

Hospital governance and quality of care in Algeria: an analysis of institutional constraints and reform perspectives, the case of the University Hospital Center of Tizi-Ouzou

الحكومة الاستشفائية وجودة الرعاية الصحية في الجزائر: تحليل القيود المؤسسية وآفاق الإصلاح،
حالة المركز الاستشفائي الجامعي لتيزي وزو

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Abstract:

Public hospitals in Algeria face multidimensional constraints and challenges, despite the reforms undertaken by the public authorities. Improving the quality of care is one of the main challenges, and governance is a major lever. The objectives of this article are to analyse the constraints and their effects on the quality of care and to identify areas for reform. To achieve this, we adopted a qualitative methodological approach based on an interpretative paradigm. Our survey of practitioners at the Tizi-Ouzou University Hospital Centre enabled us to identify the governance mechanisms that constitute an obstacle to improving the quality of care and to identify possible reforms to remedy this situation based on the perceptions of the actors concerned.

Keywords: hospital governance; quality of care; healthcare system; hospital management; institutions.

JEL Classification Codes: I18, H75, L32.

ملخص:

تواجه المستشفيات العمومية في الجزائر قيودًا وتحديات متعددة الأبعاد، على الرغم من الإصلاحات التي قامت بها السلطات العامة. ويعد تحسين جودة الرعاية أحد التحديات الرئيسية، وتعد الحوكمة أحد العوامل الأساسية في هذا الصدد. يهدف هذا المقال إلى تحليل القيود المؤسسية وآثارها على جودة الرعاية وتحديد مجالات الإصلاح. ولتحقيق ذلك، اعتمدنا نهجًا منهجيًا نوعيًا قائمًا على نموذج تفسيري. وقد مكنتنا استطلاعنا للممارسين في المركز الاستشفائي الجامعي بتيزي وزو من تحديد آليات الحوكمة التي تشكل عائقًا أمام تحسين جودة الرعاية، وتحديد الإصلاحات الممكنة لتدارك هذا الوضع بناءً على تصورات الأطراف المعنية.

كلمات مفتاحية: حوكمة المستشفيات، جودة الرعاية، نظام الرعاية الصحية، إدارة المستشفيات، المؤسسات.

تصنيفات JEL: I18، H75، L32.

INTRODUCTION:

Healthcare systems around the world are designed to provide a public service. The purpose of these systems is to offer protection against illness to insured persons and the entire population without discrimination (OUFRIHA, 1991, p. 7). In all its constitutions adopted since independence, Algeria has considered health to be a fundamental element and an absolute universal right. It has thus considered health policy to be an essential factor in economic development and individual fulfilment. The efforts made to build and develop this health system are considerable and the results undeniable.

In principle, the national health system advocates universality, free access and equitable access to care for all. The reforms and perspectives adopted by the public authorities aim to put these principles into practice. However, reconciling the doctrine of free care with the provision of quality care remains difficult and complex to achieve. Indeed, the concept of quality of care is multidimensional. It is based on several structural determinants linked to the availability of resources, clinical effectiveness in terms of results, but also on determinants linked to the governance and organisation of healthcare structures (DONABEDIAN, 1988, p. 1744).

Several scientific studies have demonstrated the decisive role of hospital governance in determining the quality of care provided by a healthcare facility. After fifteen years of research, a scientific study shows that a participatory governance system, which includes practitioners in decision-making processes, is associated with better hospital performance (DE REGGE & EECKLOO, 2020). In this paper, hospital governance refers to the various incentive and dissemination mechanisms that organise relations between the different stakeholders, in this case the public authorities that steer health policies in Algeria and their branches, comprising various health departments and actors responsible for implementing them at the operational level, structured around the various healthcare facilities.

Despite the reforms undertaken in the Algerian hospital sector, the quality of care remains marked by inequalities that fall short of patients' expectations. Based on the premise that hospital governance is a major determinant of the quality of care, we will attempt to answer the following questions: What are the institutional and managerial obstacles within hospital governance that explain this persistence? What reforms could remedy this situation?

