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## Evolution of Quality Management and Quality of Care Management

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# Evolution of Quality Management and Quality of Care Management

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During the last half of the twentieth century, the development of quality concepts in the field of medical care has been accompanied by important changes in the politics and ethics of the health sector and has led to an evolution in terms of health care performance. It is obvious that the progress of quality concepts and methods in the field of health care is originally the result of the evolution of quality management in the industrial world.

The analysis of the historical evolution of the quality movement, first in the industrial world where this movement has taken roots, then in the hospital environment allows to define and to underline the importance of quality not only in the industrial environment but also in the health field.

The history of hospital quality is marked by two main phases, according to E. Minvielle, these two phases are called: the professional administrative phase and the organizational phase.

In this article we will analyze the historical stages of industrial quality and quality of care. To do this, we will take the following path: historical foundation of quality management and the evolution of hospital quality management.

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## I. INTRODUCTION

The word "quality" refers to the Latin word "quais" which means what. For the Robert, quality "is a way of being, a characteristic", it is intrinsic to a product or service.

For the A. F. N. O. R., quality is defined as "the set of properties and characteristics of a product or service that gives it the ability to satisfy explicit or implicit needs." (ISO Standard 802 - 2.1)

The International Organization for Standardization (ISO) defines quality as "the ability of a product or service to satisfy the explicit or implicit needs of users. This forward-looking definition is presented as a result to be expected based on needs that must be identified and understood. It refers to the need for stakeholders to find a balance between customer expectations, costs, deadlines, staff satisfaction and the strategic choices of the hospital structure.

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Based on the World Health Organization's (WHO) definition of quality as "providing each patient with the range of diagnostic and therapeutic procedures that will ensure the best health outcome, according to the current state of medical science at the lowest cost for the same result, with the least iatrogenic risk, and for the greatest satisfaction in terms of procedures, results and human contact within the health care system", we can conclude that medical and care activities are at the center of any reflection on hospital quality. However, this definition broadens the concept of quality to include all functions of the hospital organization, including cost control, risk management and user satisfaction in the broadest sense.

According to the WHO definition, quality is defined in the context of a global and multi-professional approach. Thus, some dimensions of quality of care cannot be based solely on the commitment of health care professionals. According to this approach, the perception of quality is systemic and total in relation to the hospital organization. This approach to quality is the result of a long historical evolution, which began in the industrial world before spreading to the healthcare sector.

The development of quality approaches in hospitals is directly linked to the quality movement that has taken off in industry. This movement, although focused on a common objective, includes several currents that it is important to identify. Today, quality approaches have only been transferred to the hospital sector in a fragmented and localized way. The difficulty of these transfers lies in adapting the concepts, methodologies and tools to the specific context of health care institutions, particularly in terms of culture and terminology.

## II. QUALITY MANAGEMENT

The word "quality" refers to the Latin word "quais" which means what. For the Robert, quality "is a way of being, a characteristic", it is intrinsic to a product or service. For the A. F. N. O. R., quality is defined as "the set of properties and characteristics of a product or service that gives it the ability to satisfy explicit or implicit needs." (ISO Standard 802 - 2.1) The International Organization for Standardization (ISO) defines quality as "the ability of a product or service to satisfy the explicit or implicit needs of users. This forward-looking definition is presented as a result to be expected based on needs

that must be identified and understood. It refers to the need for stakeholders to find a balance between customer expectations, costs, deadlines, staff satisfaction and the strategic choices of the hospital structure. In order to better understand the evolution of quality in the healthcare field, it was necessary to analyze its genesis in the industrial world where this movement took root.

### III. HISTORICAL EVOLUTION OF QUALITY

#### 1. Quality inspection

In the 20th century, quality was perceived as a concern for inspection. This was accompanied by the emergence of scientific management based on the Taylorian firm model, theorized in the United States by F.W. Taylor in 1911, which was subsequently adopted in French-language literature under the term Organisation Scientifique du Travail (OST). OST is based on three essential points: observe, standardize and inspect. Observe the workers and identify the coherence of the tasks performed in order to produce, to break down the production phase into tasks as elementary as possible. Standardize the best way to do things based on the observations, ensuring the efficiency of the production and To inspect the tasks performed and their conformity to the set standards by drawing tolerance limits.

