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Patients and quality of primary health care services. Survey of practitioners at the Bahía de Cádiz and La Janda health centers

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Aim. To report the opinions of practitioners at health centers on dimensions of quality that affect user satisfaction.
Design. Cross-sectional study of focus groups (FG).
Setting. Bahía de Cádiz and La Janda health centers in southwestern Spain.
Participants. We studied 4 FG whose participants were staff members of the two health centers: FG1, physicians; FG2, user satisfaction service staff; FG3, social workers; FG4, nurses. The groups were based on the different functions of staff at the two centers.
Method. The analysis was based on variables in the SERCAL model (an adaptation of the SERVQUAL model for the Spanish health care system) of opinions regarding service quality: access, comfort (tangibles), personalized service (courtesy), competence, and loyalty. The data were analyzed with version N-Vivo of the NUDIST program.
Results. All dimensions of the theoretical model were identified by practitioners as constructs of users' perceptions of service quality. Users' and practitioners' views contrasted with and complemented each other to generate a model that could be validated. Access, personalized service and problem-solving (responsiveness) were key variables.
Conclusions. Practitioners' opinions provided information of use in improving the quality model. Differences in opinion between users and practitioners merit further study based on an understanding of these groups' values and interests, and on the care provision context. Practitioners identified access, personalized service and problem-solving as features that influenced users' opinions of the quality of the health center.

Key words: Perceived quality. Satisfaction. Qualitative research. Practitioners.

LOS PACIENTES Y LA CALIDAD DE LOS SERVICIOS DE ATENCIÓN PRIMARIA DE SALUD. OPINIÓN DE LOS PROFESIONALES DE LOS CENTROS DE SALUD DE LA BAHÍA DE CÁDIZ Y LA JANDA

Objetivo. Conocer la opinión de los profesionales de los centros de salud (CS) sobre las dimensiones de la calidad que afectan a la satisfacción de los usuarios.
Diseño. Estudio transversal mediante grupos focales (GF).
Emplazamiento. CS de la Bahía de Cádiz y La Janda (BCJ).
Participantes. Se realizaron cuatro GF con personal de los CS. GF1: médicos; GF2: servicios de atención al usuario; GF3: trabajadores sociales; GF4: enfermeras. La selección de los segmentos se realizó según las funciones desempeñadas en el CS.
Método. El análisis se hizo según variables del modelo SERCAL de opinión sobre la calidad del servicio: accesible, confortable, personalizado, garantía y fidelidad. Se utilizó el programa NUDIST, versión N-Vivo.
Resultados. Todas las dimensiones del modelo teórico han sido identificadas por los profesionales como constructoras de la percepción que el usuario tiene de la calidad del servicio. Las visiones de usuarios y profesionales se contraponen y se complementan, generando un modelo susceptible de validación. El acceso, el trato y la solución del problema son variables clave.
Conclusiones. La opinión de los profesionales proporciona información para mejorar el modelo de calidad predefinido. Es necesario estudiar las diferencias en la opinión entre usuarios y profesionales según los valores e intereses de estos colectivos y el contexto de la atención.
Los profesionales identifican la accesibilidad, el trato y la solución del problema como características que influyen en la opinión que tiene el usuario sobre la calidad del CS.

Palabras clave: Calidad percibida. Satisfacción. Investigación cualitativa. Profesionales.

Introduction

Evaluating service quality and identifying critical factors that determine user satisfaction are challenges for client-oriented policies in primary health care services.[1,2] The problems inherent in identifying the attributes of quality and evaluating services from the user´s perspective have become issues that now attract the interest of professionals, managers, politicians and researchers.[3] In the health sector, different methodological approaches and models that explain service quality from the user´s perspective are currently being tested.[4-6]

Several authors[7,8] have discovered that for users, service quality does not consist simply of actions and behaviors in themselves, but also comprises the subjective manner in which these are perceived and interpreted. The complexity of measuring service quality becomes evident if we realize that it is intangible and heterogeneous, and that it is impossible to separate the moment of production from the moment of consumption.[7-9]

In recent years a number of instruments have been used to try to measure patient satisfaction as a fundamental factor in health care outcomes.[10,11] This task is not without problems. For example, it is hard to distinguish between the care process (service) and its outcomes.[12] Traditionally, studies designed to measure perceived service quality have been based on an analysis of the degree of user satisfaction, and have evolved from simple questionnaires to factorial studies with considerable statistical backing.[12-14] Qualitative methods seek to obtain in-depth information about the phenomenon, and to produce an in-depth interpretation of opinions on quality.

