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The hospital performance evaluation process : Case of the University Hospital Center “UHC" in Morocco

Le processus d’évaluation de la performance hospitalière : Cas des Centres Hospitalo-Universitaires (CHU) au Maroc

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Abstract:

The Moroccan Ministry of Health is seeking to standardize the performance evaluation process in its various hospitals.

University hospitals (UHC) are specialized health organizations that provide tertiary level care services, and whose missions also include teaching and scientific research.

Moroccan (UHC) evaluates their performance through a set of indicators grouped in their activity reports, following an almost standard process.

The objective of this paper is to describe and analyze the process of evaluating the performance of Moroccan UHC, as well as the content of their activity reports.

This is a case study of five UHC, Casablanca, Rabat, Fes, Oujda and Marrakech.

The methodology adopted is non-participant observation and benchmarking with the various actors involved in the process.

The analysis of the latter and its indicators has enabled us to detect dysfunctions and propose ways to improve the performance of Moroccan hospitals.

Keywords: hospital performance; measurement; evaluation; indicators; hospitals.

Résumé :

Le ministère de la santé marocain cherche à standardiser le processus d'évaluation de la performance dans ses différents hôpitaux.

Les centres hospitalo-universitaires (CHUs) sont des organisations spécialisées qui prodiguent des offres de soins de niveaux tertiaires, et qui ont comme missions aussi l'enseignement et la recherche scientifique.

Les CHUs marocains évaluent leurs performances par indicateurs regroupés dans leurs bilans d'activités, en suivant un processus quasi standard.

L'objectif de cet écrit est de décrire et analyser le processus d'évaluation de la performance des CHUs marocains, le contenu de leurs bilans d'activités.

Il s'agit d'une étude de cas de cinq CHUs, celui de Casablanca, Rabat, Fès, Oujda et Marrakech.

La méthodologie adoptée est l'observation non participante et un benchmarking auprès des acteurs intervenant dans le processus.

Cette analyse nous a permis de déceler des dysfonctionnements et de proposer des pistes d'amélioration de la performance des hôpitaux marocains.

Mots clés : performance hospitalière ; mesure ; évaluation ; indicateurs ; hôpitaux.

Introduction:

His Majesty King Mohammed VIth has repeatedly insisted on the government to accelerate the adoption of a new efficient reform of the Moroccan health system, and to provide better quality health care to citizens. This reform must take on many challenges: competence, technological progress, quality, economic efficiency, value for money, and especially the question of performance, which raises the issue of measuring and management(DosSantos and Mousli, 2016).

In the health sector and especially in secondary and tertiary level hospitals, the issue of performance evaluation and management was not a strategic priority for hospital managers. The performance evaluation was retroactively a simple calculation of indicators according to standard established grids, whose role is to make a basic comparison between hospitals (BELGHITI, 2013).

In Morocco, no model of hospital performance, that integrates the different dimensions, is yet generalized in Moroccan hospitals. On the other hand, the Ministry of Health has developed a matrix to analyze hospital performance. The latter monitors performance, based on four priorities functions of the hospital: diagnosis (imaging and laboratory), care (emergencies, outpatient consultations, and hospitalization), hospitality (stay), and financial management (billing, collection, and own revenues). The main attributes of the selected indicators were: production, productivity, quality and efficiency (BELGHITI ,ALAOUI, 2001).

The problematic:

The question of evaluating the performance of hospital structures is a serious problem raised on the table of managers of the Ministry of Health, and also for researchers in management sciences specialized in hospital performance. This issue depends actually on several contingent factors such as the nature and diversity of the hospital's missions, the multiplicity of actors and professions, the organization of the decision-making system, and the turbulence of the internal and especially external environment.

That is the reason we were enormously interested of analyzing the process of hospital performance’s evaluation in university hospitals. Therefore, the problematic of this article could be formulated as following: what is the process of performance evaluation in Moroccan university hospitals? And can we consider this process as efficient, taking into account the different dimensions of hospital performance?