The quality is therefore the creation of the scientific organization of work, it is based on universal standards.

At the time when Taylorism became widespread, the first standardization bodies were created, such as the BSI (British Standard Institution) in 1901, the DIN (Deutsches Institut für Normung) in 1917, and the AFNOR (Association Française de Normalisation).

That said, it is important to note that its Taylorian quality inspection systems are not linked to customer expectations for several reasons, two of which are worth mentioning:

The company's objective is to manufacture, at the lowest cost, products that conform to specifications established by specialized engineers only.

The majority of the companies which manufacture in mass, sell semi-finished products to other companies and not to final consumers

#### 2. Quality control

##### *Questioning of quality inspection*

The economic development that the world of industry experienced between 1900 and 1930 made the market become mass, production increased, which made it difficult to maintain quality inspection, because of the large number of products manufactured and employees. This made quality inspection costly and manufacturing defects keep increasing, in this case Taylor's scientific approach no longer fulfills the role of reducing overall production costs.

#### Appearance of statistical quality control

The concept of quality control was born in the late 1920s in the United States, within the American Bell Telephone Company and its subsidiary, the Western Electric Company, which launched research on the statistical analysis of quality defects. In 1931, the engineer W. A. Shewhart published a seminal work on the subject.

The quality control comes as an answer to the problems related to the high costs of the inspection, the engineer W.A. Shewhart succeeded in conceiving a control chart which allows the statistical control of the manufacturing quality, this last one is based on two main concepts: the level of the acceptable quality (NQA) and the limits of control.

- NQA: tolerated percentage of defective product determined from a cost benefit trade-off.
- Control limits: the limits that the characteristics of samples taken must not be exceeded. Quality control is an analytical process that provides information on error probabilities, limits, and their numbers.

*Deficiencies in statistical quality control in quality control*, quality is determined and perceived by the quality engineers, far from the customer's vision, since the NQA is set by the company's engineers. In this approach the company defines quality according to its own interest, which is the minimization of inspection costs, and not from the interest and preferences of the customer. After the Second World War, it was realized that quality control, which is a control done at the end of the chain, is very costly, the detection of defects beforehand is the best solution.

#### 3. Quality assurance

##### *The emergence of the customer focus*

After the Second World War, the relationship between producers and consumers underwent a gradual change, in the United States and in Europe after a few years. Indeed, as consumers became more and more numerous, the increasingly different products on the market posed two concerns: on the one hand, the evaluation of product quality, and on the other hand, the lack of an exchange link that was present between craftsmen and customers. This led the producers to ask themselves the question: how to know the needs and preferences of a large and anonymous clientele in order to adjust the offer to the demand? In order to evaluate the quality, the company was faced with two possibilities: either to determine the quality according to the perception of the consumer, in this case how to know this consumer and his needs? Or it is the company that establishes the quality, but how to adjust it to the market demand?

J.M. Juran, A.V. Feigenbaum and W.E. Deming made the customer one of the main actors of the

economy, and enters the concept of quality, they affirm that the customer directs the economic activity by desires that the market must satisfy, the goal of the production is to satisfy the need of the customer and to know them.

#### *Quality assurance as a preventive approach*

Quality assurance appeared with M. Juran and W.E. Deming. With the increase of the customer focus, the quality assurance is based on an external orientation, the quality has as an objective to satisfy the needs of the customer, so the company is committed to produce goods and services that are designed to spread to the expectations of consumers. All the means of control and correction undertaken by the company are integrated in this same objective.

Quality assurance proposes control procedures and preventive devices that have the role of ensuring the quality of the product during all levels of production. The control is only done at the end of the production line.