In order to carry out our research, we have set three objectives. First, we will identify the institutional and managerial constraints inherent in the Algerian healthcare system. Second, we will examine the impact of these constraints on the quality of care. Third, we will collect and analyse data on the impact of reforms.

To achieve our research objectives, our approach is based on an interpretative epistemological paradigm, adopting a qualitative approach. First, we will conduct a structured analysis of various documents and studies dealing with the healthcare system in Algeria. Second, to validate our research, we will conduct interviews with stakeholders involved in various healthcare reforms and policies in Algeria.

1- The healthcare system in Algeria: current situation, challenges and prospects:

The Algerian healthcare system is a colonial legacy, to which the public authorities have made numerous reforms. Since independence (1962), the national healthcare doctrine has been marked by the principle of free healthcare. However, despite the political will to implement this principle, the national healthcare sector faces numerous obstacles related to financing,

governance and quality requirements or standards.

1-1 Historical evolution of the healthcare system in Algeria

The evolution of the health system in Algeria has been marked by several key, even decisive, periods. During the 1960s, the government's efforts were focused on restoring the health system inherited from the colonial era. The government tried, as best it could, to respond to the pressing demands of the population in terms of combating communicable diseases and providing medical care.

During the 1970s, the health sector underwent profound reforms. In accordance with constitutional principles, the nationalisation of hydrocarbons (1972) and the resulting financial windfall enabled the public authorities to implement the principle of free healthcare. This was implemented by Presidential Order No. 73-65 of 26 December 1973, stipulating that "all Algerian citizens are entitled to receive free healthcare in any public health facility, regardless of their professional or social status". However, with a rapidly growing population, the public healthcare system remains insufficient to meet the needs expressed (particularly due to a lack of human resources).

During the 1980s, the public health sector saw an expansion in healthcare provision and significant institutional changes. This sector benefited from extensive investment in infrastructure and healthcare equipment. This action reinforced the principle of free healthcare by integrating social security as a new player in the financing of the healthcare system through the introduction of a flat-rate hospital fee. During this temporary phase, the enactment of Law 85-05 enabled the public authorities to organise the healthcare system into a health sector, allowing for the geographical or spatial distribution of healthcare provision. This objective also led to a gradual opening up to the private sector, which gained momentum during the 1980s and 1990s. (CHAOUI, 2012, p. 49).

In the early 2000s, the public authorities, in their drive for decentralisation, initiated reforms that favoured peripheral health areas. New healthcare organisational structures were created, such as public hospitals (EPH) and local public health establishments (EPSP). Through this healthcare restructuring, decision-makers sought to:

- implement a comprehensive strategy,
- improve the quality of the healthcare system,
- reorganise hospital management,
- improve hospital infrastructure,
- modernise medical equipment,
- optimise human resources in healthcare establishments.

On 2 July 2018, the public authorities enacted the first major health law since 1985. It includes an overhaul of the healthcare system. Nevertheless, the principle of free healthcare remains an immutable constant in national doctrine. This law aims to ensure the harmonious, equitable and rational distribution of human and material resources according to the needs of the population. To achieve this, the public authorities are reviving the health map as a planning tool. This reform abolishes EPHs and EPSPs in favour of a new type of establishment called "health districts", which are similar to the health sectors of the 1980s (JORADP, 2018).

In summary, we would say that the public authorities have always expressed a firm

commitment to building a health system based on the principle of free and accessible care. However, we question whether this socialist vision meets the requirements and needs of the population, particularly in terms of quality of care.

1-2 Challenges and constraints of the healthcare system in Algeria

We would like to point out that the national healthcare system provides universal, free and equitable access to quality care for all citizens. On the ground, we observe:

- Organisational, management and operational dysfunctions
- Weak governance of healthcare institutions
- Insufficient budgets for hospitals have prevented the principles and objectives that have been expressed or expected from being realised.