The article is divided into two main parts. The first section reviews the literature on hospital performance assessment models and attempts to clarify the performance as a polymorphic and multidimensional concept, while the second one describes the performance evaluation process within the Moroccan UHCs and analyzes its different stages.

The contribution of this work can be marked on two levels:

First, we should recall the main models for measuring and evaluating the performance of health care institutions, which exist in the literature and can serve as a key basis for analyzing the process adopted in Moroccan hospitals.

Then, this allows us to analyze the process of evaluating the performance of a management science researcher's perspective, by adopting a descriptive method with an analytical focus, to explain the different mechanisms of the process, starting from the specificities of HUCs, which are organizations providing tertiary level care.

1. Literature review:

The concept of hospital performance has gradually taken a key place in the discourse of hospital managers, division heads, and also carers. The measurement and evaluation of a hospital's performance through existing models in the literature is at the center of a debate between researchers and professionals, and it is depending on the judicious choice of indicators. In this work, we will try to clarify the concept of performance, starting from divergent models.

1.1 Hospital performance: characteristics and attempted definition

In the literature, performance is a difficult concept to define because of its multidimensional nature. This idea is particularly relevant in the field of health, because hospital performance depends on the design of the different stakeholders (carers, patients, hospital managers, different institutions). These different actors have their opinions on the performance of health facilities, which can sometimes be divergent. One of the main concerns of the Ministry responsible is to ensure the financial balance of the organization, to guarantee a quality care offer and well distributed throughout the territory without any sort of discrimination. Caregivers are particularly concerned with the quality of the provided care in the favor of patients, while patients will be sensitive to the accomplished care and also to relationships

with caregivers. The community will be particularly interested in seeing how well the supply of care meets patient demand.

It is important to mention the diversity of the performance models, depending on the design of the different stakeholders in the organization. As a result, the literature proposes a contingent approach to notion of performance, which depends on the environment that is constantly changing. In this sense, existing models in the literature are relevant only in their own context and cannot be generalized. Another important point added to the multidimensional and contingent nature of the concept is the paradoxical dimension of performance. Indeed, objectives taken in pairs may appear contradictory and taken together; they may prove to be convergent. For example, the search for cost reduction may seem contradictory to user satisfaction in care.

The last characteristic related to hospital performance comes from the nature of the proposed property. In the recognized complex context of care, the offer provided is literally the service provision, having the characteristics associated with this type of activity. The offered care appears indivisible and intangible. This service provision depends on the work of the carers, but also on the contribution of the users. The very nature of the service adds to the complexity of defining the concept of performance.

By taking all these characteristics into consideration, the first definition we can give to the performance of a care facility can be depended on the specific objectives of any public hospital. As a result, a hospital is efficient when it is able to respond effectively to the needs of health citizens equitably throughout the territory, to guarantee a quality care offer, thanks to the optimal care for users and also to ensure that economic and organizational efficiency is continually enhanced. This definition is aligned with that of various guardians who consider hospital performance as socioeconomic effectiveness (associated with a quality care offer that meets the health needs of citizens), efficiency (the quality of care provided taking into account available resources) and quality of service (regarding accessibility of care and waiting times and response to requests).(Le Pogam et al., 2009).

These definitions emphasize that hospital performance is measured at the level of a hospital establishment, concerning efficiency or monitoring the quality of care provided, and also at the level of the health territory, through the regional and national supply of care, as well as the definition of sectoral health strategies and the optimal allocation of resources. But the most

important question that seems be asked is: what are the possible performance models in this hospital management framework?

1.2 Hospital performance models

In the literature, there are two main categories of models, depending on whether they incorporate one or more objectives.

Organizational theory abounds in various models of organizational performance. This abundance can be explained by the wealth of literature on organizational theories and their diversity, which describes the purpose of organizations regarding achieving goals, the quality of internal processes, interactivity with internal and external environments, and the ability to acquire resources (Cameron, 1978).

Contingency theory and the school of strategic choices are best suited to the framework of the health organization as an open system to its changing environment. The design of a performance model depends on the degree of coherence and congruence between the different dimensions of performance (Arah, 2003; Cameron, 1978).