Quality has moved from a product-centered quality to a production process-centered quality. This has been achieved by:

- Identification and formulation of processes.
- Creation of indicators that ensure the control and management of processes.
- Management reviews and audits to keep the system efficient for evolution and improvement.

The quality assurance focuses on the customer, his expectations and needs which are changing, it implies a continuous improvement of the quality of the product, it is a kind of adaptation to these changes, also implies the continuous improvement of the production processes.

The implementation of quality assurance has led to the formulation of several procedures for the control of manufacturing processes in all levels of production, which has given a formalist aspect see bureaucratic approach, which is far from the staff concerned and not adapted to the organizational reality of the company, which has created several problems and dysfunctions.

Several authors, such as J.M. Juran and A.V. Feigenbaum (Feigenbaum A.V.), have affirmed that quality assurance requires much more than statistical skills such as: planning, coordination, establishment of standards, evaluation... All of this is part of management know-how. It is from this moment that a new trend appears which is the total quality.

#### *Total quality*

The bases of the total quality have been highlighted by the quality assurance previously mentioned which are:

- Quality control begins at the product design stage and continues until delivery to the consumer.

- Quality control involves everyone who is involved in the manufacturing process.

A new concept of quality is born, which has as a conceptual basis the main features of quality assurance, developed in 1950 in Japan and then in the rest of the world called: Total Quality Management (TQM).

#### 4. The birth of total quality

During the reconstruction of Japan, after the second world war, several industrial and scientific groups were created, one of them named Union of Scientists and Engineers (JUSE), it realizes that the survival of the country will depend on the export, and that the quality will take a major place in the world market, what pushed him to conceive a program of promotion of the quality, thereafter the JUSE organizes a series of conference animated by Deming, in 1950, and which turns around the statistical control and the preventive methods of the assurance of the quality

After Deming, J. M. Juran presents management courses that deal with the major problems of quality, according to him "the major obstacle to the improvement of quality in the United States was located in the organizational barriers that corresponded to the compartmentalization between departments.

In the United States, at the end of the 1950s, several new concepts of quality assurance appeared, the prevention established by J. M. Juran affected the entire organization, and it is A.V. Feigenbaum, who is the first to speak of total quality (Total Quality Control (TQC)), according to him all the functions influence the quality of products, not only manufacturing.

Subsequently, in 1960, a program called 0 defects, developed by the Martin Company, specialized in the military industry, was born, and through it, the principle of continuous quality improvement was theorized for the first time.

In 1962, JUSE introduced the quality program to all Japanese employees under the guidance of Kaoru Ishikawa, a professor at the University of Tokyo and one of the leaders in quality, who believed that all company personnel should be involved in quality control. This gave rise to a Japanese school of quality, named Company-Wide Quality Control (CWQC) by Mr. Juran. CWQC is based on five fundamental principles:

- Focus on the customer, one of the key principles of quality assurance.
- To be based on the process approach with a preventive vision, the second key principle of quality assurance.
- Involve all functions in the quality approach (work of A.V. Feigenbaum).
- Set the goal of continuous improvement, based on the notion of 0 defects.
- Involve all the staff, one of the distinctive points of the Japanese school.



Indeed, the Japanese school has had a great impact on the conception and application of total quality in the industrial world, thanks to the different techniques and tools it has developed.

*We quote:* Quality circles: a participative management tool.

- Quality Function Deployment (QFD): a tool for integrating the implicit and explicit needs of customers within the company (customer focus).
- The 5M diagram designed by Kaoru Ishikawa: which focuses on the preventive logic opposed to the processes.
- The Kan-ban invented by Taiichi Ohno, an engineer at Toyota: a just-in-time management system for supplier orders and production.

#### *The application of the total quality concept at the international level*

In the 1970s, the world of industry was in crisis, Fordism, considered as a production mode that replaced Taylorism, was called into question, mass consumption was replaced by a more selective consumption, in fact the nature of the demand was changing and the individual, in a progressive way, takes a central place in the market, it became a main concern for the system of production. The concept of the representative customer gives way to the singularized customer, its purchasing power decreases and its needs are more and more specific with a lower cost, without forgetting that the offer and the competition are from now on on a world scale.

