Locator web
Article 52.966

Health Care Workers' Expectations: What Features of Health Centers do They Value Most? A Qualitative and Quantitative Study

F. Palacio Lapuente,[a] R. Marquet Palomar,[b] A. Oliver Esteve,[c] P. Castro Guardiola,[c] M. Bel Reverter[d] and J.L. Piñol Moreso[e]

Objectives. To identify features of health care centers valued by health care workers as positive, to group features into dimensions, and to determine their relative importance.
Design. Qualitative phase: focus groups and content analysis. Quantitative phase: survey with a questionnaire developed from the features identified in the qualitative phase.
Setting. Primary care services in Reus and Tarragona (Catalonia, northeastern Spain).
Participants. Managers, medical care providers and admissions staff. A total of 33 workers took part in focus groups, and 136 questionnaires were distributed for the survey, with a 78.6% response rate.
Main measures. Identification by focus groups of the features to be evaluated. Features were grouped into dimensions at different levels by content analysis. Survey to determine the relative importance of different features.
Results. We identified 133 features to be evaluated by workers: 36 related with structural features of the center (architecture, staffing and equipment), 33 with organization (accessibility, team functioning), 23 with workers (knowledge and attitudes) 20 with the services provided (needs and information management, care services provided) and 21 with management. The most highly valued dimensions were workers´ attitudes and management.
Conclusions. Relations with patients and colleagues, and management issues, were valued most highly by workers. Some problematic features such as shared decision-making, team work and minority cultures revealed different levels of awareness and sensitivity within the health care system.

Key words: Satisfaction. Expectations. Primary care. Workers. Qualitative. Survey.

LAS EXPECTATIVAS DE LOS PROFESIONALES: ¿QUÉ ASPECTOS VALORAN EN UN CENTRO DE SALUD? UN ESTUDIO CUALI-CUANTITATIVO

Objetivos. Identificar los aspectos que los profesionales consideran positivos en un centro de salud, agruparlos en dimensiones y ponderar su importancia relativa.
Diseño. Fase cualitativa: grupos focales y análisis de contenido de los mismos. Fase cuantitativa: encuesta mediante cuestionario elaborado a partir de los aspectos identificados en la fase cualitativa.
Emplazamiento. Direcciones de Atención Primaria de Reus y Tarragona (Cataluña).
Participantes. Directivos, profesionales asistenciales y de admisión. En los grupos focales participaron 33 profesionales. En la encuesta se distribuyeron 136 cuestionarios (tasa de respuesta del 78,6%).
Mediciones principales. Identificación de los aspectos a valorar mediante los grupos focales. Agrupación en dimensiones, con diferentes niveles de agrupamiento, mediante análisis de contenido. Encuesta para ponderar la importancia relativa de los aspectos identificados.
Resultados. Se identificaron 133 aspectos valorables por los profesionales: 36 se referían a estructura (arquitectura, dotación), 33 a organización (accesibilidad, funcionamiento del equipo), 23 a profesionales (conocimiento, actitudes), 20 a cartera de servicios (gestión de necesidades e información, servicios asistenciales) y 21 a gestión directiva. Las dimensiones más valoradas fueron que se las refieren a actitudes y a gestión directiva.
Conclusiones. Las relaciones con los pacientes y los otros profesionales y cómo son gestionados son los campos más valorados por los profesionales. Algunos aspectos problemáticos, como la toma de decisiones compartida, el trabajo en equipo o las culturas minoritarias, ponen en evidencia las diferentes sensibilidades presentes en el ámbito sanitario.

Palabras clave: Satisfacción. Expectativas. Atención primaria. Profesionales. Cualitativa. Encuesta.

Spanish version available at
www.atencionprimaria.com/84.474

A commentary follow this article (pág. 142)

[a]Centro de Salud Ondarreta, Osakidetza, Spain.
[b]Physician, Institut Català de la Salut, Spain.
[c]Nurse, [d]Médico, CAP Sant Jordi, Institut Català de la Salut, Spain.
[e]Physician, Centro de Salud Paterna, Servicio Valenciano de Salud, Spain.
[f]Physician, Dirección de Atención Primaria Reus Altebrat, Institut Català de la Salut, Spain.