First of all, we will try to describe one-dimensional models of organizational performance and then multidimensional models.

1.2.1 Single objective models

In these models, we can distinguish between four primitive ones: the rational model, the human relations model, the adaptation model and the process model.

Multiple series of single-objective models have been applied in the health sector. The first one is the rational objectives or goal achievement model, that was initiated by (Price, 1972), and applied to the health field by (Magnussen, 1996), its objective is to monitor technical efficiency (e.g., the production of treatment at the lowest cost) and allocative efficiency, which consists of the optimal allocation of resources, taking on the availability constraints, skill requirements and labor legislation. It implies the mathematical resolution of functions to be optimized, under different constraints, such as the reducing the costs of a surgical department, via trying the possible combinations between the capacities of the different operating rooms, and the availability of surgeons.

The second model is related to the human relations (or interest groups) (CONNOLLY et al., 1980), known by its political tendency, this model is based on two principles: stability and consensus. An organization is supposed as successful when it succeeds in meeting the needs of stakeholder groups by maintaining a satisfactory climate of collaboration; it is based on the assumption that organizations represent a place of conflict between the different actors. Indeed, it is important to ensure a good social climate and the satisfaction of various interests groups. In this context, an organization is considered efficient if it operates without internal tension.

Another model introduced by Yutchman and Seashore (Cunningham, 1978), is called the resource model or adaptation model, can be applied in hospitals as well. This model examines the organization as an open system, requiring the acquisition and maintenance of resources for the survival of the structure. The challenge for the organization is to have sufficient resources available for its development. Indeed, performance is measured by the organization's ability to acquire and maintain resources.

The last model is the process efficiency model or the process analysis model, stipulating that an organization is qualified as efficient if it runs an efficient internal production and inefficient decision-making processes (Cameron, 1978). It is a model that is widely developed through total quality management, continuous quality improvement and process re-engineering approaches (e. g. Activity-Based Management approach).

However, these one-dimensional models are not adapted to represent the performance of organizations, and do not accurately reflect this complex, sometimes paradoxical and contingent construct that results from a dynamic interaction between the organization's internal and external forces, and the continuous change of its environment. This explains the requirement to work with multidimensional performance models (Siccotte et al., 1999; Sicotte et al., 1998).

1.2.2 Multidimensional models

The construction of a standard multidimensional model was a great challenge for researchers, as it is absolutely not easy to achieve, since not all stakeholders have the same objectives, and the effect of the paradoxical nature of the concept of performance.

The first model cited in this work is that of (Siccotte et al., 1999), which allows organizations to adapt to different contexts, including of course the health organizations. This model is based on theory of social action (Parsons et al., 1978). It hypothesizes the survival of an organization is literally conditioned by the omnipresence and respect of complementarity and the balance of the different dimensions of performance. This theory states that any organization is composed of four essential functions: a goal orientation, interaction with its environment to acquire resources and adapt integration of its internal processes to produce, and maintenance of values and norms that facilitate and constrain the three previous functions. These fours functions must be interrelated and the challenge is to maintain a balance in their consideration.

For a hospital organization, the achievement of goals corresponds to the improvement of the population's health status, financial balance and efficiency. Adaptation refers to the organization's ability to acquire resources, meet the needs of populations and community expectations, increase its attractiveness, and the potential for innovation and creativity. Resource generation corresponds to the function of care production as the main activity of the hospital.

Similarly, the Balanced Scorecard model (Kaplan and Norton, 1992)focuses on defining the organization's strategy to define it concerning four important axes in monitoring the implementation of the strategy, which are: a financial axis, customer, internal processes, and learning/innovation. In this model, the four axes are linked by cause-and-effect relationships. The main objective of this dashboard is to follow the four perspectives, and to make sure both are fair regarding neither of the expense.

Another important model is the model of(Donabedian, 1985), whose main interest is to give different dimensions to the concept of performance, as in the models mentioned above, but this time focusing on the quality of patient care, which can be defined by the technical quality, but also by the quality of the interpersonal relationship between the caregiver and the care receiver.