One of the instruments used during the previous ten years to measure quality is the SERVQUAL model,[15] which is based on a definition of quality as the difference between users´ expectations and their perceptions. An adaptation of this model to the health care setting is the SERCAL model,[4,6] developed from research aimed at evaluating users´ opinions on health service quality and constructed from a combination of qualitative and quantitative methods. The quality factors that the SERCAL model evaluates are *access*, *comfort*, *personalized service*, *competence (guarantees to patients)* and *loyalty* to the health center.

Although the patients´ view is of fundamental importance in understanding their opinion about service, improving the quality of care does not seem possible without involving practitioners. Some authors[8,16] consider client satisfaction to be based on the satisfaction of professionals and their concept of service quality as providers of the service. An organization must consider not only the degree to which users´ interests are satisfied; if improvement is desired, it should also serve the interests of professionals.[17] From this perspective, quality can be defined in terms of professionals´ decisions and behaviors that are expected to yield the greatest benefits for patients.

It is therefore of interest to determine how professionals perceive the benefits of care, and what actions they consider to contribute to patients´ perceptions of better primary health care service. Relating users´ views on quality and professionals´ perspectives may be a crucial step in designing health care processes and improving their outcomes.

The aim of the present study was to report on professionals´ opinions on service quality at primary health care centers. We also set out to determine how salient the dimensions defined in the SERCAL model were in the resulting information.

Methods

In this cross-sectional study qualitative methods were used to obtain in-depth information on the opinions of practitioners´ working at primary health care centers.

The setting was the Bahía de Cádiz and La Janda health centers in the province of Cádiz (southwestern Spain).
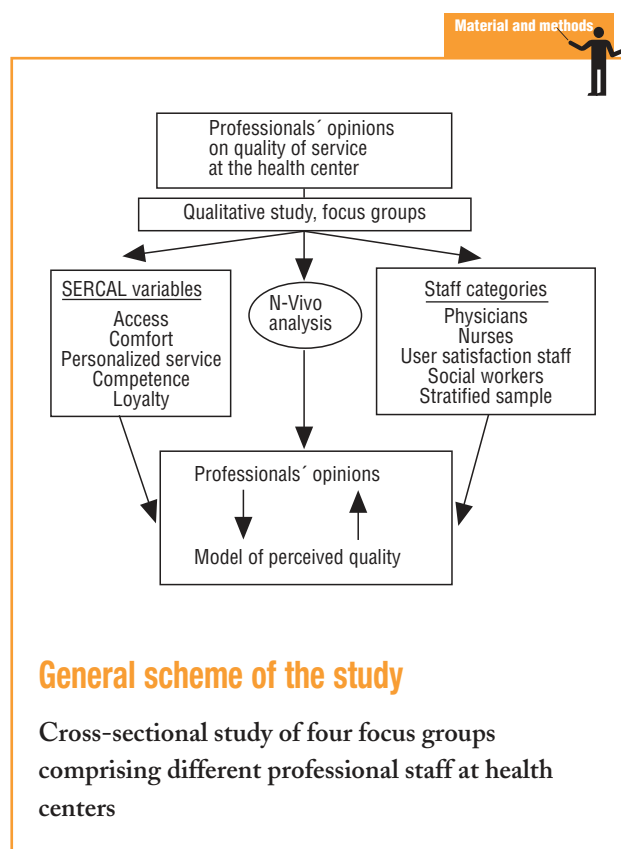
Information was obtained with the focus group technique, based on the so-called grounded theory.[18] A meeting was held with different staff members selected on the basis of similarities in their profiles, and participants were selected on the basis of their functions at the centers regarding services provided to users. The aim was to record the opinions of all professionals, and their different perspectives and views on users´ perceptions of quality. Four focus groups were studied:

– *Group 1:* family physicians and pediatricians at both centers.
– *Group 2:* user satisfaction service staff.
– *Group 3:* social workers.
– *Group 4:* nurses.

During the meeting a script was developed on the basis of the dimensions in the model (Table 1), with sufficient internal flexibility to allow exploration of new aspects and dimensions of the topic while respecting the options and terms used by participants. Relations were sought between the model and three types of question: what are professionals´ views on how patients perceive quality? What opinions do professionals have on service quality at each center? What factors do professionals consider most important in defining a user-oriented quality service?

The information was analyzed with the N-Vivo program, a qualitative data analysis assistant. N-Vivo[19] brings together the features and applications needed to facilitate and systematize text analysis: it can be used initially to identify discourse categories in the data, and subsequently to explore existing combinations of such categories with nodes that facilitate the identification of redundant text elements.

Redundancy and saturation were ensured by repeat analysis of the information by more than one investigator. The information

Material and methods


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Professionals´ opinions
on quality of service
at the health center

Qualitative study, focus groups

SERCAL variables          N-Vivo          Staff categories
  Access                 analysis           Physicians
  Comfort                                   Nurses
  Personalized service                      User satisfaction staff
  Competence                                Social workers
  Loyalty                                   Stratified sample

Professionals´ opinions

Model of perceived quality
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General scheme of the study

Cross-sectional study of four focus groups comprising different professional staff at health centers

was also checked by selecting intragroup and intergroup redundant elements.

