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Management of Quality at the Hospital: Evaluation of Patient Satisfaction as a Lever for Improvement Continues

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Abstract

Continuous improvement in the quality of care is a major challenge for hospitals. Among the tools available to managers, the assessment of patient satisfaction occupies a central place, enabling them to identify the strengths and areas for improvement of healthcare services. This article provides an in-depth analysis of the role of patient satisfaction as a lever for continuous improvement in hospital quality management. We explore the main theories and models for assessing patient satisfaction, including the gap model, expectation confirmation theory and Donabedian's structure, process and outcome approach. The study highlights the impact of perceived care on patient experience and hospital performance. In addition, we discuss the survey methodologies used to measure satisfaction and the challenges associated with their reliability and validity. The article thus highlights the importance of integrating patient satisfaction into hospital management strategies for a sustainable and effective quality approach.

Keywords: *Patient satisfaction, Quality of care, Hospital quality management, Continuous improvement, Quality assessment*

Introduction

"Nowadays people know the priœ ut evcrything and the value ut nothing ", Oscar Wilde (1854-1900).

"J'expect not to wait", Serge Briançon (2002).

"The satisfaction of human is a complex concept that is linked to a number of factors, including the lifestyle, past experiences, future experiments and the values of the'individual and companyy "

Several recent reviews of the literature are interested in the concept of patient satisfaction, vis-à-vis the primary care services of the services of mental health consultants (Kravitz, 1996) (Hays, 1990) (van Campen, 1995). That said, it is important to know that most of them critiquaient the existing studies on the satisfaction of patients. Regarding the patients ' satisfaction with the services of consultation, Pascoe (1983) argues that there are very few theories or models developed, little d'instruments of measurements standardisedes, the

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instruments of low reliability and a doubt concerning the validity of these instruments (Pascoe Gc., 1983). Van Campen (van Campen, 1995) confirms the results obtained by Pascoe and declares that the research was conducted on the satisfaction of the patients lacked theoretical bases sufficient, and that all of the instruments lacked d'a methodology for the reliability and validity of the scales.

In order to be able to identify the different from the methodological to the extent of the satisfaction of patients, it is necessary to understand its conceptualization theoretical, but the term " patient satisfaction, despite its frequent use, remains rarely defined with clarity.

To begin with the definition of the concept of satisfaction, we present several definitions of the satisfaction of the patients existing in the areas of sociological, psychological and health research.

Definitions

It is certain that for many years, The needs and wishes of the patient are taken into account by systems of care, and are considered as a priority.

The purpose of medical care n'is not only to'improve'state of sante of the patient, but also to meet his expectation and d'to ensure his satisfaction. Patient satisfaction represents an important ffundamental, it is a way of measuring the quality of care, it can provide information on the ability of health professionals to meet the values and expectations of the client, which are areas where the client is the'supreme authority.

Patient satisfaction is one of the qualitative indicators of the performance of'a hospital: it may be regarded as "a result of care, and even a part of the state of santé itself", or as an indicator of the performance of health care programs and staff, seeking thus, any dysfunction in the various departments of health.

It is an indicator of'evaluation of health actions to improve the quality of care. Any assessment of the quality of care should theoretically include d'as a measure of patient satisfaction, in conjunction with the'use of'other more objective indicators, such as mortality or morbidity.

The satisfaction of the people is a complex concept that is determined through a number of factors, including the lifestyle, past experiences, future experiments and the values of each individual, and even those of the company, or which is related to the therapeutic follow-up, continuity of care and, in some cases, the clinical prognosis.

The indicators of customer satisfaction are the most unreliable, They are nonetheless Essential, because the perceived quality is without doubt the most important: they will influence the consumer behavior in his relationship with external customer/supplier .

Patient satisfaction is defined as being her reaction to his personal experience in the services. In this formulation, the satisfaction is a cognitive evaluation (concept of knowledge) and emotional response (affective domain) for the structures, procedures and results of the service.

Patient satisfaction is conceptually defined as the judgments of the value of patients and the subsequent reactions to the stimuli that they perceive in the'environment of health just before, during, and after their stay hasthe'hospital or a consultation (Strasser, 1991), cited by ANDEM .

Satisfaction is determined by the disparity d'a standard (expectations, values, or standards) and

of the benefits received.

The patient satisfaction – one of the types of'evaluation by patients – is widely known by the Investigators and politicians/managers/directors as a key measure of care, separate from the'effectiveness of care.

Patient satisfaction has emerged as an important component of the quality of medical care. During the last decade, the patient was regarded as the centre of the system of health. The structures of care using data from patient satisfaction to improve their service. Thus, the patients ' satisfaction has been implicated as'antecedent and consequence of good health.