As for the overall performance model of (Le Pogam et al., 2009)which takes into consideration the patient satisfaction, confidence and also resistance. In this model, measuring whether the health care facility meets the patient's expectations ensures "trust capital" and

patient satisfaction, understood as a dual affective and cognitive process. This concept of trust has its origins in marketing and is based on three essential points:

- Credibility for the consumer: it is the image the patient gives to the institution and the unit taking care of him/her.

- Integrity: it is the respect of what has been announced, such as the effects of a treatment given to the patient.

- Caring: this is what is felt by the user in the provision of care(Gurviez and Korchia, 2002). For example, a patient who has lost confidence in the hospital may prefer to go to a private clinic where he/she feels that he/she will be properly managed and better cared for, thus demonstrating what is known as "individual or collective resistance" that can challenge the patient's attachment to the public hospital. This model also raises another important question, concerning the evaluation of hospital performance, which is the knowledge management(Le Pogam et al., 2009). Indeed, this knowledge management is a source of motivation for healthcare personnel, because it represents one of the elements of recognition, including knowledge and know-how, as well as the dissemination of this knowledge. It is the transformation of tacit knowledge into explicit knowledge through the learning process. These processes help to promote the evolution of health organizations towards performance objectives.

Finally, the latest model cited in this work is the Performance Assessment Tool for Quality Improvement in Hospital (PATH) (Groene et al., 2008), which was developed by the World Health Organization, and focuses on six key dimensions: clinical effectiveness, efficiency, accountability to human resources, safety, patient-centered approach and accountability to the local population. This model derives its originality from the interest in accountability to the local population. In this sense, the PATH model has a very advanced internal vision of performance, through its first five dimensions mentioned above, but also an external concern, through its last dimension, accountability to the external population. In the practical context, this model allows the different dimensions to be broken down into sub-dimensions. Several European countries have experimented with this model and France joined this project in 2007 (High Authority for Health, 2007). The table below summarizes the different models, highlighting the value of each approach.

Table 1: Summary of performance evaluation models:

Models	Definition of performance	Possible indicators
Rational model	- Technical efficiency - Allocation efficiency	-Cost -Amount of resources allocated
Human Resources Model	-Quality of the working environment - Shared values and norms	-Staff satisfaction -Turn over -Sick leave -Adherence to projects
Resource Model	- Acquisition and maintenance of resources	-Hiring of staff -Amount of funding
Process Efficiency Model	- Efficiency in internal processes	-Patient satisfaction rate -Speed in the flow of flows -Quality measurement
Quality-centered model	- Technical quality - Interpersonal quality	-The quality of care -Caregiver relationship - cared for
Social action model	- Achievement of goals - Resource acquisition - Efficiency in internal processes - Shared values and norms	-Rate of achievement of goals -Hiring rate -Patient satisfaction rate -Evaluation of project adherence
Model of the Balanced Scorecard	- Financial - Customers - Internal process -Organizational learning and innovation	-Financial balance -Patient satisfaction rate -Speed in the flow of flows -The degree of innovation and training
PATH model	- Clinical Efficacy - Efficiency and effectiveness - Responsibility to HR -Responsibility to the local population - Safety and security - Patient-centered approach	-Financial balance -Employee satisfaction rate -Public satisfaction rate -Security index -Patient satisfaction rate.

Source: authors

Each health organization seeks to evaluate its performance based on various multidimensional models available in the literature, and through measurement indicators.

2. Methodological approach:

As a part of this work, we interviewed some stakeholders in the performance evaluation process in five Moroccan university hospitals (Casablanca, Rabat, Fez, Oujda and Marrakech) and followed up with some series of non-participating observations, and conducted a targeted

literature search, the objective is to understand the instrumental and managerial characteristics of the concept and the different used tools used in evaluating hospital performance.

The interviewees are the majors of hospital and medical technical services (also known as head nurses), heads of professional affairs departments and heads of management control departments.