The challenge for firms is to adapt the production system to the new market context, which leads companies to draw inspiration from the successful Japanese experience, and therefore focuses more on quality as a competitive element.

From the 1970s, in the United States and then in Europe, companies began to adopt the Japanese management model: Total Quality Management (TQM), which took the form of the importation of Japanese managerial tools. Thus, American and European companies are applying the Japanese management method which establishes the link between employees and the continuous improvement of quality as a common objective (participative management).

In the United States and Europe, the human dimension of quality is developing more within the framework of the application and adaptation of Japanese management. In 1979, Philip Crosby published a book that had a major impact on the international development of total quality management, in which he stated that participative management and economic gains for the company were two related elements.

## IV. HOSPITAL QUALITY MANAGEMENT

### 1. Hospital Quality Management Movement

The hospital world is characterized by a great complexity, indeed the hospital, whose main mission is the production of care, is a field of interaction between medical knowledge, care and administrative management.

In order to assimilate the evolution of hospital quality, a perspective of its history is required.

The history of hospital quality is marked by two main phases. According to E. Minvielle, these two phases are called: the professional administrative phase and the organizational phase.

Before going into more detail on the history of quality, we present definitions of hospital quality.

#### *Definitions of hospital quality*

Several definitions of hospital quality have emerged, the most recognized worldwide are:

"Quality is to guarantee to each patient the assortment of diagnostic and therapeutic acts, which will ensure the best result in terms of health, in accordance with the current state of science, at the best cost for the same result, with the least iatrogenic risk and for his or her greatest satisfaction in terms of procedures and human contacts within the care system." WHO

"High quality care is care aimed at maximizing the well-being of patients after considering the benefit/risk ratio at each step of the care process." Avedis Donabedian

"High-quality care contributes strongly to increasing or maintaining quality of life and/or length of life." American Medical Association, 1984

The ability of health services for individuals and populations to increase the likelihood of achieving desired health outcomes, consistent with current professional knowledge." Institute of Medicine, 1990

The term "quality" has a multidimensional character, and depends on the vision of each health care actor, generally speaking its definition has evolved from a professional definition centered on the technical quality of the finished product or service, to a definition that includes the degree of patient satisfaction as a main element.

Avedis Donabedian, one of the pillars of quality of care, distinguishes three dimensions of quality of care:

- Structures: all resources used in the care process such as equipment, devices, premises, etc.
- Processes: refers to the care delivered to patients, and how well it conforms to pre-established rules and standards.
- Outcomes of care are generally influenced by the patient's health status, survival, quality of life,

progression of health status, satisfaction is also considered in this category

According to Donabedian, quality of care has several dimensions: effectiveness, which is reflected in the results of care in terms of health status after the course of care, but also the patient's point of view; efficiency, which links the results of care to the resources used; accessibility, which is summarized by the degree of conformity to the patient's preferences and values; legitimacy, which encompasses the values of society; and finally, equity.

One of the most relevant ways of measuring quality of care is from the perspective of the patient and his/her satisfaction. Quality assessment is done through the measurement of the user's opinion, as the user's perception of the quality of care is an essential aspect along with the measurement of outcomes.

While the Institute of Medicine (Crossing the Quality Chasm) states that quality of care includes the elements of: safety, effectiveness, efficiency, timeliness, equity, and patient-centeredness.

The Pickler/Commonwealth Program for Patient-Centered Care is a patient-centered quality of care program developed in 1988, it emphasized 8 characteristics of quality most important to the patient, they are:

- respect for the values, preferences, and needs expressed by the patient;
- integrated and coordinated care;
- clear and high quality education and information for the patient and his family;
- physical comfort, including pain management
- emotional support and alleviation of fear and anxiety
- appropriate involvement of family members and friends
- continuity;
- accessibility.

