

Perceptions and Expectations of Primary Health Care: a New Form of Identifying Improvements in the Care System

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Objective. To analyse the opinions of the users of primary care on the care that they receive and to identify the principal areas of satisfaction.

Design. Qualitative study using discussion groups and open interviews during the period January-May 2003.

Setting Health areas of Valladolid, Spain.

Participants. The inclusion criteria were: to have attended a primary care clinic at sometime and to be between 35 and 80 years old. Recruitment was carried out through key informants, using the snowball technique.

Method. 6 discussion groups and interviews with representatives of 3 nursing and 1 residents association were carried out. Structural sampling was carried out as regards the variables that influenced satisfaction. The conversations were recorded using tape recorders and literally transcribed on paper. The analysis of the texts was carried out by 2 investigators and concordance was sought between them.

Results. The principal areas related to satisfaction were: the treatment received from the professionals, which is considered a fundamental part of care, combined with the technical quality, continuity of the care, the admission services, the bureaucratic procedures, the barriers for accessing specialised services, and waiting lists.

Conclusions. Personalised care, the time dedicated by the professional, the continuity of care, and waiting lists are the principal areas related to the perceived satisfaction of the patients. The possible responses to improve this situation are: the implementation of changes in the care management and organisation which would simplify the procedures, investment of resources (human and economic), changes in the model of the professional-patient relationship and improvements in undergraduate and postgraduate training.

Key words: Primary care. Perceived quality. Users. Discussion groups. Qualitative methodology.

PERCEPCIONES Y EXPECTATIVAS SOBRE LA ATENCIÓN PRIMARIA DE SALUD: UNA NUEVA FORMA DE IDENTIFICAR MEJORAS EN EL SISTEMA DE ATENCIÓN

Objetivo. Analizar las opiniones de los usuarios de atención primaria sobre la atención que reciben e identificar las principales áreas de satisfacción.

Diseño. Estudio cualitativo mediante grupos de discusión y entrevistas abiertas durante el período enero-mayo de 2003.

Emplazamiento. Áreas de salud de Valladolid.

Participantes. Los criterios de inclusión fueron: haber acudido alguna vez a la consulta de atención primaria y tener entre 35 y 80 años. La captación se ha realizado a través de informadores clave, mediante la técnica de bola de nieve.

Método. Se realizaron 6 grupos de discusión y entrevistas con representantes de 3 asociaciones de enfermos y una de vecinos. Se llevó a cabo un muestreo estructural en función de las variables que influyen en la satisfacción. Las conversaciones fueron recogidas en cintas magnetofónicas y transcritas literalmente en papel. El análisis de los textos ha sido realizado por dos investigadoras y se ha buscado la concordancia entre ambas.

Resultados. Las áreas principales relacionadas con la satisfacción han sido: el trato recibido de los profesionales, que se valora como una parte fundamental de la atención, unida a la calidad técnica, la continuidad de los cuidados, los servicios de admisión, los trámites burocráticos, las barreras para acceder a los servicios especializados y las listas de espera.

Conclusiones. La atención personalizada, el tiempo dedicado por el profesional, la continuidad de los cuidados y las listas de espera son las principales áreas relacionadas con la satisfacción percibida por los pacientes. Las posibles respuestas para mejorar esta situación son: la implementación de cambios en la gestión y la organización asistencial que simplifiquen los procesos, la inversión de recursos (humanos y económicos), los cambios en el modelo de relación profesional-paciente y la mejora en la formación de pregrado y posgrado.

Palabras clave: Atención primaria. Calidad percibida. Usuarios. Grupos de discusión. Metodología cualitativa.

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Introduction

The primary care (PC) model has been continually improving since its introduction,^{1,2} although there are still important challenges ahead. The quality of health care concerns the users, professionals and managers, who are the principal route for improving the services. Among the different concepts of quality (quality control, guarantee of quality, quality management, and total quality), satisfaction is one of the most important factors to take into account,³⁻⁵ as is highlighted in the European Model of Excellence (EFQM).⁶⁻⁹ For this reason, to go into depth into the opinion of the users, their needs and expectations, from the perspective of perceived quality^{10,11} is of great importance. Also, it must not be forgotten that satisfaction is currently considered as part of the results of health care.^{12,13} However, in many of the satisfaction surveys, high marks are obtained which do not correspond to the feeling of the population⁵ and they do not identify the problems. Qualitative methodology enables these aspects to be examined in detail and understood¹⁴⁻¹⁹ by the identification of new areas of improvement in the services and by analysing new aspects to optimise satisfaction surveys.^{1,16} The objective of this study has been to analyse the opinions and expectations of the users on the care that they receive in PC and to identify the principal areas related with satisfaction.