Results

Service accessibility (Table 2)
Access to the service is one of the dimensions the professionals considered most important for quality service, and for which there was notable agreement regarding its influence on the user´s perception.

According to professionals, users value speed in accessing the system, a feature identified as a characteristic of service quality and a positive image of the center.

Participants considered that the perception of waiting times varies depending on *a)* the location of the health center in a rural or an urban area; *b)* the reason for visiting the center, and *c)* the level of care involved in the consultation. They believed that accessibility was related with the user´s understanding of the functions performed by certain members of the staff (user satisfaction staff), and that users consider this an obstacle that interferes with their main interest as a patient: being seen by their doctor. They also noted that *telephone access* generated complaints and negative views on the part of users, and that the complaints are identified by user satisfaction staff as a source of tension and problems that affect their workplace conditions, and can trigger arguments with users.

With regard to *routine paperwork*, professionals noted confusion and lack of coordination, reflected in the need for users to visit different centers and offices and in the fact that users «need to do some running around.»

Efficiency and speed of the paperwork was an element that participants said should be improved. They related excess bureaucracy with a lack of coordination between professionals and services. They also felt that inadequate training of professionals in the use of new technologies led to an increase in paperwork and often brought the system to a halt.

Waiting time at the center to make an appointment or while waiting in line for other services, time spent in waiting rooms, and delays in answering the phone led to negative perceptions regarding service quality.

On the other hand, when users encountered initiative, a sense of responsibility, and personal interest in their problem on the part of the professional, perceived quality was greater.

Comfort of the service (Table 3)
This dimension was closely related to accessibility of the center´s facilities. Professionals believed that the *appearan-*

TABLE 1	Components of the SERCAL model of service quality at health centers
Access to the service	
Accessible by public transport, telephone contact, paperwork and time spent waiting	
Comfort of the service	
Comfort and appearance of the building and facilities	
Personalized service	
Willingness of staff to listen to users, friendliness, and coordination between services and professionals	
Competence of the service	
Competence of the staff, confidence in the health center, use of technology and understandability of the information provided by physicians	
Loyalty to the service	

TABLE 2	Opinions of professionals regarding access to the service	
Waiting times	«…I think people appreciate efficiency, that is, an absence of delays.» (Nurse)	
	«But as long as things get done according to their expectations and within the periods they consider normal, the user is satisfied with the service received.» (Physician)	
	«Rapid access to the system, whatever it is, however fancy it aims to be.» (User satisfaction staff)	
Telephone access	«The phone is a problem that generates a lot of…not official, written complaints because they don´t go that far, but problems, which are obvious and which cause verbal complaints on an every-day basis-phone problems are a daily occurrence.» (User satisfaction staff)	
	«What people complain about most often is the telephone.» (Physician)	
Opening hours	«I´ve been a user, with my son, at another center, and I think the strictly limited opening hours are awful. Check-ups for healthy children at 8:30 in the morning. Any mother --or maybe I am just slow-- has to get up at 7 am or earlier to get ready, get the child ready, and get the child´s breakfast, to be at the pediatrician´s office by 8:30.» (User satisfaction staff)	
	«…In other words, it´s not our fault because we have to do everything at once—healthy child clinic, ultrasounds, vaccinations, blood collection, everything. It´s all structured around a schedule, but the schedule is inconvenient.» (Nurse)	
	«The impression I always get, as a user, is that the opening hours are based on the staff's convenience, not the user's convenience. That's my view as a user.» (Nurse)	
Paperwork	«The user often gets the feeling that when you enter the health center, you´re not entering a specific center but a system, and you don´t know how you´re going to get out, and also you don´t understand why someone says to you "You must do this or that." This throws users off track, and completely confuses them.» (User satisfaction staff)	
	«I think it´s disastrous for them when users are treated like little balls being bounced around inside the center.» (Nurse)	

ce of the exterior and interior of the center and accessibility accounted for users´ first impression of the center, and were essential in creating satisfaction and an impression of quality.

The participants felt that the physical conditions and comfort were relevant for users, who reach favorable or unfavorable judgments about the physical surroundings in which health care services are provided. Improvements in the physical surroundings were most clearly appreciated by users.
Comfort of the facilities was considered to affect working conditions and the way users are treated.

Personalized service (Table 4)

The greatest discrepancies between groups of staff members were found with regard to the importance of a pleasant demeanor. This was identified by all groups as a factor that influenced users´ opinions on quality, but we interpret their responses as evidence that the relevance given to this factor differed between categories of professionals. All participants agreed that recent improvements in this area were essential in offering quality service. However, physicians maintained that the main thing for users was obtaining a solution for their problem. Accor-

ding to physicians, technical quality is the most important aspect of service.