Correspondence:
Fernando Palacio
C/ Mañueta, 2, 2.º D.
31001 Pamplona. Navarra.
Spain.
E-mail: fpalacio2001@yahoo.es

This study was financed in part by project FIS 99/1154.
The present study is part of a larger project aimed at investigating patients´ expectations. Part of the results were reported at the most recent congresses of the Spanish Society of Family and Community Medicine (semFYC) and the Spanish Society for Quality of Care (SECA).

Manuscript received 28 October 2002.
Manuscript accepted for publication 20 January 2003.

Introduction

Health care enterprises that have adopted a business paradigm for total quality management are characterized by their clear concern for the client, and by the particular emphasis they place on human resources. If client satisfaction is the goal which will lead to survival of the enterprise, satisfaction of the workers, i.e., «persons who provide services to other persons»[1] is fundamental to achieve this aim. In fact, the European model of managerial excellence[2,3] considers worker satisfaction to be one of the 9 fundamental criteria for evaluating how the concern is run.

Health care workers´ satisfaction has been studied in much less detail than patients´ satisfaction.[4-7] Carrasco, in a review published in 2000,[8] found 15 263 articles on client satisfaction, but only 181 on health care employee satisfaction in a search of Medline items published between 1966 and 2000.

The literature on health care workers usually deals with professional quality of life, which can be considered an indicator of satisfaction as it reveals how health workers experience their relationship with their work.[9,10]

With regard to workers' expectations, some interesting studies have looked at clients and service providers in parallel[11-13] to compare different interests. In this area the extensive study directed by Artells[14] on the profile, attitudes, values and expectations of primary care workers is a fundamental source of information.

As is well known, a necessary part of any attempt to determine client satisfaction with a service is identification by the client of those areas, aspects or features are of greatest interest. If this right to define the areas of interest is handed over to experts, the results are incomplete, to say the least.[15] It is therefore clear that determining expectations involves asking workers what features they value most.

This reasoning led us to undertake a study designed to identify the features that health care workers´ value as positive characteristics of a health center (i.e., their expectations) and their possible classification in different dimensions. Once the relevant features were identified, their relative importance was determined.

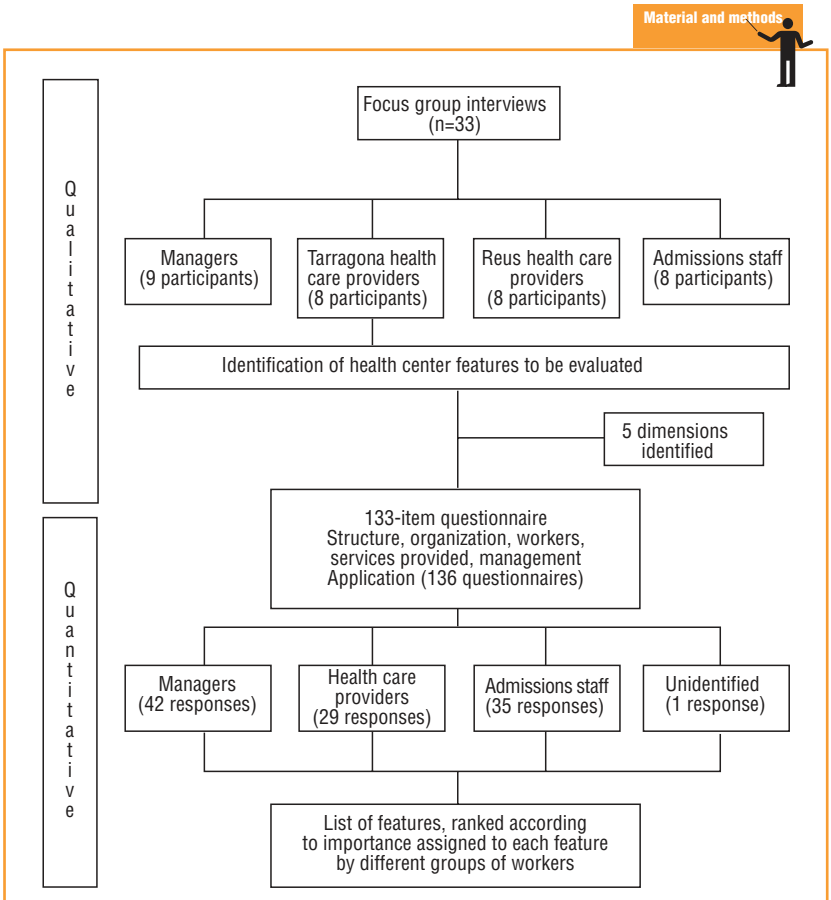
Material and methods

The study was carried out in two phases. The first used qualitative methods, and the second used quantitative methods.