Patients and Methods

Design

Qualitative methodology is the most suitable for covering the objectives of the study.²⁰ These designs are constructed as the investigation process advances, gathering the different views and perspectives of the participants in the study.^{21,22} Thus focal groups and their Spanish variant, discussion groups, have been used in several studies on satisfaction.^{1,15,23,24} Using the interaction of the discussions of the participants, who tend to represent the social groups that express them,^{23,25,26} information of interest is generated.^{1,16} The most important points in the development of the groups are indicated in Table 1. The thematic guide used by the preceptor is shown in Table 2. Lastly, we should point out that each group had an observer. Additionally, interviews were carried out^{27,28} with people from different associations (Table 3) who could have a particular view of PC.

Sample and Participants and/or Contexts

The sample design is structural and was carried out according to the most important variables of the social structure (which influences the discussions) in relation to the objectives. Also, the interviews were carried out on people from the most important nursing associations of Valladolid and the most influential residents association (Table 3).

TABLE 1 Description of the Discussion Groups

1. Site of carrying out and origin of the participants
Urban area: Faculty of Medicine, University of Valladolid. Valladolid capital (Basic Health Zone of the 2 areas)
Rural area: Pozal de Gallinas House of Culture. Participation of people from the following municipalities: La Zarza (Olmeda Basic Health Zone), Bobadilla del Campo, Pozal de Gallinas and Nueva Villa de las Torres (Medina del Campo Basic Health Zone)
2. Initial instruction: "Let's talk about the aspects which help us to maintain or improve our health in day to day life"
3. Development: the discussion is centred on the aspects related to the objectives, as they were spontaneously mentioned by the speakers. In the case where any topic may not have arisen spontaneously, its discussion was put forward at a suitable time
4. Duration: 90 min and 2 h. The group was brought to a close when, in the opinion of the observer, the group output had been exhausted and was starting to be repetitive

TABLE 2 Subject Matter of the Discussion Groups

Ways of maintaining and improving their health
Aspects which they valued most positively in primary care
Aspects of primary care with which they are most dissatisfied
Opinion of the professionals who attend to their health
Opinion on the other professionals in the health centres
Suggestions and requests to improve assistance in the health centres

The variables considered in the design of the profiles which should be included in the groups have been:

1. Age. Influences the opinions and appraisals,^{12,13} also, it is related with the use of the health services. People between 35 and 80 years participate, as they are the ones who use the health services most,²⁸ separated into 2 age intervals (35-55 years and 65-80 years), since from 65 years the chronic diseases increase and, therefore, the use of the health services.²⁸
2. Sex. The social differences between men and women influence their opinions, their values and even in the use of the health system.¹³ Also, many women are carers of some family member,²⁹ which can involve different types of health care needs from the rest of the population.^{30,31}
3. Place of residence. Living in a rural or urban environment has an effect on accessibility and the type of services received and, therefore, on satisfaction.¹²
4. Educational level. Educational level has been considered as an acceptable indicator of social class,³³ and these are aspects which influence satisfaction.¹²
5. Activity. Active work, domestic work, retirement. The type of activity carried out is also associated with the access to and the use of health services.

Exclusion criteria (Table 4) have been taken into account for the composition of the groups, as well as a minimum of homogeneity and heterogeneity to guarantee discursive output and eliminate blocks. The composition of the groups is described in Table 5.

TABLE 3
Description of the Interviews

1. Site of carrying out and origin of the participants: the interviews were carried out on representatives of the groups in the premises where these associations are located
Patient Associations: Spanish Association Against Cancer (AECC), the El Puente Association of Mental Patients, and the Valladolid Association of Rehabilitated Alcoholics
La Rondilla Residents Association
2. Initial instruction: "the idea is to find out the opinion you in the Association have on the care given in primary care health centres and the problems which concern you"
3. Development: the discussion was centred on the aspects related to the objectives of specific health, as they were spontaneously mentioned by the speakers. In the case where any topic may not have arisen spontaneously, its discussion was put forward at a suitable time
4. Duration: between 45 min and 1 h

TABLE 4
Exclusion Criteria

Any type of incapacity or cognitive decline, hearing or diction which made it difficult to communicate orally
To be a health professional or direct family
To be linked professionally to the health services
To have any type of physical incapacity which would make movement difficult at the site where the groups worked
Persons who have never used assistance in primary care, either directly or through close family

Recruitment of Participants

This was carried out by the snowball effect method or a recruitment network using consecutive steps. Contact is made with people with social connections in different environments and with local government social workers. The health service network was not used to avoid biases in the selection or the discussions of the users.