The measurement of satisfaction is, therefore, an important tool for research, l'administration and planning .

Through these definitions, nous conclude that patient satisfaction is:

One of the indicators of quality of care.

Considered as the difference between the expectations of patients and their assessments of the benefits received.

Composed of several elements.

The multiple determinants.

In order to better understand the concept of satisfaction, it is necessary to go through some points

Place the patient satisfaction as an indicator of the quality of care.

Analyze the components of patient satisfaction.

Develop a taxonomy of aspects (dimensions) of the patients ' satisfaction.

To identify factors that influence patient satisfaction.

The constituent elements of patient satisfaction

The satisfaction is the'gap between the expectations and the experiences experienced by patients in a clinical context. The portion of the experiences will be detailed in the following paragraph concerning the taxonomies of aspects of care experienced by patients. Therefore, in this subsection we present two elements: the expectations and variances.

Expectations

This makes the definition of the concept of satisfaction is difficult, it is its multidimensional nature, and many other factors (socio-demographic characteristics, health care, structure of care,...) that can influence this concept.

Definition

Consider the following definition: "The satisfaction is determined by the difference between the needs/expectations of the patients and the care they received". Therefore, it is essential to understand the concept of waiting patients and to include it in the measurement of satisfaction. The most recent studies on patient expectations elucidate the problem with these definitions, but only a certain number of them defined in a precise way their subject. It is therefore necessary to place the needs of patients in a clinical setting and describe their development and their ability to affect outcomes of care.

The conceptualization of the expectations, "expectation" in English, varies according to the authors. The Webster Collegiate Dictionary (Merriam-Webster, 10th ed., 1993) provides several definitions of " expectation " : year early (was looking forward to), an entitlement Looking for as due, proper, or necessary), justification (reason gold warrant for looking forward to something), and a like hood (the degree of probability of the occurrence, duration, etc, of something). French translation: an anticipation, a law (considéré as due, proper, or needed), justification (reason'wait for something), and a likelihood (the degree of probability of occurrence, duration, etc, of something). The'Encyclopedia, the Hachette (Hatchet MultiMedia, version 5.0, 2000) provides several definitions of the'waiting, both of them are hope, anticipation. Synonyms of expectation are expectatifs (a policy of waiting), or calculation, desire, hope, hope, anticipation, desire (to disappoint the expectations of someone).

The Dictionary of psychology (www.granddictionnaire.com) provides a definition of the'waiting like the feeling, expressed or not, of'to have an answer to that desire. And that of the'expectation coturne waiting tinted d'hope or active focus to the consequences of'a result of'experiences or d'eveevents to which the subject feels interested, but which he does not connaît not l'outcome accurately. This complexitye in the definitions is the reflection of the literature, where the term'patients ' expectations is used in theu.s. in a sense widely different.

Type d'waiting

In a review of the recent literature on expectations, Thompson and Sunol' identify four types of expectations: the ideal (ideal), expected (predicted), normative (prescriptive), "non-formulated" (unformed). However, it is clear that this modelling of expectations is difficult isunderstanding. Another classification exists, this classification is elaborated on the basis of two types of expectations: the so-called "built" and the so-called "non-built". The first type is broken down into three sub-types: the expectations of an ideal, pragmatic (that match the type expected or "predicted"), and normative. The second type corresponds only to the expectations of non-built (that corresponds to the type "unformed").

The expectations built

Ideal (Ideal): the researchers who conceptualize the expectations of the consumer as an ideal, refer to expectations that exist only in the mind and not in the real world.

Pragmatic (predicted): the researchers, who conceptualized the expectations of the consumer, such as expectations, believe that the expectations of the consumer are predictions about what is likely to happen in a realistic, pragmatic.

Prescriptive (normative): "expectations have also been conceptualized as standards (standards) standards. The normative expectations are taken to represent what should or should occur, and could be compared to what we have said to the patients or what they were made to believe, or what they deduce personally what they should receive health services. The normative expectations are related to a subjective assessment of what is earned in a given situation, and some of the'also extend to an evaluation approved socially.

Expectations of non-built

Expectations not being built are uncommunicated expectations by consumers, they occur when consumers can't or don't want to, for different reasons, the reveal, perhaps because'they'have not, or that c'is too hard to express, or do not wish to confide their feeling, due to the fear, to the'concerns, compliance with social norms, etc... This may be a temporary phenomenon

before'having acquired the'experience and knowledge. The authors discuss the fact that the expectations of non-built can be quite common in the context of health care, where the previously healthy persons can meet a lot of new aspects of the system of health once that'they become ill. So they can meet the health care system without waiting preset.