This choice is justified by the crucial role-played by these actors. The majors are in charge of preparing and sending indicators to the administration of various hospitals units. The heads of professional affairs departments are responsible for collecting and sending these indicators to the general administration after verification and analysis by the management control department.

2.1 Study area:

In Morocco, there are five universities hospitals, which are in operation: Casablanca, Rabat, Fez, Marrakech and Oujda. As we will witness soon, the inauguration of two others in Agadir and Tangier. Knowing that the ministry, within the framework of advanced regionalization, is currently seeking to establish one university hospital per region, totaling 12establishments.

The main mission of the UHCs is to provide better quality in the tertiary level care, through participation in university clinical teaching, and training of health professionals, and finally scientific research, via carrying out medical research, with the maximum strict of respect for the physical and moral integrity and dignity of patients. All these missions must be in accordance with the objectives of the Ministry of Health.

The UHCs are institutions under the supervision of the Ministry of Health, complex pavilion organizational structures are trying to match between the needs of the population in coordination with regional health departments, these institutions try to evaluate their performance through a range of results-based indicators, this evaluation goes through a scale of stages, the most significant of which are the management board and the board of directors.

3. Performance evaluation in Moroccan university hospitals:

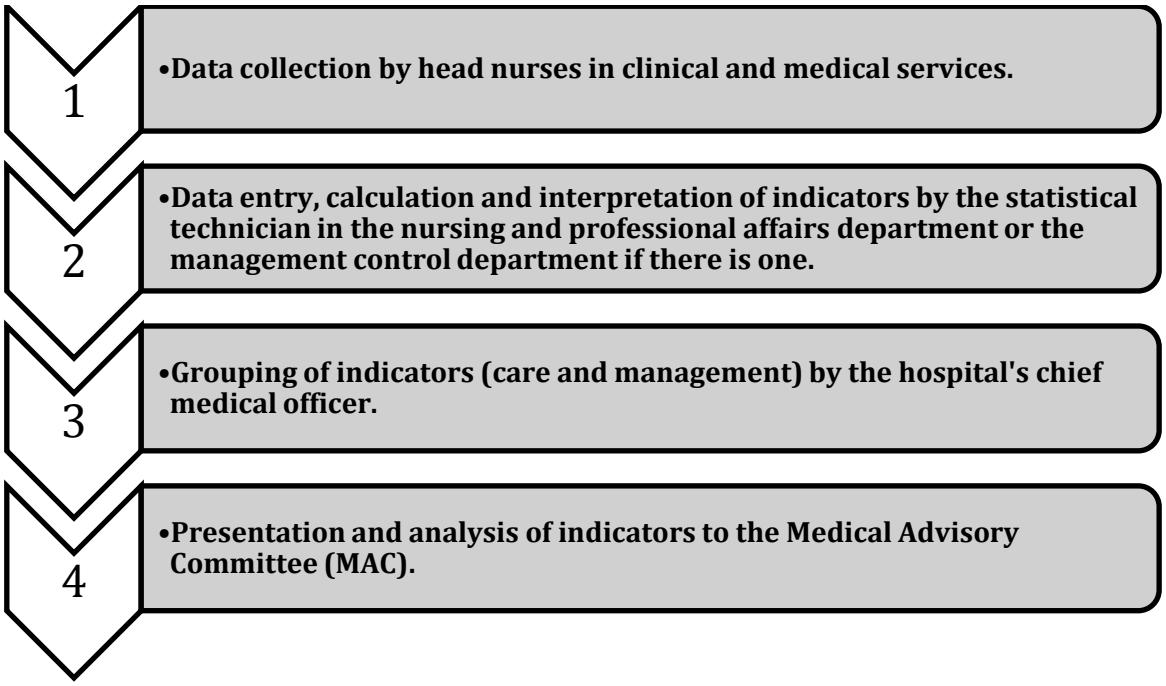
According to this study, we found out that Moroccan hospitals adopt a performance evaluation and measurement process divided into two micro processes, the first takes place in

hospital units (the hospitals that make up each university hospital) and the second at the strategic level in its various general departments.