TABLE 5
Composition of the Discussion Groups*

	Age, Years		Sex		Level of Studies		Origin		Activity					
	35-55	65-80	M	F	No Education or Primary	Secondary or University	Rural	Urban	Active Work	Domestic Work	Retired			
G1		9	4	5	9			9		5	4			
G2	7		3	4	7			7	5	2				
G3	5		3	2		5		5	4	1				
G4		8	4	4	8		8			4	4			
G5	7		5	2	7		7		5	2				
G6	5			5	3	2		5	3	2				

*M indicates male; F, female; G1, urban group of elderly people; G2, younger urban group uneducated or primary education; G3, younger urban group with secondary or university education; G4, rural group of elderly people; G5, younger rural group; G6, urban group of female carers.

Analysis

The discussion generated was recorded on magnetic tape, with the previous consent of the participants, and subsequently transcribed literally. The analysis and the interpretation of the information were carried out independently by 2 investigators, who had meetings to contrast and discuss the material analysed. Firstly, they repeatedly read the texts and noted the possible significances. Afterwards the most representative sayings and phrases were selected, and the information categories were listed, grouped and identified. These were subsequently structured into the information focal points which take into account the perspectives of the users, from the understanding of the significances and directions contained in their discussions.

Results and discussion

The field work was carried out between February and June 2003. The most important aspects related to satisfaction are described below (Table 6).

Accessibility

One of the aspects most valued by the participants is the accessibility to the health services.^{1,5,24,33,34} They highlight as the most important, physical proximity, the ease of telephone contact, and the morning/afternoon opening times of the clinics.

*"But if you weren't so far away, it would be accessible" (G2).
"...there are times it is not so, because you call and call and you are saying; what are the telephonists doing that they cannot pick up the telephone?..." (G6).*

The informants have a positive opinion of the previous appointment, since it allows for better organisation and helps the professional to access the clinical history. However, this perception is maintained even although the appointment may be given for the same day.

"Its fantastic, but not when they tell me: come the day after tomorrow" (G2).

TABLE 6 Principal Factors Associated With Satisfaction

1. Accessibility
Physical proximity
Telephone contact
Morning and afternoon care
Rural zone daily care
Previous appointment
2. Referral to specialised care
Ease of access
Waiting list
3. Care time
Waiting time
Time dedicated
4. Continuity of care
Professional-patient knowledge
Knowledge of clinical history and follow ups
5. Health and non-health professionals
Interpersonal communication
Confidence
Information
Administration personnel
6. Prevention
Need for these activities
7. Psychosocial resources
Mental Health
Social health support

In rural areas, daily medical care is considered as very important and determines the difference in opinion between the people who rely on this resource and those that do not.

"We have, for example, the family doctor every day here, at home, which is not like other rural villages, where the doctor comes once a week" (G4).

Referring to Specialised Care

From the discussion, it arose that one of the basic functions of PC is to channel the patient to specialised care. Satisfaction seems to be related with better availability and speed of the professional to refer, when the health problem does not show a clear improvement.

"For me, the family doctor is the one who has to raise the alarm and send you to the specialist because they do not have the means, but they already see that it can be something and advise" (G5).

In this sense and as in other studies,^{34,35} the most frequent complaint centres on the waiting lists to access specialised care.

"That is the problem, that...they take so long from when you are poorly until they call you so that you can be seen" (G2).

Care Time

Overcrowding^{5,33,36} has an affect on other aspects of satisfaction, such as the waiting time in the clinics³⁵ and the time dedicated to the patient by the professionals. Opinions centre on the incompatibility between quality and speed.

"In PC they have little time to dedicate to patient and often the patient requires more, because often it is not so much the illness but care of the soul" (AECC).

The waiting time is less in the rural environment. However, the users have the perception that they normally wait longer than is desirable, before entering the clinic.

"It is not as if it such a big village to have to wait so long; there are times when it is half an hour" (G4).

Continuity in the Carers

The users put great value on the continuity of the carers, although it is a rarely indicated variable.³³ On the one hand, reference is made to the professional-patient mutual understanding in the framework of a good relationship, since when the professional changes, costs related to the need to adapt and interconnect are generated.

"The person who has been many years with you, gives you more confidence" (G4).

Another aspect is the use of clinical history.¹ Much importance is given to that the professionals know the history of the patients and it contains a rigorous follow up of the illnesses, the risk factors, the treatments and tests carried out.

