, 2000; Mohammad Mosadeghrad,
8 2003; Chiarini and Baccarani, 2016). However, the literature shows that in this new millennium the effect of
9 TQM on healthcare has been reduced. Some authors highlighted that TQM is considered more a philosophy
10 than a real management system (Paton, 1994) and that Six Sigma cast a shadow over TQM (Black and
11 Revere, 2006; Chiarini, 2013), in spite of the significant differences between Six Sigma and TQM.

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16 There is a huge quantity of literature about TQM but, according to Knights and Wilmott (2000),
17 sometimes authors contradict each other and it is not clear what TQM contains, although leadership has a
18 role. It seems that Western TQM is losing its identity (Chiarini, 2011). A review of the literature shows that
19 many improvement projects have been carried out under the TQM 'umbrella' but they do not follow similar
20 paths. Paton (1994) argued that TQM cannot be developed through a precise roadmap or pattern. Hellsten
21 and Klefsjö (2000) found that the gurus of TQM themselves sometimes did not like the concept of TQM.
22 Furthermore, the same authors found that the same TQM concept could have different names and that
23 there are vague descriptions and few definitions of TQM. By contrast, in Japan, TQM still seems to have its
24 own identity, strictly linked to JTQC (Yamaji and Amasaka, 2008); other Eastern countries also recognise
25 that there is a successful Japanese TQM style that can be followed (Nassir Shaari, 2010).

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32 In our opinion, the causes of the West's declining interest in TQM are not well known or debated. In this
33 light, we analyse whether the West's declining interest in TQM lies not in a cultural or technical dimension
34 but in a pure managerial dimension. In particular, our viewpoint is that there is a combination of factors
35 leading to the declining interest in TQM in the public healthcare sector, including a lack of leadership from
36 the top and senior management. It is well known that leadership is necessary for the success of complex
37 management systems such as TQM. We want to open a debate among scholars and practitioners on the
38 factors behind this lack of leadership in the healthcare sector.

39 40 41 42 43 44 **TQM and leadership**

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46 The TQM movement arose from the culture and organisations of Japan that developed JTQC. There are
47 differences between American Total Quality Control and JTQC (Martinez-Lorente et al., 1998); these
48 differences characterised the TQM models.

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Ishikawa was the first to shift attention from control towards the term management. According to
Martinez-Lorente et al. (1998), the idea that quality does not just have to be controlled but managed
emerged in the literature. We are not completely sure, but this was probably the beginning of the TQM
movement around the world. In any case, the most relevant works which contributed and still contribute to
the dissemination of TQM principles are Deming's well-known books *Out of the Crisis* (1986) and *The New*

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3 *Economics* (Deming, 1993). It was Deming who, for the first time, drew attention to TQM combined with
4 leadership. The most relevant TQM characteristic and principle is leadership supported by senior
5 management involvement and commitment (Sila and Ebrahimpour, 2002). The characteristics of leadership
6 that Deming proposed can be traced in the so-called Deming Management Method; the Deming
7 Management Method depicts visionary leadership as the ability of management to establish, practice and
8 lead a long-term vision for the organisation, which is driven by changing customer requirements as
9 opposed to internal management control. Leadership is also a specific criterion of the American Malcolm
10 Baldrige model forming a triad with the criteria of strategy and customer (Baldrige Foundation, 2016).
11 According to the Malcolm Baldrige model, leadership is not just about senior managers' behaviour from a
12 strategic point of view but is also a matter of corporate governance and how the organisation fulfils its
13 legal, ethical and societal responsibilities. Leadership is structured with processes such as vision and values;
14 it promotes legal and ethical behaviour, communication and organisational performance and creates a
15 successful organisation. Furthermore, leadership is the first and principle criterion of the EFQM model,
16 which is also based on TQM principles. According to the EFQM model (EFQM, 2012) a leader is not just the
17 CEO or the top management of the organisation but the management as a whole.