3.1 Performance evaluation at the level of various hospitals units:

The collection and analysis of data of the activities of hospital and medical technical services in hospital units, enabling performance to be measured and evaluated, shall follow the following process

Figure n° 1: Performance evaluation process in UHCs training courses:



Source: authors

Data collection in the clinical and medical technical departments is always done by the head nurses and validated by their line managers, before sending them to the administration and particularly to the professional affairs department or directly to the management control department.

Figure n°2: The different indicators used in hospital and medical technical services.

a. Litter capacity b. Admissions c. Day Hospital Admissions d. Hospitalization days e. Number of consultations f. Number of medical procedures g. Medical procedures: number of surgeons, major procedures, minor procedures, emergency procedures, scheduled procedures, conventional hospitalization, day hospital.	h. Surgical procedures: number of surgeons, major procedures, minor procedures, emergency procedures, scheduled procedures, conventional hospitalization, day hospital. i. Therapeutic procedures: medical and surgical j. Exploratory acts k. Activities of the poles of excellence l. Radiological and laboratory procedures: inpatient and outpatient M. Mortality.

Source: authors

At the service level, the main role of head nurses is reporting back after validation by the line manager in the professional affairs department. All information collected by head nurses is used for statistical purposes and not as an aid in the decision-making process.

At the level of the nursing and professional affairs department, the statistical technician working in the management control department, if exists so, or working directly under the responsibility of the professional affairs department, enters the data each month and calculates the following indicators:

Figure n°3: indicators collected at the level of the nursing and professional affairs department or management control department.

➢ Average Occupancy Rate (APR) ➢ Average Length of Stay (ASL) ➢ Turnover Rate (TROT) ➢ K of the Medical Acts ➢ K.C and K.A of Surgical Procedures ➢ Number of operations per surgeon	➢ Z of radiological procedures: inpatient and outpatient ➢ B of biological procedures: inpatient and outpatient ➢ Percentage change compared to the previous semester and the previous year for all data and indicators collected.

Source: authors

Subsequently, the head of the management control or professional affairs department presents these data in the form of graphs and tables, with comments and sometimes interpretations of the results, and then presents them to the Hospital Director.

If we take the case of the Casablanca University Hospital, the performance attributes that are measured by the current dashboard are as follows:

Productivity: TOM, DMS, number of operations per surgeon.

Production: K of Medical Acts, K.C and K.A of Surgical Acts, Z of Radiology Acts: hospitalized and outpatient, and B of Medical Biology Acts (hospitalized and outpatient).

Efficiency, quality: TROT.

It should be mentioned that the following dimensions are not taken considered at the level of clinical services:

- User and staff satisfaction
- The social climate
- Hospital technologies.

At the level of the management of each hospital formation:

The Chief Medical Officer meets every semester with the heads of departments and various managers of the administration to present the indicators, analyze them, compare them with previous years and take the necessary readjustment decisions. After that, the hospital director aggregates the results (care and management), comments on them and presents them to the Medical Advisory Board (MAC).

At the level of the Medical Advisory Committee (MAC):