Based on our observations and visits to certain establishments in the wilaya of Tizi-Ouzou, we have identified a number of constraints and causes of dysfunction in the national health system that substantially reduce the scope, effectiveness and quality of health care in Algeria.

1-2-1 Access to and organisation of the healthcare system

The lack of a coherent organisation of the healthcare system is a major dysfunction. This situation leads to discontinuity of care on the one hand and difficulty in controlling expenditure on the other.

This dysfunction is particularly evident in the hierarchy of care. General practitioners no longer play their role in this healthcare system, even though they are supposed to monitor patients' files and guide them through their care pathway. This shortcoming or dysfunction leads to an uncontrolled increase in healthcare expenditure, particularly for households. Professor BRAHMIA (2023) alerts the public authorities to this dysfunction, which remains a challenge for the healthcare system (BRAHAMIA, 2023, p. 518).

In addition to these organisational constraints, there are difficulties in accessing the healthcare provided by the public sector. Indeed, difficulties in accessing healthcare facilities are particularly linked to specialist consultation services. This is related to the conditions of reception, referral, care and accommodation of patients, particularly in emergency situations. Added to this is the loss of continuity and hierarchy of care linked to the issue of integration and complementarity in the private health sector (MSPRH, 2021).

1-2-2 Human resources

The public sector suffers from several constraints related to both insufficient management and staff motivation. Indeed, medical management, particularly in terms of specialist doctors, is insufficient to cover the entire country and is concentrated in university hospitals. As a result, many hospital departments lack specialists. These are mainly concentrated in the main cities in the north of the country. Despite the existence of a civil service incentive scheme to encourage doctors to settle in remote areas, medical deserts persist.

These shortcomings in medical supervision are further exacerbated by the large-scale departure of public sector health personnel, due to widespread demotivation caused by the deterioration of their working conditions and the management of their practice and careers, with little recognition of their status. On the other hand, the attractive salaries offered by the private sector encourage the brain drain, thereby increasing household expenditure on healthcare.

Other constraints in terms of training should also be highlighted. These include the mismatch between the content of training for healthcare practitioners and the skills required to meet

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healthcare needs, as well as inequalities in the quality of training provided by training centres depending on their geographical location (MSPRH, 2021).

1-2-3 Health system financing

The public sector of the health system faces numerous financing issues. In particular, there are concerns regarding the sources of funding for this system. Household contributions to funding have become more significant than those from social security, with the state budget still being the primary source of funding. This has created a situation that completely undermines the principle of free healthcare. As a result, paid healthcare is placing an increasing burden on household income, thereby creating inequalities in access to healthcare.

Table (1): Evolution of the financing structure of health expenditure in %

	2002	2005	2006	2008	2010	2012	2014	2016
Results 1	50.6	47.5	45.6	48.3	44.7	51.6	46.7	42.1
Results 2	26.9	24.4	25.3	25.6	26.4	22.7	26.6	27.0
Results 3	22.5	28.1	29.1	26.1	28.9	25.7	26.7	30.9

Source: (BRAHAMIA, 2023, p. 473)

We note that household contributions have been steadily increasing and have become the second largest source of funding since 2005, after contributions from the public treasury and ahead of contributions from social security funds. This situation is due to the use of the private sector, particularly for specialist consultations. Budgetary restrictions and deteriorating working conditions in the public sector are pushing practitioners to join the private sector and users to increasingly turn to the latter.

In addition to these constraints related to sources of funding, there are those related to the "hospital flat rate" financing model, which has not changed since the 1980s. As a result, the public healthcare sector faces an extremely damaging lack of resources. The health budget is mainly used to pay civil servants (ABBOU & BRAHAMIA, 2017, p. 156). From 2000 to 2010, this share tended to decline, falling from nearly 62% in 2000 to nearly 55% in 2010. However, since 2012, this budget has increased to 60% and 61% in 2012 and 2016, respectively (see Table 1). According to the 2012 Finance Act, this rapidly growing budget was mainly devoted to the payment of salary arrears, which increased in 2008. (MAHFOUD, 2020, p. 11).