Qualitative phase

In this phase, four focus groups were formed in 1999 and 2000 for content analysis. The four groups were as follows:

– Managers in Reus and Tarragona (Northeastern Spain), understood to be directors of local primary care teams, nursing adjuncts, medical directors, nursing directors, health technicians, training directors, and user service directors. To avoid skewing the participants´ opinions, regional primary care directors were not included in this phase.
– Physicians and nurses (health care providers) belonging to the Reus Primary Care Administration.
– Physicians and nurses belonging to the Tarragona Primary Care Administration. A group of participants from each admi-



General scheme of the study

Study consisting of a qualitative phase in which features that workers most valued in health care centers were identified, and a quantitative phase in which the relative value of each feature was determined.

nistration was included in order to study as many opinions as possible from employees who worked in different settings.
– Client service staff members who worked in direct contact with clients at the health centers.

Each of the four groups consisted of 12 persons. The script for the interview began with the question «What features do you think an ideal but possible health center should have? What do you think it should be like?» and continued with questions about the organization and internal relations, structure, services provided and relations with users.
Participants were selected so that all possible points of view were represented, and recruitment was aided by persons familiar with the organization of the health service and with the employees who worked there.
The selection criteria were designed to obtain balanced numbers of participants in Reus and Tarragona, of men and women, physicians and nurses, rural and urban workers, senior and junior employees, workers younger and older than 40 years, care providers and non-medical/non-nursing staff, and critics of the system and «conformists». We also sought a balanced number of physicians who had and had not completed specialist training in family and community medicine.
Meetings were held in private dining rooms at restaurants to reduce noise and distractions. All discussions were recorded with two cassette recorders. An observer was present to note instances of nonverbal communication. The recordings were transcribed by a professional transcriber who added the observer´s notes to the transcripts.
Content analysis of the transcripts consisted of identification of units of interest in the text; in this case such units consisted of the features that were mentioned during the interviews. Each interview was analyzed independently by two researchers, who then agreed on a consensus analysis. The units of interest were then grouped into factors or dimensions that referred to the same topic.
The result of this phase was a list of features that different groups of participants considered important for primary care health centers. The features were grouped into dimensions.

Quantitative phase
This phase took place during 2000. The features identified in the qualitative phase were used to prepare a questionnaire that asked participants to evaluate on a scale from 1 (not important at all) to 10 (very important) the importance of each item. The questionnaire was sent to all managers at the Reus and Tarragona administrations, and to one health care provider and one admissions staff member at each local basic health care center. In all 136 questionnaires were distributed, with a covering letter and self-addressed envelope, to 52 managers (including those at the main administrative offices), 42 health care providers and 42 client service staff members. All participants received a telephone reminder to complete and return the questionnaire.
The results of the survey were used to prepare a list of items ranked by mean score for all participants, by type of employee, by function (manager, care provider or client service staff) and by sex.
The initial results were used to identify items whose responses showed a bimodal distribution; these items made up a second questionnaire which was also sent out to participants.
Spearman´s rho was calculated to compare the results obtained with the two lists of questionnaire items. Exploratory principal components analysis was done for the «general» (first) list to provide statistical support for the dimensions defined in the content analysis.