In 1996, A review of the literature, Kravitz RL proposes an alternative classification of the wait. For him, the expectations of patients can be classified according to two fundamental directions different: as probabilities or values.

Expectations such as probabilities: are the expressions of what patients think, what are the beliefs of the likelihood of occurrence in the future. These expectations are aligned to the "expectations" (expectancies). They correspond to the type "predicted" or "pragmatic" in the class of "expectations built". Patients see a likelihood that a set of events to occur.

This classification does not receive particular attention. Even if several studies affirm the existence of an association between expectations as probabilities, and the satisfaction, the evidence is insufficient to conclude that the "hopes " that influence patient satisfaction after controlling for expectations, such as the values and the'performance of the'expectation.

Expectations such as values: are expressions of what patients want: wishes, or desires of the patients regarding the clinical events. Patients review subjectively compliance with their expectations as values expressed as perceived needs, nuns, or of rights. Expectations as a value can be expressions of desire (what is wanted), the need (which is perceived as necessary), the right (the one who is possessed or what it was right), standards (which should be), or the'importance (a hybrid category, because the desires, needs, and rights can all be classified according to their importance). They correspond to the type of "ideal " and "normative" in the class of "expectations built ".

Theories and Models of Patient Satisfaction (the concept of'gap)

Theories (basic) satisfaction

The majority of studies conducted on the satisfaction is not theoretical, this said, in 1982 Linder-Pelz is an exception, he designed several types of theories, psycho-social, such as : the theory of the gap, the theory of accomplishment, and the theory of fairness to formulate hypotheses about the determinants of patient satisfaction.

These three theories fit into the paradigm of disconfirmation, a model that predicts the formation of satisfaction as a comparative process: it is the result of the disparity between a standard (expectations, values or standards) and of the benefits received . Expectations can be positively disconfirmées: c'is-to-say that exceeded expectations (expectations exceeded), confirmed: c'is-to-say that the expectations are met (expectations met); or adversely disconfirsummary: c'is-to-say that the expectations are not met (expectations not met).

Theory of the fulfillment (fulfillment theor)

In the theory of the'achievement, satisfaction is conceptualized as a simple difference between the expectations of the patient or subject had beforehand and the service that is provided to him.

Theory of the'gap (discrepaney theory)

In the theory of the'gap, the satisfaction is conceptualized as a difference between what's'is actually happened and what was expected, reported to what is expected.

Theory of the'equity (equity theory)

In the theory of the'equity, the patients are satisfied when they perceive their sharing of the resources in relation to what others receive, adjusted to standards or rules of agreement, c'is-to-say that people think that'they are treated fairly. The theory of the'equity differs from the theories of the'achievement and the'gap ' in the sense that it highlights the'importance of comparisons interpersonal between the way a person is treated compared to others, rather than comparisons of intra-personal between her own expectations and perceptions of what occurs.

The Models of the Patients ' Satisfaction

Conceptual models by sophisticated patient satisfaction, which introduce the theory of disconfirmation were built. A model including the three theories has been proposed by Oliver . Thethree other models are the models proposed by Thompson and Sunoln based on the market research conducted by Anderson (1973) and Parasuraman (1991) .

The model "assimilation-contraste"

Anderson offers this model of perception, which is based on the theory of cognitive dissonance. According to this model, the perceptions of the performance to differ only slightly from the expectations, it is common for people to move their perceptions to their expectations: c'is the'effect of'assimilation. However, there is a threshold to each side of the interval over which the people can no longer perform the move but begin to exaggerate the difference increases between the perceptions and expectations: c'is the'effect of contrast.

The model of the "zone of tolerance"

This model asserts that there is a zone of tolerance as an interval between the levels adequate and desired expectations vis-à-vis the services provided. The tolerance zone in this model refers to the effect of'assimilation proposed in the previous model. This model of Parasuraman makes a distinction between the expectations of the process and the results. This distinction seems to be relevant in the context of the glitch, where the patients may have different expectations between the process and the results.

For example, the quality of the food of the'hospital can have a wide tolerance zone and a lower level of service performance that the'effectiveness of treatments.