1-2-3 Governance and administration of healthcare facilities

The governance system in place is one of the main factors limiting the performance of the national health system in general and public healthcare facilities in particular. This mode of governance is characterised in particular by excessive centralisation of decision-making at the highest hierarchical level.

This centralisation leaves little room for manoeuvre for stakeholders in healthcare facilities and very little discretion for their managers. This situation leads to low participation by healthcare actors, low autonomy in management and the absence of a regulatory and evaluation framework, which generates numerous dysfunctions inherent to healthcare facilities, particularly in terms of the quality of service provided, the culture of performance and results in managerial practices (MSPRH, 2021).

Referring to the principles of good governance, namely: stakeholder participation in

decision-making, accountability or identification of responsibilities, subsidiarity and transparency, (DEHBI, 2017, p. 123) highlights a number of constraints related to non-compliance with these principles in the performance of the health system's functions in Algeria.

The first attribute of the national health system is to identify the needs and priorities of the population. The various stakeholders in this system contribute to this process. However, user participation remains informal or even non-existent. Furthermore, the central health authorities bear the greatest responsibility for the results of this process, which leads to centralised decision-making regarding the design of strategies, objectives and priority actions. This centralisation, far removed from other stakeholders, creates a certain opacity in the system. This reduces their commitment and motivation in implementing the various strategies.

The public sector of the national health system accounts for more than 70% of healthcare provision. As a result, the greatest share of responsibility for this function lies with the public authorities, which control most of the factors of production for healthcare services. Consequently, they are responsible for ensuring the continuity, quality and continuous improvement of public services. Despite the efforts made and the resources committed, the quality of care remains inadequate and its distribution generates significant geographical disparities, particularly between urban and rural areas. These disparities create difficulties in accessing care, which tends to lead to unhealthy behaviours.

With regard to the administration of the various health structures, it is still the central authorities that hold most of the decision-making power and therefore responsibility. Nevertheless, other local actors (councillors, public or private institutions, the pharmaceutical industry, etc.) and other international partners (UN, WHO, etc.) can play an advisory or incentive role within the framework of cooperation. On the other hand, the participation of the population or its representatives remains embryonic. However, considerable efforts are being made towards decentralisation with the aim of transferring part of the decision-making power to local officials in order to ensure greater openness and transparency in the system.

We have outlined above, without claiming to be exhaustive, the main constraints and major challenges facing the Algerian health system. In order to address these issues, the public authorities have adopted an action plan covering several areas, thus forming the prospects for health system reforms, which we will discuss below.

1-3 Prospects for the healthcare system in Algeria

In its projection for 2030, the public authorities have expressed their willingness to bring about profound reforms to the national health system through their action plan. The planned actions focus in particular on improving the quality of care by humanising the activities of health establishments, improving health coverage and strengthening the participation of civil society (Services du premier ministre , 2021, p. 52).

The quality of care is a major challenge for the healthcare system in Algeria. As it is a complex and, above all, multidimensional concept, improving the quality of care requires action on several fronts. In their reform programme, the health authorities have recommended a set of action plans covering several areas. These include the standardisation and widespread adoption of good practices in hospitals and the pharmaceutical industry (MSPRH, 2021).

In order to respond to the challenges associated with the excessive centralisation that characterises the Algerian health system, decentralisation has become a key focus of national health policy and a necessity for improving the performance, resilience and quality of the health

system. A decentralisation process has therefore been initiated, with a series of actions to be carried out. In the short term, the aim is to initiate a process of decentralising management in order to facilitate procedures for healthcare professionals and users. This process involves several measures, including the restructuring of the private healthcare sector.

In the medium term, the Ministry of Health will refocus on its core responsibilities as the body in charge of strategic direction, regulation, standardisation, monitoring and evaluation. With a view to reform, this core role will involve drawing up a national health development plan, setting its priority objectives, defining its implementation strategy and carrying out its evaluation and monitoring. At the same time, the governance of the national health system will be decentralised through the regionalisation of health in terms of its organisation, functioning and procedures.