TABLE 1 **Dimensions used to group the features workers identified**

Dimensions			Aspects included
First level	Second level	Third level	
Structure (36)	Architecture (24)	Location and access (6)	4,7
		Space (18)	1,20
	Staffing (12)	Staff (3)	5
		Means (3)	*
		Computerization and communication (6)	*
Organization (33)	Accessibility (16)	To different services (6)	14,23
		To the examination room (10)	28
	Team functioning (17)	Team functioning (17)	25,26,32,35
Workers (23)	Knowledge (5)	Knowledge (5)	9,12
	Attitudes (18)	Toward patients (10)	2,8,13,24,31,33
		Toward the team (8)	10,16,19,21,22
Services provided (20)	Needs and information management (9)	Needs management (4)	*
		Information (5)	15
	Health care services (11)	Health care services (11)	17,37
Management (21)	Management (21)	Management (21)	3,6,11,18,27,29,30,34,36,38,39

Three levels of classification are shown, with the number of features given in parentheses. The fourth column identifies the features included in each category according to the rank number shown in Table 3. Only the 39 features that scored higher than 8.9 are shown.
*None of these features was among the top 39.

Results

Nine persons participated in the managers´ focus group, 8 participated in the Reus health care providers´ group, 8 in the Tarragona health care providers´ group, and 8 in the client service staff group. All participants satisfied the inclusion criteria.

The managers´ group identified 50 features for evaluation, the Reus health care providers´ group identified 54, the Tarragona health care providers´ group 53, and the client service staff group 39. After duplicate features were eliminated across groups, a total of 133 features for evaluation were identified.

Content analysis grouped these features into 5 dimensions or factors: structure, organization, workers, services provided, and management. These five dimensions were divided into 9 and finally 15 areas (Table 1) that identified the main features included in each level.

A total of 107 completed questionnaires were obtained (78.6% response rate): 42 from managers, 29 from health care providers, and 35 from admissions staff members; the employee category was unknown in 1 questionnaire. Responses were obtained from 36 physicians, 29 nurses and 30 administrators; in 12 cases the type of employee was not known.

The second round of analysis identified 9 items that showed a bimodal distribution (Table 2). A total of 110 statistically useful responses were obtained (80.8% response rate). The results did not differ significantly from those of the first round with regard to the mean score for each item, so for the final analysis we included the results from the first round.

These responses were used to prepare a ranked list of features of health centers that different participants valued. A general list (Table 3) was prepared first, then features were grouped according to type of employee, sex and age. Spearman´s rho revealed no differences between these lists.

TABLE 2 **Features whose scores showed a bimodal distribution**

Nursing services oriented toward general practice. Each nurse performs all duties
There is a social worker at the health center
Clients receive information about the work done at the center
The center provides a psychology service
The center provides specific care for drug addiction
Plain x-rays can be made at the center
Basic laboratory tests can be done at the center
Training is provided in minority group cultures
Nursing is specialized. Some are home-care nurses, some are community-care nurses, and some are health center nurses

Exploratory factor analysis was done for four factors, but because fewer than 1 case was found for each variable, this analysis was not pursued further.

Discussion

The method we used appears to be the most suitable for the aims of the present study. The design, built on an initial exploratory phase with qualitative methods and an evaluation phase with quantitative methods, is becoming more widespread[7,16] because of its usefulness in opinion studies.

It can be reasonably assumed that the qualitative phase yielded all information of interest on the topic, as participants were selected in a way that ensured that different points of view toward the organization of primary care services were represented, and recruitment was stopped only when information saturation became evident. However, the quantitative study, although based on a number of cases large enough for the purposes of obtaining a general list of features, did not provide enough power for subgroup analysis. The high response rate by managers might also have skewed the final results. On the other hand, the participation of physicians, nurses and administrative staff was well balanced.

Content analysis was aimed initially at developing a first level classification based on 5 dimensions — a conceptually straightforward approach that reflects reality (structure, organization, workers, services provided, and management, as the data were from an internal client) and which had been used previously in a similar study of external clients.[7] Further second — and third — level analyses provided a more finely grained view of how the main dimensions were organized. We decided to include the feature «Workers have enough time to treat patients according to their individual needs» (no. 5) within the structure dimension under «number and type of staff», as we considered that the response to this problem is more closely related with adequate staffing than with improvements in organization (although the influence of organizational measures in improving time management is undeniable). However, the feature «Social worker available at the center» (no. 85) was included under «health care services» in the services provided dimension, as here the decision involves whether this type of service is available, not in determining the necessary number of staff.