## 2. Quality of care from different perspectives

Improving the quality of hospital care has been a priority since the 1960s in the Anglo-Saxon countries, and much work has been done in this area, stating that + quality of care can be expressed from several points of view of the different actors in care: the patient/consumer, the professional, the health care institution, the social welfare system, (5) the government.

Each type of point of view must have different criteria for standardization and a different perception of the quality of care.

According to the patient's point of view, quality depends on his needs and expectations in terms of care and services. According to him, quality is clinical effectiveness in terms of diagnostic accuracy to the effectiveness of the treatment and care provided.

For health / care institutions, quality is the production of the most effective care possible, at the

lowest cost (cost, efficiency), with the condition that the patient returns to the institution when needed.

From the point of view of the social welfare system, quality is the cost-effectiveness, management and use of resources to achieve the desired health outcomes.

And finally for society, quality is the optimization of resources in favor of the communities and the citizen in general.

The concept of satisfaction is one of the tools for measuring the quality of care, from the patient's point of view, it is essential for its evaluation.

## 3. Genesis of hospital quality

*Quality as seen from the perspective of a professional bureaucracy*

H. Mintzberg describes the hospital organization as a professional bureaucracy, this model of structures is based primarily on the skills and knowledge of the operational center (professionals), in the case of the hospital, the service provided, which is the production of care must be controlled by the operators who perform it. This type of organization is also based on the development of standards and norms that have the role of coordinating work and determining what must be done beforehand.

Quality in the hospital is therefore based on the control of professional practices on the one hand, and on the respect of rules and norms pre-established by the management or legal texts on the other hand.

*First phase: evaluation of hospital quality.*

In 1980, two different orientations emerged, in the United States and then in Europe, namely the evaluation of the quality of professional practices, and the evaluation of the quality of care provided within the hospital institution.

*The quality of professional practices*

This approach sums up quality in terms of professional expertise, or the mastery of knowledge in each hospital specialty. In fact, quality is defined as the technical mastery of care acts.

In 1970, several American studies noted differences in the performance of medical and surgical procedures, which were not directly related to the patient's condition or even to the technical conditions of the hospital environment. This led experts in the field to create a movement whose objective was to draw up recommendations for good clinical practice, considered to be a standardized description of the best medical attitude for a given pathological case.

The evaluation of the quality of professional practices has affected several specialties, we cite: the indicators of prescription of specific acts such as chest x-rays, nosocomial infections.

Quality for nurses can be summarized as the control of technical acts or gestures such as intravenous injections, the insertion of a catheter, etc., and the

control of preventive acts, which is based on medical knowledge.

#### *The quality of hospital services*

The result of the first phase is the development of written procedures in order to avoid the organizational risks linked to the oral transmission of information.

The second step is to carry out corrective actions in order to minimize the discrepancies between what has been done and what should be done, based on pre-established standards. A standard includes laws, recommendations, rules and pre-established standards. Sometimes corrective actions can be stated in a baseline.

#### *Hospital quality under the impact of the bureaucratic-professional approach*

The production of quality in the hospital is done through two successive phases: the evaluation phase and the phase of development of corrective actions, it is the administrative and professional who have the common role of ensuring them, so this production begins with the evaluation stage.

To ensure its application, professionals and administrators are both involved in the quality process, so we distinguish two categories:

- The autonomous co-productions of the quality: they are the steps made by the professionals or the administrators, it engages only one of the two.
- Crossed co-productions: there are certain tasks that require the cooperation of both professionals and administrators, for their accomplishment and to ensure their quality, as for example: the placement of patients admitted to the emergency room in downstream beds, this task requires coordination between the two for the co-production of quality. (Minvielle, 1999).

In both cases, in order to ensure the quality of care, professionals and administrators must set themselves the goal of quality while respecting the rules and standards pre-established under a professional bureaucracy angle.