A review of the various constraints inherent in the health system in Algeria reveals, on the one hand, palpable dysfunctions at the level of healthcare structures, i.e. at the base of the pyramid. On the other hand, we note a considerable willingness and effort on the part of the health authorities, i.e. at the top of the pyramid, to implement reforms and remedy these dysfunctions. Furthermore, excessive centralisation seems to be causing a rift between healthcare structures and central authorities. This may partly explain the failure of previous reforms and determine the success of future ones. We will therefore examine the effects of centralisation on healthcare structures before identifying possible levers for overcoming these constraints.

2- Methodological framework of the research:

In order to carry out this research project and address our research question, we are adopting an interpretive epistemological paradigm. Among other things, this paradigm posits that knowledge is derived from lived experience, which means that the construction of knowledge relating to a given situation aims first and foremost to understand the interpretation that the actors participating in that same situation give to it (GAVARD-PERRET, GOTTELAND, HAON, & JOLIBERT, 2012, p. 38).

2-1 Case studies as a strategy for accessing reality

As a strategy for accessing reality, we opted for the single case method. Although this method is controversial in the research community, it is justified in a number of cases. This choice is duly justified in the context of an interpretative perspective and contextualised action research. Yin (2014) believes that the single case can be considered an experiment. It is particularly justified in the choice of a case that reveals a recurring phenomenon (THIETART, 2014, p. 251). As our research topic relates to the governance of public hospitals in Algeria, and given that these organisations are governed by regulations that produce a standard and iterative governance system, we believe that the study of a single case is justified in our approach and will enable us to access the reality of our research topic.

In our case study, we chose the Nedir Mohamed University Hospital Centre in Tizi-Ouzou. This is a public administrative institution with legal personality and financial autonomy. It was inaugurated in 1955 and received its university hospital status in 1986. Under the supervision of the Ministry of Health, the Tizi-Ouzou University Hospital Centre is considered a benchmark institution and covers a population estimated at over three million users. It has 980 beds organised into 43 departments representing all medical and surgical disciplines. The university

hospital carries out medical and surgical care, prevention, training and scientific research. Our choice of this institution is justified by its regional importance within the health system, its size and the diversity of activities carried out there, and for reasons of accessibility to information. In addition, the Tizi-Ouzou University Hospital is large enough to constitute a subject of study that can address our research question.

2-2 Semi-structured interviews as a data collection tool

In the data collection phase, we used semi-structured interviews as a tool for collecting discursive data. In order to access information that most accurately reflects the interviewees' world, in relation to our research question and proposals (HUBERMAN & MILES, 1991, p. 72). We developed an interview guide consisting of three main areas in order to gather the interviewees' perceptions of hospital governance, their involvement in the quality of care, and the constraints and levers they identify.

The first area of our interview guide focused on hospital governance and its impact in the field. The purpose of this part of the guide is to understand how managerial decisions affect the interviewees' daily work. The questions asked in this section relate to decision-making processes, communication and transparency, as well as the obstacles and constraints associated with governance.

The second section focuses on practices and challenges related to quality of care. It aims to report on the interviewees' perceptions of the definition of quality of care; to identify the tools they have at their disposal to promote and improve it, and to identify the main obstacles they encounter in the performance of their duties. The questions asked focus in particular on the criteria used to assess the quality of care, continuous improvement processes, the resources available to them and the constraints they face.

Finally, the third area addresses the cross-cutting issue of identifying the determinants of quality of care linked to hospital governance, including understanding the links between hospital organisation and clinical outcomes. Interviewees are asked about the various mechanisms for interprofessional collaboration and cooperation, the processes of digitisation and the introduction of new management tools, as well as their personal and daily experiences.