"The good thing that I see in our doctor is this, that an injection or something he gives you, immediately he writes it down and gives you a thorough check-up" (G5).

Health and Non-Health Professionals

One of the aspects most highlighted by the users is relative to the professional-patient relationship, and is one of the questions referred to most in other studies.^{24,33-35,37} Kindness, interest, personalised attention, listening and empathy are valued both in health and non-health professionals, that is, the variables which humanise care, although these points appear to be associate to the need for technical competence on the part of the professional.

"In the end what you want is for them to listen to you; when I go down with a problem, what I want is for them to listen to me and if you haven't been listened to and you are given a lot of medicines, it has no value for me" (G2).

The capacity of the professionals to provide clear and useful information is another valued aspect.

"If it is a person with some experience, and knows how to explain things to you, who understands you a little, who knows how to guide you" (G2).

Confidence is one of the words which appears most often in the different conversations analysed and is presented as a cornerstone. When patients perceive confidence, they arrive at the health services more relaxed and secure.

"The patient, to be cured, has to confide in the doctor; if you go there with distrust..." (G5).

There are complaints about the way the administrative staff treats the users. The importance of their function as the key to accessing the system is also recognised. For the informants, the work of these professionals in offering basic information, facilitating the passage through the health system, clarifying doubts, etc, is totally unquestionable.

"And they are the first point of entry so that the patient can be well attended, and if it is a old person you have to explain things or make the numbers so that they can be seen without glasses or more evident, in such a way that later they don't have to call you stupid for not knowing that the appointment was for 5.30 instead of 6.30" (G2).

Prevention

On this aspect, they consider that the activities and messages on prevention are essential in primary health care,^{5,13} but this role is not sufficiently covered.

"Real prevention, where every year they might give you a check-up which is due, where you might waste 2 hours or an hour and a half once a year and you don't have to arrive at..., or the least possible" (GUJB).

Psychosocial Resources

The participants saw gaps and shortages in relation to psychosocial resources, particularly those which dealt with mental health. This problem is emphasised in the discussions by people who, due to their situation or belonging to some association, might have experienced the need to have support of this type and the lack of response given by the health services.

"In primary care there is no specific service for the early detection of mental illness and, of course, we need this shortage from our associations" (Asociacion El Puente).

Discussion Key points



What Is Known About the Subject

- Satisfaction of the users is a very important factor in the evaluation of care quality in primary care. Questionnaires/surveys which are used to evaluate satisfaction are not sensitive to the opinion of the population and do not allow areas of improvement to be detected.

What This Study Contributes

- Qualitative methodology has been used to find out the opinion of the users of PC.
- As in other studies, they highlight accessibility, the treatment and technical competency as the keys to understanding the opinion of the users.
- One of the elements which generates more problems is related to the waiting times to access specialised care.
- In this study, the patients demand continuity in the professionals, more prevention activities and improved psychosocial resources, with special attention to the mental health of the population.

Conclusions, Usefulness, and Limitations

The opinions of the participants centre on 3 pillars which constitute the basis of satisfaction/dissatisfaction. Firstly, and coinciding with the results from other studies,^{24,33,34,35} we find the structural and organisational aspects which determine access to the specialised care services, waiting lists and the continuity of care.

Secondly, the treatment received from the professionals who attend the patients is valued. In particular, as regards health personnel, technical competency, the relationships with the patients based on kindness, listening and empathy, the offering of clear information³⁹ and adapted to the different needs, are the most prominent aspects. These variables are also shown to be central in other studies.^{24,33-35,37,40,41} In this sense, undergraduate and postgraduate training in the field of interpersonal communication is needed to improve and humanise the health services.

The third aspect refers to the lack of some services, such as those concerning prevention programs in some age groups,^{5,33} mental health services and the response to psychosocial type needs, as in the case of women who look af-

ter dependent patients and which have been demonstrated in other studies.^{42,43}

In conclusion, the need to carry out changes in the organisation and management to improve the use of available resources, investment in new human and material resources, the simplification of procedures and better employment stability which favours the continuity of the professionals, is noted. On the other hand, it is necessary to create mechanisms of analysis and reflection which redefine the model of the relationship between professionals and patients, considering the political, social and cultural variables that this entails.

Therefore, the use of qualitative methodology has been interesting and valuable to obtain the views of the users and identify areas of improvement associated with satisfaction, as is recommended in other works.^{34,44,45}

Lastly, it important to stress that the study does not deal with the opinion of more specific groups (immigrants, gypsies, young people). Also it has to be taken into account, on interpreting the results, the possibility that it may have produced a positive bias in the opinion of the participants, since quite a lot of resistance to take part has been encountered.^{15,33} To improve the validity, the analysis of the results was carried out by 2 investigators and it has tried to maximise the diversity of opinions according to the structural variable, achieving saturation of the discussion in the groups formed, and the profiles and the results have been described in a way that they could apply in similar contexts. However, we must not forget that the results cannot be extrapolated to other population groups, but they might be applicable to populations similar to those studied.