#### 4. The emergence of a new reflection on the organization of quality work.

At the end of the 1980s, a new trend emerged in the United States, and later in Europe, in which the classic methods and approaches of quality assessment and quality assurance were questioned, despite their successes, especially in the logistical and technical sectors of the hospital. The aim of this questioning was to broaden the field of investigation of quality.

#### 5. The questioning of traditional approaches.

There are several criticisms of traditional approaches to quality, which can be divided into two main points: the first concerns the lack of consideration given to the organizational dimensions of the hospital in the traditional approach to quality, and the second

concerns the prescriptive aspect of the methods for improving quality.

#### *Professional practices to organization*

The vision of quality oriented towards professional practices is narrow, and neglects other aspects of the quality of care, such as the involvement of users and other care actors in the care process, D. Berwick and D.N. Schumacher were the first to emphasize the reductive nature of this approach, which focuses on the analysis of professional practices and on medical expertise alone.

This questioning is based on classical approaches from the industrial world, mainly the work of W.E. Deming, who states that only 15% of deficiencies are related to the technical expertise of professionals, and 85% are the result of organizational factors, which shows that dysfunctions are not always the responsibility of health professionals, but due to errors in the management of the hospital organization to the various services of care.

#### 6. Continuous improvement and compliance with standards

According to traditional approaches, quality is compliance with norms and standards, such an approach limits the level that could be reached in the quality of care services, the risk is to develop norms and standards that affect only a minimal level of quality and far from excellence.

#### 7. Total quality management

Following these observations criticizing the traditional approaches, a new movement is born, called the total quality management, following the example of the industrial world, the hospital is committed to make the transition from the detection of defects to a quality management system.

This movement is based on several principles:

The search for continuous improvement of excellence in work, so quality improvement is a permanent process.

Quality is no longer the conformity to standards and norms, but the ability of the health care institution to present services and health care benefits that are as close as possible to the requirements of the patients.

The organizational aspect is essential, the care entity must master the organizational modes as well as possible, a break with functional management is then required, all the care actors must be involved in the quality process.

Quality management sets several objectives related to the quality of care and the organization of the entity, its success is based on a process approach, each activity is presented in the form of a process and not described as a function only, this allows the detection of malfunctions with the help of methods and tools: control diagrams that allow the mapping and evaluation of processes as well as the intensity of

malfunctions; "fishbone" diagrams that allow to visualize the causes at the origin of malfunctions and to locate the responsibilities

Following the implementation of quality management, quality departments were set up in hospitals, and accreditation institutions were created, while giving major importance to the patient.

#### 8. Accreditation of health care institutions and quality improvement

The purpose of accreditation is to evaluate the quality of a health care institution and to ensure its continuous improvement through changes in medical, paramedical and managerial practices. The accreditation procedure provides a general and independent assessment of quality in the health care organisation, using indicators, criteria and reference systems, covering procedures, good clinical practice and the results of the various services and activities in the organisation. The accreditation process must be external and independent of the health care organisation, and its evaluation affects all of its activities and practices. It verifies that the conditions for the safety and quality of care and patient management are taken into account by the health care organisation.

In 1918, the first accreditation program was created in the United States, with the help of an association of surgeons, and then adopted by four other associations of health professionals, who created an organization, called today: joint commission, this organization is responsible for the certification of all American hospitals today.

In Canada, health professionals joined the joint commission in 1950, and in 1956, created their own accreditation organization called Accreditation Canada. The Australian certification program was developed in 1974, based on the Canadian experience.

Most other countries applied the principle of accreditation later, as did France, which created the ANAES "Agence Nationale d'Accréditation et d'Évaluation en Santé" in 1996, based on the Anglo-Saxon model.

Morocco has recently embarked on a project to establish a hospital accreditation program with the cooperation of the WHO, in a process aimed at developing a national hospital accreditation system that would provide institutions with a frame of reference for better functional organization and technical capacity and, consequently, higher quality care.