The model Kravitz

This general model introduces several theories of socio-psychological . The figure represents the model of the expectations of patients, taking into account another clinical context is important. According to Kravitz, the first patient expectations for care are formulated prior to the meeting medical but can be change in the conduct of the meeting. The initial expectations can be clearly stated ("I want the doctor to me prescrive an antibiotic") or amorphous ("J'hope that the doctor is interested in my problem and really try to solve it"). What determines the initial expectations of the patient includes the socio-demographic characteristics, previous experience with the system of care (including prior contact with the doctor) and character-specific bio-psycho-social

During hospitalization, patients notice the various events which are likely to happen (this actually happened). These perceptions are, of course based on that which is truly past, but are influenced by the feelings and the psychological structure of the patient. The valuation of the hospital, which began during the visit and continues after, is the result of a comparative process in which the perceptions, what happened, are related to expectations (beliefs about the

probability of occurrence of an event) and values (attitudes to potential events). Appreciation is also directly affected by other factors such as the age, the origin of ethnic and state of health of the patient.

The level of specificity of expectations in the model, the distinction between the expectations and conditions, which are viewed as one of the determinants of the specific expectations and specific expectations. The overall expectations and specific, are generally consistent. For example, a patient who has waited for a medical consultation lasts 30 minutes (general expectations) can estimate that 10 minutes is perfectly adequate for a simple problem that is already known by the doctor.

The content developed by Donabedian (1980), he asserts that the patients may have expectations about the structures of the system of health, the procedures or process and the results.

The time of the study: the expectations obtained prior to the meeting are not identical to those built after the meeting of the care. Under the framework depicted in the figure, the patients compare their expectations to what actually happened in forming judgments evaluative. As mentioned earlier, an expectation is a belief or an attitude that is formed prior to the visit, as amended during the visit, and reference after the tour in order to make an overall judgement about the satisfaction. Although the expectations of'pre-consultation to be influenced by occurring clinical later (such as the negotiation of physician-patient), they may be less appropriate than those that persist during and after the consultation.

The model "assimilation-contrast" adapted from Thompson and Sünol

Thompson and Sunol' do not accept the notion of a measure of the performance objective. In their model, the performance is judged only by users in terms of perception. Initial perceptions of the performance represented by a diagonal axis slope descending (top-down), and perceptions of post-assimilation/contrast are represented by a diagonal sloping upward. A tolerance zone around the expectations set is defined, and limited by an expected minimum and a normative level possible, on the'assumption that the normative expectations exceeds expectations.

When the initial perceptions exceed expectations in the tolerance zone, the model shows that'there is a little less satisfying than expected due to the effect of'assimilation. However, when the initial perceptions exceed expectations outside of the box, the model shows that'there is more satisfaction than expected due to a contrast effect. Thompson and Sunol propose that the curves represented in their model differ across domains d'assessment of patients.

The model "cognition-affect,"

This model of Oliver (1983) combines the paradigm of disconfirmation, the theory of the'equity and also introduces an intermediary between the real performance and satisfaction. The emotional, both positive and negative, which are influenced by d'other phenomena, independent of the performance of the care provided

The expectations and the benefits are actually received as well as their difference determines the level of patient satisfaction, according to the paradigm of disconfirmation, this model predicts the formation of satisfaction as a process of comparison between a standard (expectations) and the services provided. Expectations can be positively disconfirmées, that is to say that expectations are exceeded (expectations exceeded), confirmed, c'is to say that the expectations are met (expectations met) or negatively disconfirmées, that is to say that the expectations are not met (expectations not met).

To summarize, these models are based on the theories mentioned above, the differences between the expectations and the care received or the services provided perceived. The aim of these models is to allow for a more precise analysis of the causes of dissatisfaction of patients and offer a glimpse of the fields of action more vast, which can meet the objectives of different actors of health .

Aspects of Care in the Measurement of Satisfaction

There are several aspects of care that influence the assessment and satisfaction of the patient, and on which they are likely to give an opinion. The identification of these different aspects is essential, because on the basis of this classification is the choice of items d'a satisfaction questionnaire. The study questions are divided into sections which cover widely the'experience as a hospital patient. There are different classifications of aspects of care, according to the different cut-outs, on which is based the measurement of satisfaction. These aspects are commonly referred to as "dimensions of satisfaction" , or "areas of satisfaction". The classification of Donabedian is based on the objectives of the evaluation of care . It est applied by the other authors .

The structure (or the resources): It refers to the characteristics relatively stable aspects of the'organization of the structures of care : level of care providers (caregivers, and administrative), resources (equipment medical and non-medical), the'physical location and organisation in which they work.

procedures: It is the main purpose of the'evaluation, but the judgment of the quality of the procedures is based on the relational aspect, in other words the relationship between the procedure and ses consequences on the health and well-being of individuals and society. The quality of processes of care is defined byt medicine in terms of standards, and the company of'ethical values. For example: in support of the pain and social problems, or psychological, medical information, relations with the'team health care, behaviors, caregivers, procedure, interpersonal (relationship clinicians/patients and clinicians/clinicians). It assumes a cutting with different activities.

results: It refers to the change between the'current state of health is somatic as psychosocial and the'future health status of the patient due to the care provided in the short-term and long-term

In addition, as the care of the patient requires a large number of'activities, it is possible to separate these activities into two areas :

technical field: this is the quality of diagnostic techniques, therapeutic procedures and equipment, fitness and of the'effectiveness of the treatment of the'effectiveness of the system of delivery of care (the'access to care and equity: heals-t-be the good the sick, those who really justify the care, the structures of care are they adapted to their environment).