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COMMENTARY

On the Perceived Quality of Primary Care

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The perception which the users have on the quality of the services offered by primary care centres and the health teams varies according to factors which have their origin in the different elements that have a bearing on the care process and in its results: the organisation and staff of the centres and clinics, and the characteristics of the professionals and the users themselves. Satisfaction with the care received is a result of the joint interaction of this group of factors and, for this reason, it used to be very difficult to analyse, under the perspective of cause and effect, the role of any one of them in isolation.¹

Of the group of elements which define the organisation of primary health care, accessibility,¹ time availability² and continuity³⁻⁹ are the factors which most influence the perception and satisfaction of the users.

In the group of factors related to the characteristics of the professionals, those which help to establish an appropriate relationship with the patient and a pleasant and personalised care are highlighted.^{10,11}

Some characteristics of the patients also appear to play an important role in their perception and expectations on

Key Points

- The satisfaction of the users with the attention received is a result of multiple factors originating within the health system, the professionals, and the patients themselves.
- Accessibility, continuity, and an optimal doctor-patient relationship, to a great extent, determines the final satisfaction.
- The elements for evaluating primary care should abandon evaluation centred on the number of visits made and basically pay attention to quality and satisfaction.
- The new primary care should be contextualised in the heart of a subsystem of clinical care personnel and take advantage of the new organisational approaches which information and communication technology provide.

the quality of care received; age, socioeconomic situation, the presence of chronic diseases and the poor health situation, and the frequent use of the health resources are factors which have normally been analysed in this perspective.¹²⁻¹⁹

In the work by Redondo Martín, et al in this issue of PRIMARY CARE, the perceptions and expectations of the patients are qualitatively analysed (discussion groups), translated in terms of satisfaction, on the different aspects of the care received in health centres and, from them, possible improvement initiatives are deduced. To homogenise the characteristics of the participating patients, 6 discussion groups composed of 5-7 people were established. This group compartmentalisation could be considered excessive for the objective of the study. The conclusions corroborate the role of the principle factors that influence satisfaction and which have frequently been analysed in the scientific literature, and they add some more, such as the references to the relevance of prevention activities and the deficiencies observed in the assistance for mental health in the context of primary care, which has received little attention in previous studies.²⁰⁻²⁴

As pointed out at the beginning, the satisfaction of the user/patient has its origin in many factors, but there is wide agreement in the scientific literature on considering that continuity and the accessibility to care and, in relation to these, the establishment of a patient/doctor relationship based on confidence and in the bilateral participation in decision making,²⁵⁻²⁷ and placed in a context of availability of sufficient time, are central factors in determining not only the satisfaction of the user, but also the results in terms of effectiveness and efficiency of the care rendered. In this framework, the nursing professionals are called upon to fulfil an increasingly leading role.²⁸

This nuclear conglomerate which should characterise the increasingly important activity of primary care, as it increases the level of dependency of the patient in relation to the health and social services (chronic diseases, the physically and mentally handicapped, etc). In short, we are talking about a primary care built with the basic mission of giving personalised clinical attention and in which the resources of mental and social health have to be increasingly integrated. This subsystem of personal clinical care is different (although not separate) from technological clinical care centred in acute hospitals. This new primary care should leave its almost exclusive image of gatekeeper and patient distribution point to the technology subsystem behind completely and assume a greater capacity for resolving. As described in a recent editorial of the American edition of the *British Medical Journal*,²⁹ it is necessary to redefine primary care and include in this redefinition, a new perspective of evaluating its activity which must not be centred on number of clinical visits made, but on the quality and satisfaction generated.

The full incorporation of the new information and communication technologies into the daily clinical activity will introduce profound changes in the workloads. In the previously mentioned editorial, it is pointed out that assistance via the Internet (e-mail and website) could take on an increasing percentage of care and prevention activity. It also talks of the need of new formulas of care, such as group visits of patients with chronic diseases, and of promoting the access and possibility that patients may be able to add relevant information into their clinical history, computerised and situated in the website of the centre or the professional. It is in these contexts that we have to place the new primary care and, with this, professionals capable of providing health services with an optimum level of quality and perceived as satisfactory and effective by the people, politicians and managers responsible for the health system.

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