Nurses and social workers emphasized that personalized treatment is a central component of quality. Social workers noted the importance users assign to how they are treated by physicians.
«…in fact, what is most appreciated is the medical care.» The physician plays the role of the main agent of quality. Both technical quality and personal treatment are relevant for users, and social workers considered that aspects related with personal treatment of users would improve with strategies for training and adaptation to new technologies. Social workers identified as clients not only users who come to the center because of a health problem, but also the persons who accompany them and habitual clients whose main reason for coming to the center is «to pass the time.» Social workers believed the most relevant thing for these patients is to find that the staff create a pleasant, polite atmosphere.

Competence (Table 5)

With regard to coordination between professionals and services, participants noted that this dimension is linked to ot-

TABLE 3	Opinions of professionals regarding comfort of the service	
Appearance	«All this affects the image you provide, not only what you offer in your own office, but what the center as a whole offers --whether it´s clean, whether it´s been painted recently, whether anything´s in disrepair, whether the stains on the wall were there the last time I came-- all these things are really unpleasant.» (Physician)	
	«When they notice the center´s been painted or something´s been changed they say "Hey look, that´s new. It really looks nice."» (Nurse)	
Comfort	«…at my center lots of people are concerned over personalized service, but if you don´t create a system beforehand to facilitate access, to facilitate rapid transport to the center, to make sure the center is comfortable, it makes things difficult.» (Social worker)	

TABLE 4	Opinions of professionals regarding personalized service
Personalized service	«...at a health center the only thing that people appreciate is technical quality, pure and simple.» (Physician)
	«...people forgive almost anything. They are understanding if the doctor is late, they are understanding about almost any problem. What they don´t forgive is poor personal treatment, poor manners. They won´t put up with that. It doesn´t matter if you won´t write a prescription for me as long as you treat me properly.» (Social worker)
	«There´s more and more paperwork. That´s something else. Now we have computers. In some ways, I don´t think computers have allowed me to work any faster, and they don´t solve all my problems. On top of that, we can´t see people´s faces any more.» (Nurse)

hers. Lack of coordination is partly responsible for long waits and excess paperwork, and has a negative influence on how users are treated. *Professional competence* was a secondary factor in users´ evaluations of service quality. Users assume that physicians have appropriate scientific and technical skills; in other words, the physicians´ competence is guaranteed. Physicians claimed that the user´s goal is to obtain a solution for his or her problem. On the other hand, nurses and user satisfaction staff consider their competence to be underrated by users and even by other categories of staff members.

The user´s *confidence* in the professionals was considered another relevant factor of quality. Physicians considered this the factor that most strongly influenced users´ perceptions of quality, in comparison to other factors.

Social workers expressed the opinion that the quality of the center and efforts to provide quality are perceived by users, and that this leads, on one hand, to a feeling of trust and confidence that users do not perceive in other health care settings, and on the other hand, to increased expectations and demands regarding service.

The *use of technology* was believed to have a negative influence on other factors that influence service quality. On many occasions technology inconveniences users because professionals lack information about how it should be used, or because it does not complement or enhance pre-

TABLE 5	Opinions of professionals regarding competence
Coordination between professionals and services	«For example, as a user, when I get to a place the first thing I see are two auxiliaries, which is more or less the normal thing. If one of them gives appointments over the phone and the other tends the user information counter, that, in a sense –I don´t know how to put it– that limits the work that gets done. As a way to organize things it works well, but it inconveniences users. You tell them to get in line to ask for an appointment, and the person says "No, I only answer the telephone."» (Nurse)
	«What´s happening with primary care? The system breaks down if you refer someone to a specialist, and although your own handling of the case is good, referring someone to a specialist means that some time is lost...you have to go through the bureaucratic process again, and it doesn´t always run well. A delay, then some slip-up in coordination or lack of organization means the quality is perceived to be somewhat worse, although you did your part well.» (Social worker)
Competence	«My name tag identifies me as a midwife, but 10 days ago I attended a birth at the health center and the people were saying "Wow, you took care of a childbirth" at this stage, even though they know I´m a midwife, but they don´t appreciate your skills, they don´t think you´re capable of it." (Nurse)
	«Especially the health centers in small villages, the patients themselves say "Oh, so you do know how to do this."» (Nurse)
	«We´re the ignoramuses of health care.» (Nurse)
Trust in professionals	«Patients value trust even more than scientific or technical quality or the facilities available. Patients don´t care whether the spirometer is the latest model. What matters to them is who is providing the service.» (Physician)
	«They mention their own doctor over and over again. Their doctor is beyond reproach, their doctor is at a workshop today...and if they look in and see that their own doctor isn´t in, they leave.» (Physician)
Trust in the health center	«Why do they complain about the health center but not about the specialist? Because they´ve never, ever received that quality of care at a specialist center, but they have at the health center.» (Social worker)
Technology	«...in fact, all that stuff about computers –because that´s the way things have gone these days –has not been paralleled by a better education for the people, and that really leaves its mark on people and creates dissatisfaction.» (Social worker)
Problem-solving	«I think that users believe the quality is good if they come in with a problem looking for a particular service, and they leave with a solution in the shortest time possible.» (Social worker)
	«Users are only satisfied when they go to see their doctor and the doctor prescribes the box of aspirins they wanted. For users, the auxiliary and administrative staff are just obstacles in the way of getting to see the doctor.» (User satisfaction staff)
	«...the degree of satisfaction seems to me to depend on how badly the user wants a solution to his or her problem.» (Physician)
	«Patients come to the center mainly because they want a solution to their problem. They don´t care how the problem is solved, they just want a solution.» (Social worker)