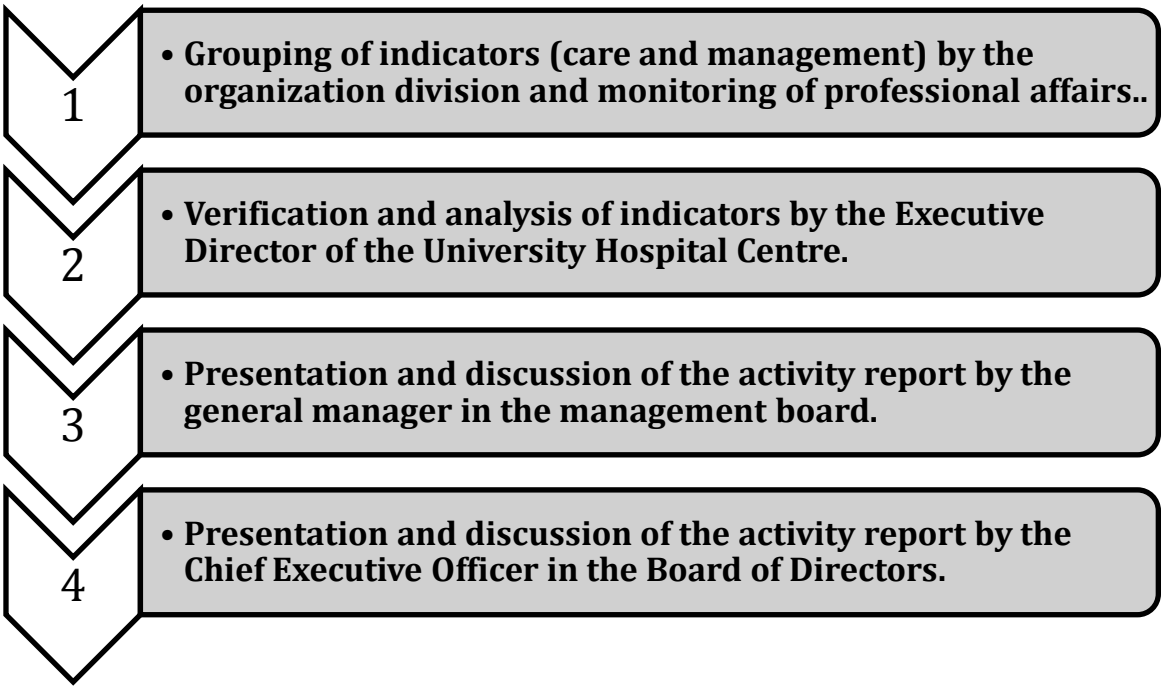
The report on activities with various indicators is presented and discussed in the presence of the heads of hospital services and also of the administrative executives. While, the head nurses do not attend this meeting, despite their important contributions to the development of the indicators. In the MAC, the result of each indicator is compared with the one of the previous semester or the previous year, and if a significant change is detected, the head of the department concerned is required to justify these differences.

The analysis of indicators at the MAC level allows strategic decisions to be made, which mainly concern the allocation of resources, and also the organization of the hospital.

3.2 Performance assessment at the strategic level:

At the level of the general management of each university hospital, performance measurement and evaluation is carried out according to the following process:

Figure n°4: Performance evaluation process at the strategic level:



Source: authors

The head of the division for the organization and monitoring of professional affairs brings together all the indicators of various hospitals formations and presents them to the General Manager, the latter, verifies and analyzes them, and to present them to the Management Board first for advice and collect recommendations, before readjusting them and presenting them to the Management Board, in the presence of the Minister of Health who represents the Head of Government, as well as the representatives of several bodies (Ministry of Finance, Ministry of the Interior, the Regional Directorate of Health...)

CHUs measure their performance for purposes:

Cost reduction

Internal management of its structures

Institutional regulation

Internal and external competition

Improvement of the quality of services provided to users.

In the half-yearly activity report, the performance of each university hospital is compared with previous years to analyze and explain gaps and deficiencies, and propose eventually, the appropriate solutions. Monitoring is carried out and discussed every semester during the presentation of the activity report and during the meeting of the medical advisory commission at the level of the hospital formations of the UHC.

4. Is the performance measurement process in Moroccan UHCs efficient?

The Performance Assessment Tool for Quality Improvement in Hospital (PATH) (Groene et al., 2008)initiated by WHO is the most appropriate model for the hospital context, and is based on six central dimensions in the assessment of hospital performance: clinical effectiveness, efficiency, responsibilities to human resources and the local population, safety and a patient-centered approach. This model is an alliance of the different one-dimensional models; the rational model, human relations, resources, internal processes.