The domain of interpersonal: The human dimension, relational and comfort. The interpersonal aspects of care include the socially-psychological aspects of the doctor/patient relationship , and is intended to satisfy the needs of physical and emotional patients through the way patients perceive and consider them to be supported by their experience and this can only be assessed by the patient himself .

This classification resembles that of Steudler, and is quoted by ANDEM , the areas are classified as follows : the fields of technical-medical areas of social and psychic and material domains and intellectuals.

The areas of technical-medical: They represent the organizational needs appropriate primary, to a quest for security, The sick “deeply moved in his body” [...] waiting for an answer to her troubles, her suffering, to the identification and partial or total restoration of his signs is functional, of his body.

The areas of social and psychic: the patients have social contacts with the new environment. The patient “in the throes of an anxiety resulting from the rupture of the middle, in a situation of fragility” ; his expectations, his research d’information are strong.

Material areas and intellectuals: The patient expects a material comfort, assistance, intellectual and spiritual to cope with suffering and death, feel a bit like home, not to be cut off from the outside world by keeping its intellectual activities or recreation. All of this reflects the desire not to be devalued, to find the’self-esteem, despite the presence of the disease.

After presenting the various ways in which the expectations of the patients are conceptualized and defined, the different elements with which patients ' expectations are influenced and modified; it is clear that the writings on the subject are extremely heterogeneous. In this part, we try to summarize the key distinctions between the theories cited above, journals and recently published articles and to develop a taxonomy helpful in regard to patients ' expectations for care.

Aspects of Care Experienced by Hospitalized Patients

A review of the literature based on 112 publications is carried out by Rubin , it offers a taxonomy of the different phases in the measurement of satisfaction with care can be used in the satisfaction surveys (table).

Thus, if the patient is generally unable to judge of the scientific basis and technical aspects of the treatments that are given to us, he knows how he is received, it knows the amount of time that he has waited in a consultation, an examination, if he has or has not been informed of her health condition and the proposed treatment, it can be noted that the politeness and care of doctors and nurses, the comfort of its installation, the nocturnal silence of his room, the quality of the food... It can even judge the management of her pain. Finally, he can set the level of confidence that it has issued to the’team which’has supported, and s’it would recommend cand establishment to a close or s’it would have l’intention d’to return to it.

The Elements Influencing the Satisfaction of the Patients

It is important to know that the concept of patient satisfaction remains our days, inaccurate, despite its common meaning. As to its extent, and based on the review of existing literature, it is based on three axes: the realization of empirical investigations, the development of methods of investigation and the’development of models and theories. A study of a measure of patient satisfaction is only complete if these three lines of research are charged. The use only of empirical investigations without underlying theoretical framework remains without interest: to give a meaning to this assessment, it is important to justify that satisfaction is related to attributes of the delivery hospital accessible to corrective actions , which makes the’identification of the determinants of satisfaction and the’interpretation of their role. In addition, the measurement of satisfaction enables comparisons to be made between the different structures of care in the presentation of the results. It is also important in the study take into account factors that can influence the measurement: state of health in the subjective and objective patient, psychological aspects and the socio-demographic. It is necessary to take account of the’all of these factors in the interpretation of the results of the satisfaction survey.

Thompson and Sunal identify a number of personal and social factors influencing such as needs, values, intentions, experiences, emotions, social norms, socio-demographic factors... The properties, measurement questionnaires are also an aspect too often overlooked and which may call into question the validity of the result .

It is important to clarify the characteristics of patients ' expectations of themselves and the characteristics of the approaches used to assess and measure.

Therefore, it israit necessary to define the socio-demographic characteristics and medical patients that affect their satisfaction, regardless of the care. This point is very important, because it helps to define variables d'fit indispensable used to compare the structures to each other or in the same structure over time. It is important to verify that the observed differences in levels of satisfaction are not entirely related to an effect of "recruitment", but rather to an effect "structure of care". It is po this that the collection of socio-demographic characteristics of the patients is systematic, although their role has not been elucidated ; and it is necessary to perform multivariate analyses, which provide additional information for the validation of the tool.