2-3 Sample composition

In compiling our sample, we chose to interview a specific category of hospital stakeholders: university hospital professors who serve as department heads. There are several reasons for our choice of this category. Firstly, these individuals have a dual role: they are both doctors dealing with the reality of healthcare provision and administrators involved in decision-making processes, which places them at the interface between governance and quality of care. Secondly, these actors often have extensive experience and long careers in the hospital environment, which translates into a good knowledge and mastery of the various formal and informal processes that govern both hospital governance and quality of care.

In our investigation, which lasted more than four months, we interviewed six university hospital professors responsible for the most important departments at the Tizi-Ouzou University Hospital, working in medical and surgical disciplines. We limited ourselves to six interviews after reaching theoretical saturation in our investigative work with this category of actors. Once we were no longer receiving additional data from new interviews, we stopped our sample at six individuals according to the principle of saturation (THIETART, 2014, p. 252).

3- Analysis and discussion of results

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After conducting our interviews with the heads of department in question, we proceeded to transcribe the interviews in detail. In order to analyse the raw data, we designed an analysis grid based on the three axes of our interview guide and research proposals. The data collected was analysed using the thematic content analysis method via simple coding.

The table below presents the results of the thematic analysis based on semi-structured interviews with six university hospital professors who are department heads at the Tizi-Ouzou University Hospital. The data is organised into five themes: institutional and managerial constraints, organisational constraints, human constraints, impacts on the quality of care, and avenues for reform. Each theme is illustrated by verbatim extracts from the interviews.

Table (2): Results of thematic coding: constraints, impacts and avenues for reform

Theme	Sub-codes / Key elements	Representative excerpts
Institutional and managerial constraints	- Excessive centralisation of decision-making - Administrative red tape - Low involvement of department heads - Lack of appropriate local protocols	"Decisions come from Algiers, we have no room for manoeuvre..."
Organisational constraints	- Lack of regular audits and assessments - Poor interdepartmental coordination - Lack of digital tools and information systems	"Coordination... it's poor, even within the same department..."
Human constraints	- Lack of medical and paramedical staff - Demotivation linked to working conditions - Conflicts between medical and administrative approaches	"We are unable to recruit the necessary staff, whether medical or paramedical..."
Impact on the quality of care	- Inequalities in quality between departments - Longer waiting times for treatment - Increased nosocomial infections - Patient/caregiver dissatisfaction	"Lots of infections... we had to sterilise the department and launch an investigation..."
Areas for reform	- Increased management autonomy - Regular and systematic audits - Implementation of a digital information system- Adaptation of local protocols- Structural reorganisation - Management training and targeted recruitment	"Conducting regular audits and implementing a digital information system..."

Source: produced by ourselves based on an analysis of survey data.

3-1 Governance marked by multi-dimensional constraints

Our investigation of the interviewees enabled us to identify a number of constraints shared by the various department heads we approached. First and foremost were constraints related to the internal and external governance of the institution. The interviewees emphasised excessive centralisation in decision-making and the low level of involvement of department heads in strategic decisions, particularly with regard to the allocation of human and material resources. Added to this situation are administrative burdens and regulatory rigidity. We also identified a

deep divide between the medical world (which has technical expertise and legitimacy in care) and the administrative world (which has decision-making and budgetary power). This conflict is not perceived as a simple difference of opinion but as a reversal of the fundamental values of a hospital, where the caregiver is at the service of the administrator and not the other way around. This leads us to conclude that **hospital governance in Algeria is highly centralised and not very participatory**. Department heads feel **marginalised in the decision-making process**, which **demotivates** them.

Secondly, there are organisational and managerial constraints. During our investigation, we identified constraints related to the lack of medical protocols specific to the establishment. This leads practitioners to adopt protocols that are not adapted to the reality and needs of the field, which is likely to cause malfunctions in intra- and inter-departmental coordination. Added to this is the lack of preventive quality measures. Quality then becomes a series of remedial actions taken in response to recurring crises, particularly in the area of nosocomial infections. Interviewees also highlighted a lack of digital tools and effective information systems, particularly in terms of patient pathway management, which has a negative impact on the effectiveness and efficiency of the care provided. This situation leads us to conclude that departments lack **formalised management and evaluation mechanisms**. Insufficient coordination, combined with the lack of modern tools, results in **reactive and fragmented** management rather than proactive governance.