The Moroccan UHCs are supposed to measure and evaluate their performance in traditional ways. The current dashboards do not meet the needs of managers at all levels in monitoring the implementation of the action plans contained in the hospital project (HP). In other words, the current organization of the centers does not allow for continuous monitoring and genuine monitoring of their performance to take preventive and corrective action in the departments concerned at the appropriate time, without having to wait until the end of the year for an assessment by the general management.

A preliminary analysis of the structure of the UHCs' activity reports, is published on their official websites except the Casablanca University Hospital, showed the fact these documents do not allow the management and communication of the hospital's strategy. They only include results indicators that describe past achievements and do not have leading indicators (processes) that reflect the degree of implementation of the strategy contained in the Establishment Project, and also how the objectives are achieved. And do not take into serious account, the opinions of all employees, especially the nursing staff, who constitute the majority of human resources and work daily with the patient.

There is also a major lack of internal customer (staff) satisfaction surveys and indicators to measure the social climate, to carry out actions to achieve a high level of motivation. As they do not contain qualitative indicators or indicators on paramedical activities, indicators on the management of hospital services, training and scientific production are also clearly lacking. For the patient, the management of the UHCs claims to say that they constantly carry out satisfaction surveys among users, but unfortunately, they refuse to give us the report for analysis (case of the Casablanca University Hospital).

In hospital services, the head nurse responsible for management under the control of the head of department has few quantitative or qualitative control elements to enable him to evaluate his performance. The main role of head nurses in performance assessment is to provide the data reporting role to the nursing and professional affairs department, and it is at this particular point that indicators are calculated. The service dashboards are only scoreboards, and head nurses do not have indicators to monitor their activities and do not have the required skills and qualities in this area.

To face this situation, the UHCs are currently working on computerization through a hospital information system project that aims to dematerialize various files and their administrative management, the production of care, the drug circuit, as well as the production of dashboards to improve the quality of patient care and control flows and costs, but this remains limited since there is no real support to involve all employees, regardless of their hierarchical levels, especially head nurses who must be actively involved in the process and be able to do real tactical work. In addition, Moroccan University Hospitals have undertaken other actions to improve their management, including certification projects, the design and generalization of dashboards for various hospitals training courses. Nevertheless, it is necessary for the head nurse to systematically have a set of information, to report on the management of the unit, to control activities by readjusting organizational resources to set up the organizational process appropriate to the requirements of the care unit system(HUBINON, 1998).

Finally, it cannot be said that the process of measuring and evaluating performance in Moroccan UHCs is not efficient, but there are always dysfunctions that need to be addressed by those in charge to control their activities.

Conclusions:

In the activity report, the indicators are results-oriented are calculated for statistical purposes at the level of the care units and used as decision-making tools for hospital management.

To be effective, the organization must have a dashboard that supports decision-making, promotes the monitoring of nursing care and evaluates resources, human and material structures, training and organization, the interpretation of the relationships between results, costs and efficiencies, to ensure the path towards overall performance.

The dashboard represents a support that helps the service manager to manage his unit, and to achieve the objectives set by the department and which is in line with the objectives of the Hospital's management while ensuring the optimal functioning of his department. This dashboard must contain indicators that accurately reflect the reality of the organization. Knowing that a good indicator is an information, generally quantified, chosen to report, at short intervals, on the performance of a mission (de Guerny et al., 1990).

To be a tool for management analysis, the characteristics of the indicators are:

Fast: Information must be provided quickly or the corrective action cannot be implemented early enough to correct the trajectory and achieve the objective.
Simple: the simpler the indicator, the more understandable and quicker it is to interpret. Its assessment should not be based on complex calculations.
Meaningful: The phenomena must be significant either by themselves or as symptoms.
Reliable: the indicators measured must vary in the same way as the measured phenomenon and be independent of changes in who is responsible.
Useful: the purpose of the indicator is action.
Homogeneous: to allow communication, it is necessary to adopt a common terminology.
Consistent: the definition of the indicator is invariable in time and space.
The question that needs to be asked is: does the current situation of Moroccan health organizations make it possible to set up a hospital dashboard? And if so, will there be a commitment from the employees, especially since the sector is currently living at the rhythm of the protests?

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