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According to Porter and Parker (1993), senior managers should express their leadership by being very involved in TQM implementation, by showing correct management behaviour and participation, such as 'management by fact' and long-term vision. In TQM implementation, usually a steering committee of senior and top managers leads the TQM programme at all stages. Strategic management is the first important stage; at this stage senior managers should link their mission, vision and values to TQM principles. The Japanese Hoshin kanri is still one of the most used strategic management systems (Akao, 2004) for TQM deployment along with the American Balanced Scorecard. Through their leadership, senior managers should also stress the use of teambuilding and team efforts (Vouzas and Psychogios, 2007) for all staff. In fact, employee involvement is mandatory in TQM programmes; many TQM implementations have failed due to a lack of employee involvement. However, the causes for failure can be attributed to: first, senior managers' weak leadership; and second, nonparticipation and an unclear connection with the strategic objectives set out by senior managers.

As a last note concerning leadership and TQM programmes, it is interesting that the latest ISO 9001:2015 standard (ISO, 2015) has introduced a well-structured requirement named leadership. ISO 9001 certification has its roots in Feigenbaum's principles of TQC and quality assurance as well as Deming's Plan-Do-Check-Act (PDCA) approach. According to Freeman and Drown (2016), leadership in ISO 9001:2015 is made up of a first process for identifying and understanding the purpose and the strategies of the organisation as well as the needs and expectations of the stakeholders. After this first process, top and senior managers finalise their strategic direction with objectives, evaluating the entailed processes,

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3 resources and risks. Furthermore, senior managers have to periodically review performance determining
4 and facilitating necessary action.
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7 8 **Analysis and discussion of TQM in the healthcare sector**

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10 TQM has been implemented in the healthcare sector since the late 1980s. At that time, some healthcare
11 organisations, especially in the USA, started exploring and implementing TQM. The success of TQM in the
12 manufacturing sector led to a debate concerning the potential of TQM to increase customer satisfaction,
13 reduce the cost of poor quality and increase productivity in all sectors. Zallocco et al. (1992) claimed that
14 the healthcare sector was second only to the manufacturing sector in implementing TQM programmes.
15 However, we found some criticisms of the application of TQM to healthcare. For example, Keyser (1989)
16 analysed the possibility of the National Health Service in the UK embracing TQM; Keyser (1989) concluded
17 that there were some pitfalls linked to terminology and quality tools that were more suited to a
18 manufacturing context.
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24 Similar to the manufacturing sector, in the literature we found a strong interest in TQM for healthcare
25 during the 1980s and 1990s with a significant drop of interest at the beginning of the 2000s. Øvretveit
26 (2000) analysed all European TQM implementations in the healthcare sector concluding that only a few of
27 them had great success, while several encountered many difficulties. Black and Revere (2006) declared the
28 TQM era in the healthcare sector had almost died.
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32 But why, after the enthusiasm of the 1990s for TQM, did interest in TQM decline in healthcare and why
33 were some difficulties in its implementation encountered? Is there a parallel with the manufacturing
34 sector? We analysed the healthcare literature and found that in many cases there was a lack of leadership.
35 For instance, Mohammad Mosadeghrad (2013) analysed several papers dedicated to TQM implementation
36 obstacles and failures in healthcare; Mohammad Mosadeghrad (2013) found three categories of failures
37 including an inappropriate environment for TQM implementation. According to Mohammad Mosadeghrad
38 (2013), the most inappropriate environment is that in which there is a lack of supportive leadership. Other
39 authors agree with this critical factor, claiming that leadership is the most important trait and the backbone
40 of TQM programmes (Oakland, 2011; Nwabueze, 2011; Irfan et al., 2014).
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47 Hence, we propose that leadership has affected TQM implementation in the healthcare sector and that
48 a lack of leadership can lead to a failed implementation. However, we would like to debate the causes
49 behind a failure of leadership from senior management. We suggest that there are three categories of
50 causes linked to this failure. The first category is intrinsically bound to a lack of involvement and
51 commitment from senior managers; motivations for this are various and we do not want to enter this
52 particular line of inquiry, which has already been debated by many scholars.
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56 The second category, which is one that we would like to analyse and discuss, is something that often
57 happens in large healthcare organisations made up of several complex departments, such as large
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3 hospitals, which we could refer to as 'combined leadership'. In large hospitals, each department usually has
4 a senior manager with strong organisational power; some senior managers' power is stronger than other
5 senior managers' power in different departments. Consequently, conflicts between senior managers can
6 jeopardise extensive implementation of a management system, such as TQM, where it is necessary to have
7 a management system for the organisation as a whole. In fact, the literature shows that many TQM
8 programmes are implemented in only one or a few departments of complex healthcare organisations.
9 Unfortunately, this leads to success in only a few departments and the benefits are often temporary. In
10 complex healthcare organisations, to achieve best performance, each department needs to be connected
11 with others in a sort of internal supply chain (Kenett and Lavi, 2014). TQM could be launched for instance in
12 the department of surgery, but what if the laboratory or radiology departments did not follow suit? Worse,
13 what if the head of the laboratory department considers TQM a waste of time? Using Deming's words,
14 complex organisations should have a visionary leader, often corresponding to the top manager, who tries
15 to create TQM leaders within the different departments whose objectives, values and attitude to
16 leadership are aligned. In fact, according to the Malcolm Baldrige model, leadership is also a matter of
17 governance and not only the power of one or a few senior managers.