TABLE 6	Opinions of professionals regarding loyalty to the service	
Loyalty	«Yes, but only if I can choose which staff members.» (Nurse)	
	«I live near the health center, and if a relative needs to go to the center where I work I´d tell him or her which persons to talk to there.» (Nurse)	
	«I agree with her. Only if you can choose the staff members.» (Nurse)	
	«I don´t agree. What if I wasn´t there? If I was, I could say "Look, talk to So-and-So or make sure it´s Dr Such-and-Such who sees you.» (Social worker)	

viously used methods. Social workers drew attention to the inadequate training professionals received in the use of technology, particularly as regards computers for information processing.

Physicians noted that deficiencies in the use of technology pointed to the need for better training of user satisfaction staff, and felt that patients do not question the physicians´ competence.

User satisfaction staff members noted problems of coordination between their service and physicians. They commented on their function as «middlemen» between the patient and the consultation with the physician, and declared that despite their belief that they are the members of the center´s staff who are best informed about user satisfaction matters, their opinions are not taken into account.

Nurses expressed the opinion that professionals employed at other health care services such as hospitals failed to appreciate the technical competence of professionals at health centers. Health center nurses noted that the general view of their professional competence was one of poor training and unclear functions. They noted that this view was the result of the fact that they «handle all sorts of tasks» and are not able to «sell» a clear image of their competence as a group. They felt that there ought to be a way to identify them as nurses and distinguish them from other staff members – a way to create a (hitherto poorly defined) professional profile.

Loyalty to the service (Table 6)
Participants noted that they would recommend the services provided by the health center to a relative or friend. However, they indicated that they would do so only if allowed to choose which staff members they would be seen by because of their friendliness, technical skills or ability to listen – characteristics that led users to trust them. This illustrates that the professionals´ attitudes and characteristics are factors that determine users´ perceptions of the service they receive.

Discussion

Focal group studies make is possible to obtain extensive, in-depth information. The limitations of this technique are the same as with any qualitative technique: open questions that may be interpreted differently or elicit different degrees of insight into how and why phenomena occur. The interest of this technique, however, is not in the measurement process per se.[20]

The categories we used generated sufficient informational redundancy and an appropriate level of saturation to consider our results an accurate reflection of the collective opinions of different professional groups in primary health care centers in our setting. The information we obtained for each participant profile is insufficient to generate reliable results for each professional collective as a whole, as we studied only one group in each professional category. This suggests that additional studies involving a larger number of groups per category would generate more complete results.

The N-Vivo program, designed to analyze qualitative results, allowed us to reduce the information and make it more easily accessible by relating and grouping different categories. However, as others have noted,[19,21] although these programs help with the more labor-intensive tasks of analysis and have many potential benefits, some caution is advisable as many studies claim that they increase the «power» of representativeness, as though they endowed the results with some quantitative features. This detracts from the main tenets that underlie qualitative methods.[21]

As shown in different studies, several methods are used to obtain users´ opinions, and each method can yield information that can be compared and contrasted.[22,23] Similar studies might determine which factors contribute the most to quality of the services offered by primary health care centers from the point of view of professionals and users; methods able to compare the findings[24] might be used to reinforce the results obtained with focus group studies.

We note that according to the professionals consulted in this study (particularly physicians), their technical competence is assumed to be beyond question by users, and is therefore guaranteed. This notion was reflected in the discourse in an implicit manner. Other factors, in contrast, appear explicitly as more important, eg, access to services, courteous treatment, the physical environment, and confidence in the professionals.

Our participants also considered that waiting and problems with user access could be explained by the excess de-

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mand for care, which in turn has a negative influence on how users are treated by staff members. One factor not mentioned in the information we obtained is the size of the center and the number of users, factors that have a determining influence on how quality is judged.[23] This element undoubtedly influences quality evaluations; however, our study design did not allow us to obtain more complete information on this issue.