The Characteristics of Psycho-Socio-Demographic

All of the theories of satisfaction to say that the expectations are one of the determinants of satisfaction, while the research on the causes of expectations shows that socio-demographic factors (such as l'age, sex, and the race/l'and ethnicity) have influence on the expectations , and that the'education, social class, marital status and perceived health may influence the levels of satisfaction that directly affect health care services. This influence of socio-demographic factors is the subject of several studies. This being said, the results remain changeable and inconsistent depending on the country and the type of structure of care studied. The determination of the existence of a relationship between these variables and the satisfaction remains difficult, it is dû levels of care expected different, the ease of'expressing negative opinions, or to differences in the quality of care received, real.

It is demonstrated that only age is linked consistently with satisfaction, generally those with less age are the least satisfied . But it turns out that this relationship is not quite linear, since it is a drop in satisfaction scores as soon as the age passes a certain threshold of more than 75 or 80 years old, according to the authors .

D'other factors are likely to influence satisfaction, they are often included in the questionnaires. These factors are: the level of'education, social class, marital status , income levels (or socio-economic level), the'ethnic origin and the place d'habitation. It is important to know that lhas satisfaction is at its best when the level of'education and the social level are low, and patients are married, or patients who do not live alone. It is best when patients live in areas of non-urban. It is important to mention that the'effect of the social level, as found in studies conducted in the United States, not the'is not in the works of English, or canadian French.

In summary, there are a number of opinions and differing opinions about des socio-demographic variables. Some authors, such as Hall and Doman , argue that the socio-demographic characteristics of the patients have a low predictive power. D'others see that the relationships of these variables with the satisfaction are fickle, and even contradictorys. It is preferable, t, however, be taken into account, even if the multivariate models the most comprehensive n'explain that'a small proportion of the variance in satisfaction . According to a review of literature Rubin, several investigations show that these socio-demographic variables have little or no relationship with the extent of satisfaction .

However, the dimensions of psychological and social scores of perceived health (perceptual) measured before the treatments seem to affect patient satisfaction .

Differently from other factors, few works are concerned with the relationship existing between the satisfaction and outcomes of care.

Patients ' expectations influence directly the level of satisfaction, it is shown that: the patients with less d'expectations and less knowledge of the service are more satisfied.

The previous experiences of the patient are important, they help to form predictions about future experiments. It is clear that patients ' expectations about future contact with the health system, conceptualized as forecasts, are usually influenced by previous experiences within the care system. In the United States, the minority's racial/ethnic groups tend to be treated in hospitals different from those of the majority white. Blacks tend to receive their care at the university hospitals, while whites tend to receive care in non-teaching hospitals. Expectations about the quality of care may also differ. And the blacks and whites canthey judge their current experiences differently because of their prior experience different.

The Characteristics of Health: The'health Status and Outcomes of Care

Perceived health status to the'admission of patients represents a variable'adjustment important because it has a direct impact on satisfaction. It is obvious that the subjects with poor health status are generally less satisfied , as are those whose state of health does not improve in the course of care . There are few works that are interested in the link between the disease and the satisfaction. According to a study conducted in France, a number of indicators of clinical severity (poor prognosis, chronicity of the disorders, comorbidity) are at the origin of a low level of satisfaction of the patients after their hospital stays . D'other studies show that patients who feel serious or very serious problem which is at the origin of their hospitalization were more satisfied (perceived severity). Patients who feel pain during the'hospitalization were less satisfaction compared with patients n'not have had.

The results of care are closely linked to the satisfaction, On outcomes of care , it is a variable to take into consideration, since the improvement of health is very attached to the great satisfaction. To ensure the reliability of a customer satisfaction survey, it is necessary to include these factors that influence the level of patient satisfaction.

The Characteristics of the Structure of Care

In the hospital, several studies affirm the existence of a close relationship between the satisfaction and the terms and conditions of support hospital as the terms d'admission, the size of the hospital, the service type (medical versus surgical), or duration of stay, with large variations in the results depending on the country.

A study in France shows that the type of service and type d'admission have an effect on the satisfaction: satisfaction is higher in the surgery and in the case of'admission programmed or the patient's private physician .