The 10 features that scored highest may represent a synthesis of primary health care employees´ ideal set of expectations: workers who work together as a team (no. 10), who are motivated (no. 3) and whose managers provide the necessary means (no. 6), who have enough knowledge (no. 9) and time to treat patients well (no. 5) in an atmosphere of trust (no. 2), courtesy (no. 8) and privacy (no. 1), at a center that is accessible (nos. 4 and

Discussion
Key points

What is known about the subjec

- Health care enterprises are increasingly oriented toward worker satisfaction.
- Satisfaction is determined from the contrast between expectations and perceptions.
- Most studies in the primary care setting have examined workers´ quality of life or perceptions. Little is known of their expectations.

What this study contributes

- We identify features of health centers that health care workers value.
- We suggest some dimensions (or factors) that could be used to group the features identified.
- The weights of each dimension are determined to reflect their relative importance for employees.

7). An analysis of the 39 items that scored higher than 8.5 shows that of the five dimensions considered here, items included in the workers´ attitudes dimension were the most frequent. Of the 18 items related with attitudes, 11 of them (61%) scored higher than 8.5. Of the 21 items from the management dimension, 11 (52%) scored higher than 8.5. The third most highly valued dimension was workers´ knowledge, with 2 of the 5 items (40%) scoring above 8.5.

Starfield and colleagues, in a study of physicians in the Washington, D.C. area, investigated how workers evaluated the characteristics that define primary care.[11] They found that among physicians who were paid according to the number of patients on their list, the most highly valued feature was services provided, whereas their colleagues who were paid according to the number of consultations valued integration of care services most highly. Of a total of 9 features, those dealing with relational aspects were ranked fourth by the former group and third by the latter. Mira and colleagues[13] asked workers what they thought clients valued most highly from a list of 82 items defined by clients and workers. The most highly valued feature was «The physician effectively resolves the patient´s health problems», an item ranked 24th out of 39 in the present study. The second most highly valued feature was «The patient is treated courteously at the doctor´s office», which in the present study was ranked 8th. The next three highest ranked features reported by Mira et al were not among the most important items identified participants in the present study.

Some of the responses in the attitudes dimension merit further comment. There appears to be a strong desire for team work, despite the difficulties this can involve.[17] The items «The basic physician-nurse unit works as a team» and «The whole staff work together as a team» were valued highly, ranking 10th and 16th respectively in the list of the 39 items with the highest scores. Artells[14] found that 52.5% of all workers surveyed considered that health services should be provided by multidisciplinary teams coordinated by a physician. On a different issue, participants rated highly the item «Workers listen, inform and negotiate», which was ranked 33rd in the present study. However, it appears that this item is valued only if workers are persuasive negotiators, as «Workers are able to accept patients´ suggestions» was ranked in 81st position, much lower down on the list. In our earlier study of external clients[7] we found similarities: patients ranked fifth on a list of 60 items the feature «Workers listen to you and pay attention to you», but relegated to 49th place the item «Workers respect patients´ decisions». Torio and García[12] also found that neither patients nor health care workers placed much value on the «professional´s advice but patient´s decision» approach. It seems evident that shared decision-making[16] is a subtle process: patients wish to have a voice and to be heard, but seem to leave the final decision up to their family doctor. In any case we should consider that many of these items obtained high scores in general, 80 items scoring higher than 8 (of a possible maximum score of 10), and 111 items scoring more than 7.

Table 2 shows features that led to a division of opinion among primary care workers. General vs specialized nursing was one of the divisions that became apparent among participants at the Tarragona center. Five different types of service were considered necessary by some but nonessential by others: availability at the heath center of social service assistance, psychological care, care for drug addictions, x-rays, and basic laboratory tests. Information provided to clients and interest in minority group cultures revealed the existence in the primary care setting of two differing levels of awareness and sensitivity toward social diversity.