Members of the user satisfaction staff felt that many of the problems that affected users and their own work were caused by a lack of adequate means and by the limited decision-making capacity of employees who deal face-to-face with users, regarding matters that directly influence their work. Although these employees see themselves as the ones who are most often expected to take steps to ensure user satisfaction, they are not involved in higher-level decision-making processes. This reveals how the workplace atmosphere and job satisfaction of these professionals affects users´ evaluations of the quality of this service.[25-27]

Some relationship was apparent between dimensions that constitute users´ views regarding the quality of services provided by the health centers. For example, the dimensions *credibility*, *competence* and *courtesy* were seen by nurses to be related. Social workers noted especially that users perceived differences between levels of care provision and care providers in the their position in the professional hierarchy. This suggests that users see the health center as a closed system disconnected from the other levels of health care. The health center is seen as being closer to the user, the lowest level in the hierarchy, where users are treated as equals. According to these opinions, this hierarchy is also perceived by users to exist among professionals at the health center, with physicians at the top of the pyramid.[28]

As others have reported, the consequences of a bad experience with a given service are that any of the user´s previously positive perceptions disappear. A bad experience, according to professionals, affects the users' overall perception of the service as a whole.[1,3]

The information we obtained confirms that the perception of quality is composed of multiple factors. We found that all dimensions of the SERCAL model were identified by professionals, which shows that validated models of quality assessment are useful for obtaining users´ opinions and comparing them with those of professionals.[29-31]

It is noteworthy that the discourse we analyzed contained no explicit mention of issues such as the use of health care technology and information provided by physicians, elements which nonetheless form part of the theoretical model. Further studies are called for to explain this absence.

We suggest that future studies based on this method should take into account features specific to the health centers – as opposed to other services such as hospitals[32]–, the diverse nature of users, and the different expectations of each type of user depending on sociodemographic va-

What is known about the subject

- The evaluation of health care service quality from the users´ point of view has become a current challenge for health care professionals.

- Different methodological approaches and models to explain quality from the user´s perspective are being tried in the health care sector.

- Studying service quality means investigating both users´ and professionals´ views in greater depth.

What this study contributes

- Users´ and professionals´ views on health care service quality are partly conflicting and partly complementary, and confirm that multiple factors influence how quality is perceived.

- Access and personalized treatment are, according to professionals, factors that influence users´ perception of quality.

- Professionals´ opinions indicate that their view of service quality may be related to that of users.

riables and on whether the center is in a rural or an urban area.[21] According to professionals, these elements weigh heavily in the user´s perception of quality.

As a final point, it is interesting to note that according to professionals (particularly physicians), the essential factor for users is that the visit to the health center results in a solution to the problem that led the user to seek medical attention (ie, a problem with physical health, according to professionals). The user´s goal is to obtain a solution as quickly as possible. Therefore user satisfaction was defined exclusively as a solution to the problem. However, other elements such as treatment by staff members, waiting times and comfort also help maintain a good perception of the services offered by the center. Therefore problem-solving should be added as a component of quality. This would ensure that the professional´s commitment to and involvement in seeking a solution to the patient´s problem as quickly as possible will influence the user´s degree of satisfaction. However, our results suggest the need for further research to determine whether what professionals perceive to be the patient´s problem, and the solution they offer, actually match the patient´s own perception of the problem and the solution he or she receives from the health center. As noted by

professionals in this study, health centers are organized and run in a way that is too inflexible and does not take into account users´ preferences.