Time of Conducting the Survey

During the'hospitalization or after discharge

In the case of the'hospitalization, it is preferable to perform the assessment after the'hospitalization, this allows to evaluate the conditions of release and satisfaction at follow-

up. This measurement is carried out just after the'hospitalization and is more reliable when'it is close to the output only when'it is performed several months after that. For the appropriate moment to send a questionnaire to a patient is 2 to 4 weeks after its release , uonly longer duration (6 months) in the case of'a surgical procedure to allow the patient d'integrate the outcomes of care . It is clear that the patient has a more thoughtful and clear after a hospitalization or consultation during them. This allows time to obtain the time necessary for the patient to detach themselves from their experiences in hospital. Avec period is too long, the patient may not remember a specific way (through memory). In addition, a study says that patients discharged for several months are more satisfied than those who are only out for a few weeks . It is preferable to exclude patients who are out of the'hospital for over 3 months, since'it is unlikely that the details of the experiences of patients will be exactly found. More recent data are likely to provide much more useful information on the strengths and weaknesses of the support so that the strategies of the'improvement can be properly considered. However, d'after a study, the time that has elapsed since the output and the time when the patient completes the questionnaire of satisfaction n'would not be on the'review of the satisfaction. Therefore, it is necessary to take into account the'element of delay between the output and the filling of the questionnaire in the'interpretation of the results of the'survey of patient satisfaction.

A Passage of the "Patient" To "Client"

The patient, who is "patient liability" tends to become a client, or a "consumer informed". This n'is not only a cultural phenomenon or a phenomenon of fashion .

In the fifties, the first research on the measurement of the satisfaction of patients are conducted, in the United States, by sociologists, and, in the 1960s, by organizations of care (Medicare /Medicaid). Les 1970s are marked by the'emergence of the role of the satisfaction of the consumers . Two main reasons account for the causes of this research :

The Americans are the first to conceptualize and to put in place the'evaluation of the quality of care, the satisfaction of which is the'one of the main components.

The health system of the United States is characterized by the diversity of its insurances and its modes d'organisation. Of this fact, the competition is significant, and given the perspective of marketing, the satisfaction of patients is part of the key points and priority. De plus, outpatient care, in the case of a Health Maintenance Organization, in particular, occupy the'attention of researchers, d'after Rossiter L. et al, cited by Goupy .

While the british health system creates a new impetus to the research conducted in this field, the competition becomes present within the National Health Service by the possibility for local authorities to enter into contracts with hospitals and care services of their choice. (Smith C., 1991), cited by Goupy.

In France, since several centuries, the goal of the'hospital is to'welcome the poor, d'lock unfit for social, receive the wounded. This makes necessary the'humanization of the hospital. This policy of'humanization develops after the second world war and sets from official texts. The'humanization can be defined as the'set of measures adopted by the'State or in a hospital from 1945 to provide inpatient comfort with their usual way of life and the free exercise of the rights of the human person. The circular of December 5, 1958 on the'humanization of the hospital especially recommend the'relaxed visiting hours, the presence of'a member of the family at theclose of the hospital (children, sick in a serious condition), the'authorization for the sick d'use of the personal effects, the'development of the hours of rising, meals, and bedtime, to

bring them closer to those of the common life, theimprovement of the care of the sick and visitors and, in particular, the awarding of a booklet and the creation of a "home service" provided by the hospital staff.

A circular dated 19 June 1947 is already planning to distribute to each hospital an exit questionnaire to express his opinion. Since the memorandum of 5 December 1958, which introduces the term "d'humanization of the hospital", a regulation that is abundant sees the light of day. Circular n° 132 of 18 December 1970 on the'humanization specifies these recommendations are considered minimum and encourages the institutions to implement them. She insists on :

Thehome: hostess, signaling, telephones, decoration of the premises, simplification of formalities d'admission, admission to the bed of the sick, in the case of'entry in the emergency. In addition, regarding thees outpatient: generalization of the appointment, the reduction of expectations.

The conditions of residence: silence, personalized relationships, food, and leisure.

The'patient information: personal contact with the doctor, the families: introduction to places and times of receipt of the families by a member of the medical team treating physician, staff: presentation of the'establishment, delivery of'a booklet, regular meetings d'information, particularly on the experiences of the sick, discount d'journal internal to the'establishment.

In the sixties, the early studies of'image of the'hospital is realized with the general public. Subsequently, in the 80's, comes the turn of satisfaction surveys. The "Charter of the Sick" – publishede in 1974 by the Ministry of Health, with the obligation for institutions to distribute to hospitalized patients, accompanied by a booklet of'home and the exit questionnaire – and the awareness of physicians to the concepts of quality of care, to 1980, are that such investigations are to be accepted.