Finally, in terms of human resources, interviewees mentioned a shortage of medical and paramedical staff across all categories. This shortage leads to low motivation caused by teams being overworked and a lack of administrative support. Staff motivation is further weakened by poor quality of life at work due to the lack of resources. We also noted the existence of role conflicts between medical and administrative staff, with the latter, who are supposed to be a support function for practitioners, tending to adopt the opposite approach. Human resources therefore appear to be a **weak link**. The staff shortage, combined with an **asymmetrical relationship with the administration**, leads to **demotivation**, which affects the perceived and actual quality of care.

3-2 Impact of the governance system on the quality of care

One of the key elements of our investigation was to gather the interviewees' perceptions of the quality of care. In their comments, the practitioners questioned first mentioned the obligation of means they have in terms of quality of care. In other words, healthcare professionals are obliged to use all the human and material resources at their disposal in the care of patients. The second criterion determining the quality of care is the scientific reference of the protocol applied in accordance with state-of-the-art medical recommendations. The third criterion mentioned relates to the clinical results obtained in terms of effectiveness but also efficiency, as the cost of care and its rationalisation are factors that cannot be overlooked, despite the obligation of means. The professors therefore define quality in a multidimensional way: resources, professional standards and results. However, they place great emphasis on the **lack of resources and the unsuitability of imported protocols**, which reflects a **gap between international standards and the local context**.

The multiple governance constraints mentioned above will have negative repercussions on the quality of care at several levels. Indeed, the existing divisions and compartmentalisation between the operational centre (care providers) and support functions (administrators) generate

inequalities between services, particularly in terms of resource allocation. These shortcomings affect the quality of care provided by lengthening waiting times and delays in patient care. This lack of resources also increases the risks to users, particularly in terms of nosocomial infections. This situation generates increased mental stress for caregivers, reducing their motivation, which undoubtedly affects patient satisfaction. Poor governance has direct **negative clinical consequences** and leads to a **deterioration in the patient and caregiver experience**.

3-3 Proposed avenues for reform

The department heads interviewed made a series of recommendations aimed at overcoming the many constraints and improving the quality of care in the long term. These proposals are based on the areas outlined below.

- a. Improving governance depends on strengthening the management autonomy of departments. Indeed, those interviewed emphasised the need to give hospital departments greater decision-making freedom, particularly in terms of resource acquisition, staffing and clinical activity planning. Greater autonomy would enable them to adapt more effectively to patient needs and the reality on the ground, as well as to be more responsive in the exercise of their caregiving duties.
- b. Institutionalising periodic audits and implementing systematic quality assessment mechanisms would lead to concrete recommendations that could be shared with medical and administrative teams. This would help to establish a culture of assessment and transparency within departments.
- c. As the lack of digital tools has been identified as a major constraint, the interviewees propose the implementation of an integrated information system. In particular, they propose the creation of a centralised electronic patient record, connected to laboratories, radiology and various departments. Such a tool would facilitate patient follow-up, performance indicator analysis and clinical and managerial decision-making based on reliable data.
- d. Current medical protocols, largely imported from international learned societies, are considered difficult to apply due to local material and human realities. Practitioners suggest
- e. developing contextualised national protocols, developed in consultation with Algerian learned societies and adapted to the specificities of the country's hospitals.
- f. Those interviewed propose a structural reorganisation of hospitals. The pavilion model is perceived as obsolete and a source of wasted time and lack of coordination. Department heads recommend a spatial reorganisation based on vertical and integrated structures, promoting coordination, proximity between complementary departments and fluidity of the care pathway.
- g. Finally, practitioners emphasise the need to increase the recruitment of qualified medical and paramedical staff, in line with the specific needs of the departments. They also mention the need to improve continuing training for human resources, in particular by allocating more budget for this purpose.