Acknowledgments

References

1. Lewis JR. Patients Views on quality care in general practice: literature review. Soc Sci Med 1994;39:665-70.
2. Sánchez JA, Saturno PJ. Las encuestas de satisfacción. En: Saturno PJ, Gascón JJ, Parra P, editores. Tratado de calidad asistencial en Atención Primaria (tomo III). Madrid: Du Pont Pharma, 1997; p. 312-9.
3. Sitzia J, Wood N. Patient satisfaction: a review of issues and concepts. Soc Sci Med 1997;45:1829-43.
4. Gea T, Hernán M, Jiménez JM, Cabrea A. Opinión de los usuarios sobre la calidad del servicio de urgencias del Centro Médico-Quirúrgico del Hospital Virgen de las Nieves. Rev Calidad Asistencial 2001;16:37-44.
5. Mira JJ, Buil A, Rodríguez A. Calidad percibida del cuidado hospitalario. Gac Sanit 1997;11:176-89.
6. Hernán M, Jiménez JM. Calidad percibida por los clientes del Hospital Costa del Sol. Granada: EASP, 1996.
7. Ross GR. Interpersonal stress reaction and service quality responses among hospital industry employees. The Service Industries Journal 1995;15:314-9.
8. Kotler P, Clark R. Marketing for health care organizations. New Jersey: Prentice-Hall, 1987; p. 4-6.
9. Parasuraman A, Zeithaml VA, Berry LL. A conceptual model of service quality and its implications for future research. Journal of Marketing 1985;49:41-50.
10. Lewis JR, Willianson V. Examining patients perceptions of quality care in general practice: comparison of quantitative and qualitative methods. Br J Gen Pract 1995;45:249-53.
11. Ware J. The measurement and meaning of patient satisfaction. Health Med Care Service Rev 1978;1:1.
12. Donabedian A. Evaluating the quality of medical care. Milbank Memorila Fund Quart 1996;44:166-202.
13. Taylor SA. Distinguishing servicce quality from patient satisfaction in developing health care marketing strategies. Hospital Health Service Administration 1994;39:221-36.
14. Mira JJ, Villater J, Aranaz J, Herrero JF, Buil JA. La satisfacción del paciente: concepto y apectos metodológicos. Revista de Psicología de la Salud 1992;4:88-116.
15. Zeithaml VA, Parasuraman A, Berry LL. Calidad total en la gestión de servicios. Madrid: Díaz de Santos, 1993.
16. Grömroos C. Marketing y gestión de Servicios. Madrid: Díaz de Santos, 1990.
17. Donabedian A. La calidad de la atención médica. Definición y métodos de evaluación. México: La Prensa Mexicana, 1991.
18. Glaser BG, Strauss AL. The discovery of grounded theory: strategies for qualitative research. Hawthorne: Aldine de Gruyter, 1967.
19. Weitzman A. Analyzing qualitative data with computer software. Health Service Research 1999;34:1241-63.
20. García MM, Mateo I. El grupo focal como técnica de investigación cualitativa en salud: diseño y puesta en práctica. Aten Primaria 2000;25:181-6.
21. Pope C, Mays N. Analising qualitative data. BMJ 2000;320:114-6.
22. Delgado Sánchez A. Factores asociados a la satisfacción de los usuarios. Cuadernos de Gestión 1997;1:90-101.
23. Magallón Botaya R, García Mata JR, Antoñanzas Lombarte A. Usuarios-médicos: a la búsqueda de nuevas técnicas de detección de problemas de calidad. Aten Primaria 1995;15:73-8.
24. Quesada F, Castro JA, Hernán M, Espejo A, Padres P. Aproximación a las creencias en salud de dos distritos sanitarios. Aten Primaria 1995;15:109-12.
25. Torío Durántez J, García Tirado MC. Relación médico-paciente y entrevista clínica (I): opinión y preferencia de los usuarios. Aten Primaria 1997;19:44-60.
26. Muñoz Adane A. La importancia del contento con la tarea para un buen funcionamiento de las empresas. Psicología del Trabajo y Organizaciones 1993;11:7-14.
27. Alonso Fernandez JA, Ovejero Bernal A. Satisfacción laboral en un centro hospitalario: un análisis del cuestionario Porter. Psicología del Trabajo y Organizaciones 1994;10:39-61.
28. Torío Durántez J, García Tirado MC. Relación médico-paciente y entrevista clínica (II): opinión y preferencia de los médicos. Aten Primaria 1997;19:63-74.
29. Minjoon JR, Peterson G. The identification and measurement of quality dimensions in health care: focus group interview results. Health Care Management Review 1998;23:81-96.
30. Thompson A, Suñol R. Las expectativas como factores determinantes en la satisfacción de los pacientes, teoría y pruebas. Rev Calidad Asistencial 1996;11:74-86.
31. Mira JJ, Galdón M, García E, Velasco MV, Lorenzo S, Vitaller J, et al. ¿Qué hace que los pacientes estén satisfechos? Análisis de la opinión de pacientes y profesionales mediante la técnica Delphi. Rev Calidad Asistencial 1999;14:165-77.
32. Saturno PJ, et al. Tratado de calidad asistencial en Atención Primaria. Madrid: Du pont Pharma, 1997.

Hernán García M, Gutiérrez Cuadra JL, Lineros González C, Ruiz Barbosa C and Rabadán Asensio A.
Patients and quality of primary health care services. Survey of practitioners at the Bahía de Cádiz and La Janda health centers

ORIGINAL ARTICLE

COMMENTARY

The other view

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Avedis Donabedian described quality of care as that type of care which is expected to provide the patient with the greatest and most complete well-being, once the losses have been balanced against the gains in the outcomes.[1] Using this definition as a starting point, we can define the concept of quality in the context of primary health care by answering the question «What requirements should services provided at primary health care centers meet to lead to the user´s well-being?» However, we must also inevitably consider who should answer this question.