In conclusion, health care workers appear to value mainly those features that are related with attitudes toward patients and toward colleagues on the health care team, and those related with management of the center. The differences between our results and those of other studies (some of which differed in focus in important ways from the present report) suggest that, as previously found in a survey of patients,[7] the findings in this type of study should not be extrapolated to other situations or systems with different cultures. Further research in this area should help us identify characteristics that are shared by different organiza-

TABLE 3 **List of the 39 features that scored higher than 8.5**

Rank number	Dimension the feature belongs to	Mean score	Feature a valorar	Group that identified the feature M	T	R	A
1	Architecture	9.20	The examination rooms provide privacy for users			X	
2	Attitudes	9.02	The workers inspire trust	X			
3	Management	8.95	The directors of the PCT are motivated and able to motivate others		X		
4	Architecture	8.89	Easy access to the inside and offices, no architectural barriers	X	X		X
5	Number of staff	8.89	Workers have enough time for each patient´s needs	X	X	X	
6	Management	8.80	The directors facilitate and provide tools for problem-solving		X		
7	Architecture	8.79	Ambulances can drive up to the entrance of the center				X
8	Attitudes	8.79	Workers are courteous	X	X		
9	Knowledge	8.78	Workers are technically qualified	X	X	X	
10	Attitudes	8.77	The basic physician-nurse unit works as a team		X	X	
11	Management	8.77	Directors recognize efforts to do a good job			X	
12	Knowledge	8.76	Workers know when to refer a patient to a specialist			X	
13	Attitudes	8.74	Workers´ problems do not affect users	X			
14	Accessibility	8.73	Telephone access is easy		X	X	X
15	NIM	8.71	The admissions unit provides all necessary information to users		X		
16	Attitudes	8.69	Employees work together as a team	X	X	X	X
17	Services provided	8.69	Preventive medicine receives serious attention		X	X	
18	Management	8.68	Directors listen and pay attention to what they hear			X	
19	Attitudes	8.66	Health care providers trust in and do not contradict or criticize the admissions staff				X
20	Architecture	8.65	The center has heating and air conditioning		X		
21	Attitudes	8.65	Workers are motivated	X	X	X	
22	Attitudes	8.63	High level of respect and understanding between specialists and primary care providers			X	
23	Accessibility	8.61	Access to the services offered by the center is easy for users		X		
24	Attitudes	8.61	Workers solve users´ problems	X		X	
25	Organization	8.61	Work is organized in a rational manner such that there is no duplication of effort	X	X		
26	Organization	8.61	Continuing education is appropriate for the needs of practice		X	X	
27	Management	8.61	Savings generated by head administrators are returned to the health care area		X		
28	Accessibility	8.60	The center provides home care for health-related or social reasons	X			
29	Management	8.60	Workers have the right to and opportunities for continuing education and research	X			
30	Management	8.59	Workers have appropriate means at their disposal to solve primary care problems		X		
31	Attitudes	8.58	Workers are able to put themselves in the patient's place (and make patients aware of this ability), and show empathy			X	
32	Organization	8.57	The admissions unit works in an integrated manner with the health care team		X		
33	Attitudes	8.56	Workers listen, inform and negotiate	X			X
34	Management	8.56	Workers have direct access to directors of the primary care administration		X		
35	Organization	8.55	In-service training (courses and extra sessions, during work hours) is good		X		
36	Management	8.55	Managers have direct knowledge of the health care work done by each care provider			X	
37	Services provided	8.54	Preventive dental care is available		X		
38	Management	8.52	Staff are chosen on the basis of knowledge, skills and attitudes			X	
39	Management	8.51	Workers feel that they have legal protection against possible complaints by users		X		

Shown are the dimension each feature belonged to on the basis of second-level analysis (NIM, needs and information management) and the group of participants that identified each feature (M, managers; T, Tarragona health care providers; R, Reus health care providers; A, administrative staff).
PCT indicates primary care team.

tions, and should also provide knowledge about local situations. However, the value of such studies for management is beyond doubt, and managers should take careful note of the aspirations of the health care providers they work for. In addition, research will make it possible to identify features that merit further study, such as shared decision-making and different levels of sensitivity among health care workers toward organizational and social issues of relevance.