#### *Accreditation and total quality*

Accreditation is a systemic approach based on six main objectives, inspired by both American and European procedures. It represents an opportunity for hospital managers to evaluate the quality of health care services and organizational practices, in order to optimize resources and improve quality by making decisions about organizational changes.

Accreditation is a strategic process, its purpose is to ensure continuous quality improvement, by measuring the hospital's ability to engage in a quality process that aims at excellence at all levels, with a strong focus on the patient, who is at the heart of the healthcare system.

#### *The accreditation process*

Accreditation, like any quality approach, encompasses all the activities undertaken in a hospital. All the activities related to care represent a chain which determines the overall level of quality of the entity (from reception to medical and nursing activities, including the hotel industry, internal transport, biomedical and medical-technical activities, etc.). The objective is to make all care professionals aware that they are involved in a quality approach that aims to organize the health establishment by adopting the methods and techniques of quality management.

It is based on a global approach to the health care facility through: audit, quality management and evaluation.

The audit enables a comparison to be made between the practices undertaken in the hospital and the quality references and standards. This comparison helps to identify the hospital's strong points and its weak points, which are called situations of non-compliance with standards and therefore of non-quality.

Non-quality can be: organizational (structure and management tools failing), medical and care (nosocomial infections, readmission ...), logistical (poor accommodation, lack of variety of meals served ...) or technical (delays in repairs ...), thereafter, action plans are made with indicators of results, which are subject to evaluation to calculate the differences between the quality objectives and achievements, these differences are analyzed in the context of an audit.

#### 9. Quality of care from different points of view

Ensuring better quality during hospitalization is a priority for the health care system.

Much work on this subject has been done in Anglo-Saxon countries since the 1960s, and it has been argued that the quality of health care can be reflected through the points of view of the different parties involved: the patient/consumer, the professional, the health care institution, the social welfare system, the government.

Each type of point of view has standardized criteria and a perception of quality of care that varies according to its structure and objectives:

Quality, according to the patients' point of view, is defined in terms of their needs and expectations for care and services.

Quality, from the practitioner's perspective, is defined as clinical effectiveness, in addition to the accuracy of diagnosis, appropriateness and effectiveness of the treatment and care provided.



Quality, for health care facilities/institutions, is the ability to produce the best delivery of care at the lowest cost (cost-effectiveness), with the objective that patients return when they need it.

Quality, from the perspective of the social welfare system, refers to the cost-effectiveness, management and use of resources to achieve the desired health outcomes.

Finally, from a societal or health system perspective, quality is often expressed in terms of value for money and benefits to the community at large.

The concept of patient satisfaction is used to assess the quality of care from the patient's perspective. Feedback from patients (users of the health care system) is generally considered essential to assess and assure quality.

## V. CONCLUSION

In this article we have analyzed the evolution of the quality movement, first in the industrial world where it originated. Then, its declension within hospital organizations. This has allowed us to understand the evolution of the perception of quality, as well as the factors that have influenced the passage of quality from a simple concern for control to a total approach of the organization. This led us to observe that the different approaches to hospital quality have followed the same pattern of evolution as in the industrial world. However, we have noted a phase shift in the two quality movements over time.

Our analysis of the evolution of the hospital quality movement has led us to conclude that the hospital organization has strong specificities that are reflected in the different parameters of the organization. Its bureaucratic-professional configuration and the complexity of the care production process, in which knowledge from the medical, nursing and administrative worlds is brought together, have forced these organizations to adapt the various quality approaches according to their parameters.

It should be noted that the emergence and evolution of quality concepts in the field of medical care during the last half of the 20th century was accompanied by significant changes in the politics and ethics of the health sector. Over time, the patient has become an increasingly important part of the health care system, and interest in the patient's perspective has grown the hospital organization has strong specificities that are reflected in the different parameters of the organization. Its bureaucratic-professional configuration and the complexity of the care production process, in which knowledge from the medical, nursing and administrative worlds is brought together, have forced these organizations to adapt the various quality approaches to their parameters.

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