In summary, the proposals put forward by the heads of department highlight the need to establish a more **decentralised and participatory** hospital governance system, equipped with

modern management tools. A system of governance in which decisions would be shared and adapted to the real needs on the ground. The central idea is to give healthcare structures **supervised autonomy**, providing them with the tools they need to manage their activities effectively. Through these proposals, practitioners clearly express their aspiration to move beyond a management style marked by **bureaucracy and crisis response**, towards a **proactive, evaluative and patient-oriented** governance system, where continuous quality improvement would become a true institutional culture.

Conclusion:

The Algerian healthcare system as it stands today is the result of a long process of evolution that began with the country's independence. This process took the form of a series of reforms aimed at adapting the system to the needs of the population. Through our analysis of this evolution, we have identified an immutable principle that has accompanied all of the reforms and is rooted in the national health doctrine. This is the principle of free healthcare. However, guaranteeing free access to the healthcare system for citizens is not enough; the quality of care received is a parameter that cannot be overlooked. Through the literature and our secondary study, we have identified a number of constraints and dysfunctions affecting the healthcare system. These include those related to a bureaucratic and centralised system of governance. We have also presented a set of resolutions taken by the public authorities to reduce these dysfunctions and improve the quality of healthcare provision.

In order to compare the assertions in the literature and the perspectives of the public authorities with the reality on the ground, we conducted an empirical study using a qualitative approach. Initially, we set ourselves three research objectives: to identify the institutional and managerial constraints perceived by healthcare practitioners, to analyse the impact of these constraints on the quality of care, and to collect and explore the reform proposals put forward by the targeted stakeholders. To achieve these objectives, we conducted a series of semi-structured interviews with department heads working at the Tizi-Ouzou University Hospital. Interpretation of the results of our survey revealed a set of converging findings that shed light on the link between hospital governance and quality of care.

Thematic analysis of the interviews revealed a shared definition of quality of care among the interviewees. Quality of care is determined by a combination of the availability of resources, the application of scientific protocols and the clinical effectiveness of treatment. However, this quality remains compromised by multidimensional constraints. Practitioners emphasised the excessive centralisation of decisions, the cumbersome nature of administrative procedures and the low level of involvement of medical professionals in decision-making processes, which runs counter to good governance practices.

In addition to these institutional constraints, there are also organisational and human constraints. The absence of protocols adapted to local realities, the lack of quality audits and the failure of inter-departmental coordination result in reactive rather than preventive management. The shortage of material resources, but above all of human resources, creates an excessive workload for healthcare professionals, which deteriorates their working conditions and reduces their motivation, thereby negatively impacting the quality of services and patient satisfaction. The impact of these constraints is reflected in inequalities in care across services, longer waiting times for patients and clinical outcomes.

In order to overcome these constraints, the interviewees expressed a shared desire to move towards a more participatory, transparent and accountable form of hospital governance. Indeed, the reform proposals converge towards greater autonomy for departments, providing them with human and material resources, implementing management tools and an integrated information system, but also restructuring to improve coordination.

In conclusion, our research has shown that the issue of quality of care is not only linked to a lack of resources, but also to an inappropriate mode of governance: centralised, bureaucratic and lacking in transparency. Practitioners aspire to a more participatory, proactive and patient-centred system, in which the administration becomes a strategic partner in the service of clinical efficiency.

Finally, our work has a number of limitations, the most significant of which are the sample size and the choice of a single case, which limits the generalisability of the results. The conclusions should be read in terms of transferability rather than representativeness. Our study also faces the risk of interviewee bias, in the sense that the high hierarchical position of department heads may lead to a different perception from that of other categories of actors (nurses, residents, administrators, etc.). However, these limitations open the way for future research by expanding the sample size, conducting comparative research between institutions, adopting a mixed approach that integrates quantitative data, or conducting longitudinal studies.

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