References

1. Daniel J, Pascual I, Espelt P, Grifoll J, Basora J, Pous A. Gestión por procesos en un equipo de atención primaria. Revista Calidad Asistencial 1999;14:247-54.
2. European Foundation for Quality Management. Modelo Europeo de Excelencia. Madrid: Club Gestión de Calidad, 1999.
3. Lorenzo S, Arcelay A, Bacigalupe M, Mira JJ, Ignacio E, Palacio F, et al. Autoevaluación de centros sanitarios, utilizando como referencia el Modelo de Excelencia de la EFQM. Madrid: MSD Ediciones, 2001.
4. Grol R. Patients' priorities with respect to general practice care: an international comparison. J Fam Pract 1999;16:4-11.
5. Lewis JR. Patient views on quality care in general practice: literature review. Soc Sci Med 1994;39:655-70.
6. Mira JJ, Galdón M, Ignacio 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. Revista Calidad Asistencial 1999;14:165-77.
7. Palacio F, Marquet R, Oliver E, Castro P, Bel M, Piñol JL. Las expectativas de los pacientes: ¿qué aspectos valoran en un centro de salud? Un estudio cuali-cuantitativo. Aten Primaria 2003; 31:307-14.
8. Carrasco Gómez G. Diferencias entre clima y satisfacción laboral [carta al director]. Revista Calidad Asistencial 2000;15:276-8.
9. Mira JJ, Vitaller J, Buil JA, Aranaz J, Rodríguez-Marín J. Satisfacción y estrés laboral en médicos generalistas del sistema público de salud. Aten Primaria 1994;14:1135-40.
10. Clua JL, Aguilar C. La calidad de vida profesional y el orgullo de trabajar en la sanidad pública. Resultados de una encuesta. Aten Primaria 1998;22:308-13.
11. Starfield B, Casidy C, Nanda J, Forrest B, Berk R. Consumer experiences and provider perceptions of the quality of Primary Care: implications for managed care. J Fam Prac 1998;46:216-24.
12. Torio Durantez J, García Tirado MC. Relación médico-paciente y entrevista clínica (II): opinión y preferencias de los médicos. Aten Primaria 1997;19:27-34.
13. Mira JJ, Galdón M, Ignacio ER, Velasco MV, Lorenzo S, et al. ¿Qué hace que los pacientes estén satisfechos? Análisis de la opinion de pacientes y profesionales mediante la técnica Delphi. Revista Calidad Asistencial 1999;14:165-77.
14. Artells Herrero JJ. Perfil, actitudes, valores y expectativas de los profesionales de la Atención Primaria en el siglo XXI. Cuadernos Gestión 1999;5(Supl 1).
15. Cottle D. El servicio centrado en el cliente. Madrid: Díaz de Santos, 1991.
16. Edwards A, Elwyn G, Smith C, Williams S, Thornton H. Consumer's views of quality in the consultation and their relevance to «shared decision-making» approaches. Health Expectations 2001;4:151-61.
17. Viñas M, Castel S. Opiniones y expectativas de los profesionales de atención primaria sobre el trabajo en equipo. Aten Primaria 2000;26:309-13.

COMMENTARY

Health Care Workers Have Reasonable Expectations!

A. Planes Magrinyà
Physician, EAP Santa Eugenia de Berga, Institut Català de la Salut, Barcelona, Spain.

Concern over the quality of health services seems to have taken root among us. We have even realized that pursuing* quality is not only a technical matter, but that it involves seeking users´ satisfaction.[1] This is a great step forward. But in this process of change, other aspects that also influence the quality of health services are often forgotten. One of these aspects is satisfaction of the workers who provide the service.

In any enterprise, the results are unlikely to be of high quality if the workers are not satisfied. In the health care sector, quality is impossible without employee satisfaction. Citizens´ satisfaction is a goal of any good health service, and worker satisfaction is a tool to achieve this goal. Workers who does not enjoy their job despite their technical skills are unlikely to be good workers.

As the authors of the article this editorial is about aptly observe, satisfaction is the result of the contrast between what we hope for (expectations) and what we get (the reality we perceive). Studies of workers´ quality of life (perception) have been published;[2,3] in general, these reports show that health workers are motivated, although there is some burnout. Features that cause the greatest dissatisfaction are related with the perception of weak managerial support, i.e., when workers feel that their managers do not support and assist them in their work.