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27 In our opinion there is also a third category of causes linked to a lack of TQM leadership in healthcare
28 organisations. These causes can be mainly found in public healthcare organisations that are in large part
29 funded by governments. In many countries there is a degree of political influence on public healthcare
30 organisations. That means that politicians, in a way, are the real leaders of these organisations and they
31 impose their own strategies and objectives, sometimes with electoral results in mind. Furthermore, in some
32 circumstances, politicians directly appoint the top and senior managers of these public organisations. We
33 refer to this third category of causes as 'political leadership'. But are we sure that these political
34 phenomena can really instil the visionary leadership described by Deming?

35 36 37 38 39 40 41 42 **Conclusions**

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44 The healthcare sector has implemented TQM programmes since the 1980s. Interest in TQM
45 implementation reached its peak at the beginning of 2000s and then started declining. Our review of the
46 literature does not show a precise pattern or cause for this phenomenon. Some authors considered that a
47 general lack of interest in TQM arose because it was viewed as a philosophical approach rather than a
48 systematic and structured one; actually, in some circumstances, Six Sigma has replaced TQM. Other authors
49 stated that the decline in the implementation of TQM in the healthcare sector is due to cultural aspects,
50 such as terminology and processes and tools that are more oriented towards manufacturing than
51 healthcare. Regardless of anything else, it is a fact that several healthcare organisations failed in
52 implementing TQM programmes or succeeded only in some parts of their complex organisations, such as in
53 some departments in large hospitals.
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Our viewpoint is that fundamentally TQM implementation needs a 'monolithic' visionary leadership, as Deming used to say, and many of the causes of failure are the result of a lack of visionary leadership. One recognised category of a lack of leadership is a lack of senior management involvement and commitment. We propose two other categories of causes which we name as 'combined leadership' and 'political leadership'. The first one is typical of large healthcare organisations with many departments and senior managers who need to be aligned and aware of a sole TQM leadership. The second category is the effect, in some countries, of external politicians on strategic objectives, which is mostly confined to public healthcare. This political influence can hinder and challenge the leadership required for the successful implementation of TQM.

We have presented our viewpoint and we request that other scholars examine TQM leadership in the healthcare sector. For example, is TQM still implemented in healthcare organisations? Is TQM still used in the West? Where is TQM successful? And why is there a decline in TQM implementation in Western healthcare? Is TQM being transformed into something different such as Six Sigma? We need to investigate the root causes of the declining interest in TQM and failures in implementation in the healthcare sector. Lastly, researchers could investigate our three categorises of a lack of leadership, in particular, combined leadership and political leadership.

Our viewpoint also encourages reflections from practitioners concerning TQM leadership in the healthcare sector. For instance, in what ways can practitioners create or sustain this 'monolithic' leadership, especially in large organisations with many departments. What is the best way to share a common vision, values and attitude for developing unitary TQM governance among different senior managers?

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