Recent years have seen a change in the approach to this topic. Traditionally, we health care professionals have decided what is best for patients, on the basis of our experience and knowledge. Even today there are many professionals who believe that quality service —understood broadly— can only be provided if physicians' acts are based on the scientific and technical norms and standards of our profession. However, the view that this is only one of the dimensions of quality —obviously necessary, but not always sufficient— that can be used to fulfil the needs and expectations our patients feel is increasingly widespread.

From this new perspective it seem obvious that the user is the essential protagonist in providing information on characteristics of health care that influence the maximization of potential benefits to be obtained, among which is, undoubtedly, satisfaction with the care received. In fact, several studies have shown that research based on the opinions of professionals is limited in what it reveals about those aspects of health care that users most appreciate. For example, in the study in this issue by Hernán García et al, health professionals offer a wide-ranging yet partial description of the components of care perceived by the user. The information provided by the physician, a habitual and particularly relevant component of quality as it is perceived by users,[2] is not identified as such by practitioners. Moreover, another study that investigated a similar issue found that primary care professionals identified their patients´ expectations-especially the most relevant ones such as continuity of care by the same physician and providing an effective solution to the problem that led the patient to seek medical advice —more clearly than did their colleagues at hospitals. However, primary care practitioners we-

- The concept of quality of care has traditionally been equated with compliance with scientific and technical standards.

- More recently, quality of care has been conceived in a wider sense to mean fulfillment of users´ needs and expectations.

- This new perspective makes it essential for health professionals to be aware of and sensitive to their patients´ perceived expectations and needs.

re less adept at identifying other aspects of treatment and individual attention, which are less relevant for users but that also influence their satisfaction.[3]

As a result, it seems essential for health professionals to be aware of, understand and sympathize with the user´s point of view in order for the quality of health care to improve.[3] The increasing frequency of efforts aimed at incorporating the user´s perspective into definitions and evaluations of quality of health care should therefore come as no surprise.[2]

Some studies designed to this end have been limited to using a questionnaire as a quantitative approach to research. However, this procedure may be appropriate to determine the relative importance of a predetermined set of possible expectations and needs, but is in itself insufficient to identify the wider range of dimensions, components and factors that make up reality. In this regard, qualitative research methods are particularly useful, as illustrated by the study by Hernán García et al. Such studies shed light on the «what» and «why» of the phenomena under investigation.[4] Although now being encouraged[4], and although they have been shown useful for designing surveys to measure satisfaction with primary care,[5] this type of study has yet to be widely used in the Spanish setting.

Two other studies done in the primary care context are also noteworthy for their attempt to reconcile the view-

points of the family physician and the user. The first study, of a theoretical nature, resulted in the publication by the Catalonian Society of Family and Community Medicine of a manual titled *On the other side of the table.* The book contains a series of narratives and commentaries that describe the experiences of different patients, and which form the basis for a description and analysis of the dimensions of perceived quality in the SERVQUAL model (responsiveness, reliability, tangibles, empathy and assurance).[6] The second study, of a more practical nature, was done as part of course work for a doctoral program. Physicians visited their general practitioner as patients, and then completed a semistructured questionnaire on the quality of care and reported on characteristics that should be improved.[7]

To sum up, as noted by J.R. Vázquez, «an excellent doctor is a doctor who, in addition to possessing a great "clinical eye," possesses a great "human ear" which he or she uses to listen to the needs patients feel, and to identify, among them, their real care needs.»

References

1. Donabedian A. The definition of quality and its approaches to its assessment. Ann Arbor (Michigan): Health Administration Press, 1980.
2. Lewis JR. Patient views on quality of care in general practice: literature review. Soc Sci Med 1994;39:665-70.
3. Mira JJ, Galdón M, García E, Velasco MV, Lorenzo S, Vitaller J. ¿Qué hace que los pacientes estén satisfechos? Análisis de la opinión de pacientes y profesionales mediante la técnica Delphi. Rev Calidad Asistencial 1999;14:165-77.
4. Saturno PJ. Exploración de necesidades y expectativas. Métodos y herramientas para el diseño de la calidad. Murcia: Universidad de Murcia, 2002; p. 17-59.
5. Navarrete S, Saturno P, López A, Ayerdi K, Pascual A, Santiago C, et al. Encuesta de satisfacción en atención primaria de salud. La experiencia de Navarra y Murcia. Rev Calidad Asistencial 2001;16:507-10.
6. Bueno JM, Casajuana J, Davins J, Fernández de Sanmamed MJ, De Marcos L, Marquet R, et al. Al otro lado... de la mesa: la perspectiva del cliente. Barcelona: Doyma, 2000.
7. Magallón Botaya R, García Mata JR, Antoñanzas Lombarte A. Usuarios-médicos: a la búsqueda de nuevas técnicas de detección de problemas de calidad. Aten Primaria 1995;15:73-80.
8. Vázquez JR. Satisfacer al ciudadano. Jano 1996;50:32.