Studies of workers´ expectations,[4] such as the one published in ATENCIÓN PRIMARIA, are few. The authors look at employees´ views, and give us an introduction to workers´ expectations regarding their habitual work environment. Like all things in life, the article has some limitations. The study was done in a specific geographical setting, and the opinions reported are likely to have been markedly influenced by the usual working conditions in these areas. For example, if spirometers were generally available in our health centers, we would probably not consider them an important element for our daily work. Moreover, the authors have surveyed three types of worker who responded to the questionnaire (managers, health care providers and admissions staff). The group that provided the largest number of responses was managers (42 questionnaires of a total of 136); we do not know whether there are relevant differences between the responses from each of the three groups, but such differences may exist and may influence the results reported by the authors.

In any case, health care workers are reasonable people! If we look at the features that scored higher than 8.5 (i.e., the 39 top-ranked items), we note that features related with workers´ attitudes clearly predominate: 12 deal with primary care team workers´ attitudes, and 11 deal with managers´ attitudes. The positive features workers identify as being most strongly related with good functioning of the health center are those related with attitudes (Table 1): a good professional attitude (toward both citizens and other workers) and a good managerial attitude are essential elements in our work.

Key points

- Citizens´ satisfaction is a goal of a good health service; workers´ satisfaction is a tool to achieve it.
- Health workers consider attitudes toward citizens and toward other team members to be of considerable importance.
- Health workers expect to be «cared for» by their managers.

*While I realize it may be unorthodox, I adore the word «pursue» with reference to quality: we are always seeking it, yet we never quite achieve it no matter how close we come.

TABLE 1 **Attitudes valued most highly in the study**

Dimensions			Features
Level 1	**Level 2**	**Level 3**	
Professionals	Attitudes	Toward patients	2. Inspires confidence
			8. Courteous
			13. Problems to not affect other team members
			10. BCU works as a team
			16. All staff work as part of a team
			19. Care providers trust admissions staff
Management			3. Managers are motivated and know how to motivate
			6. Provides tools to solve problems
			11. Good work is recognized
			12. Managers listen and pay attention to other staff

Modified from Table 1 by Palacio Lapuente et al to highlight and summarize the attitude-related features that were valued most highly. Rank order is also given. BCU indicates basic care unit (physician-nurse).

It would be interesting to determine whether workers´ expectations at the Reus and Tarragona primary care centers are similar to those expressed by other primary care teams in Spain; I would venture that expectations do not differ much. It would also be interesting to determine the expectations of admissions staff members regarding physicians and nurses, and the expectations of physicians and nurses regarding managers and colleagues with managerial responsibilities.

However, it would be even more interesting to answer some (or all) of the following questions:

1. If worker satisfaction is indispensable for improving service quality, why do our managers devote so little effort toward it?

2. It seems clear that that workers expect managers to be at «at their service» (just as they themselves «serve» citizens). How many of our managers have been trained in this task?

3. If workers, who know their own job best, realize that their attitude is an essential element for doing a good job, why do they devote so few training resources to this area, and why does training in knowledge and skills continue to predominate?

Our professions (physician, nurse, health care administrator, etc.) require service-oriented attitudes; this orientation is both an aim in itself and a professional reward. Consequently, health care professionals value highly a service-oriented attitude in their managers. They expect their managers to be enthusiastic and competent, humane and respectful, valiant and mature...in short, they want managers they can feel proud of![5] This seems a reasonable and apparently straightforward expectation.

A final word of warning: this editorial is biased. Although the author has held positions of managerial responsibility, I am basically a health care provider. The views of «career» managers may be different.

References

1. Comissió de millora de la qualitat de l'SCMFiC. Provant de seure a l'altra cadira: la perspectiva del client. Barcelona: SCMFiC, 1998.
2. Sobrequés J, Cebriá J, Segura J, Rodríguez C, García M, Juncosa S. La satisfacción laboral y el desgaste profesional de los médicos de atención primaria. Aten Primaria 2003;31:227-33.
3. Smith R. Why are doctors so unhappy? There are probably many causes, some of then deep. BMJ 2001;322:1073-4.
4. Artells JJ, Martínez JA. Estudio prospectivo Delphi sobre perfil, actitudes, valores y expectativas de los profesionales de atención primaria en el siglo XXI. Cuadernos Gestión 1999;5(Supl 1):1-124.
5. Comissió de Millora de la Qualitat de l'SCMFiC. Provant de sobreviure en la nostra cadira: manual de Directologia aplicada. Barcelona: SCMFiC, 2002.