The patient in the hospital environment is the person who suffers and the one who is in a relationship of dependence vis-à-vis the doctor, or more generally by the medical staff. In recent years, the concept of the customer replaces the notion of a patient, it transforms the person who is the actor, the client may choose from and may have some requirements. All of this is that the relationship of the person to'all services performed within the'hospital is expanding, as well by the administrative agents, the employees of the'establishment, as by external service providers that provide cleaning and restoration. That said, this perception extended to the person as the client includes the risk of influencing the extent of her satisfaction to themes, non-medical, based on the principle that the'can'raises questions about its ability to make a judgment on the quality of the'medical act so that'it can'speak only on the'environment.

"The sick n'is more of a consultant or a user but a client, in the same way that his family or his entourage. And this customer has become more demanding about the quality of service. He is more attentive to the'ahome, the length of the'waiting, the lack of'information. It views health as a right, a service is due, the'importance of its social contributions pushes him to have a critical eye". Patients regard, currently, the dysfunction of l'hospital as a clear evidence of non-quality.

This evolution can be explained by at least three factors :

The weight of heavier and heavier of the chronic pathology, due to the decrease of the'incidence of acute diseases, and due to the aging of the population in industrialized countries; the more often the patient has time to think about his decision.

L'increased competition: the doctor in the first line must take into account the preferences expressed by patients, and it can do it'all the more easily that the'provision of care is multi-faceted.

L'information more and more wide of the public on the medical techniques available: the level of a'requirement of the patient s'is increased.

When we know that'a satisfied customer said to the four people around her, and that'an unsatisfied customer tells his setbacks supposed to the nine people on average, it is clear that service-based businesses in general, and hospital institutions, public or private, in particular, cannot ignore the'importance of customer satisfaction.

L'hospital's mission is to be open to the entire population, all the social strata combined. The customer is better informed, accustomed to the campaigns of consumerism which grow to d'other sectors'French economy, is increasingly challenging in the face of the delivery hospital. In their article, published in 1979, "Qwhen users become customers", the authors analyse the'evolution of the condition of'users to the client through the behaviors and attitudes of the respective consumers and suppliers. In industrialized countries, the'increase in the standard of living, the level of'education, the satisfaction wider basic needs and travel to many off-shore lead consumers to express requirements, larger, and more varied. Consumers reach a stage where economically and culturally they are demanding the ability to choose, more broadly, a better service. The clients love to be able to choose, and their choices punishes the quality of the product or service available.

The Patient Satisfaction and the Quality Approach in the Hospital

L'ANDEM (National Agency for the Development of the'Medical Assessment), created in 1990, states that it is a priority to achieve an implementation of'concrete actions ' d'evaluation , which soon became a reference in the matter. At the request of the Directorate-general for Health and the Management of Hospitals, the'ANDEM develops a review of the literature and medical professional regarding the current knowledge on the concept of patient satisfaction.

The'order of 1996 is naître ANAES (National Agency for the'Accreditation and the'Health Evaluation), which comes to replace the'ANDEM. An implementation of'a device to measure the satisfaction of users and complement to the criteria of the repository of'self-assessment . This device must be consistent and reliable, because it contributes to the orientation of the local choices of'actions that result, subsequently, by the establishment of'a programme of'continuous quality improvement.

L'institution is willing to introduce a measure of patient satisfaction in his programme'improving the quality, and to regularly assess the'effectiveness of this program. The purpose of the health institutions is to better comprehend the expectations of patients and d'respond in the best conditions. For this, it is necessary to draw on a regulatory framework, as a basis, then d'to develop a specific approach for each facility.

It is essential to take into account the way in which the institution performs the corrective actions, because it represents, to the side of the relevance of the system used, an important element to judge the quality in hospitals. The'more objective analysis of the causes of satisfaction and dissatisfaction should be used to guide the professionals who lead the actions of'improving the quality of care and services within health facilities. In effect, this analysis allows to detect priority actions to be implemented and to respond in the most appropriate manner to the

expectations of the patients.

Conclusion

In a hospital environment where the main concern is the quality of care delivered, and where patient satisfaction remains undisputed proof, patient satisfaction assessment is a sure-fire way of improving health services in hospitals. In fact, it is one of the ways of circumventing care-related dysfunctions.

However, measuring patient satisfaction involves a number of challenges, particularly in terms of methodology and interpretation of results. Existing theoretical models, such as the Donabedian approach, offer structured frameworks for analysis, but their application requires adaptation to the specificities of each healthcare facility. Rigorous, ongoing evaluation not only identifies shortcomings in patient care, but also guides efforts towards targeted, sustainable improvements. In this way, integrating patient satisfaction into an overall approach to improving the quality of care promotes better care, boosts user confidence and contributes to optimizing hospital performance. It is essential, therefore, that healthcare establishments see this assessment not simply as an obligation, but as a strategic lever in the service of medical and organizational excellence.

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