Soft technologies as generating satisfaction in users of a family health unit

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ABSTRACT

This study had the purpose to evaluate the quality of the health service provided at a Family Health Unit (FHU), with emphasis on user satisfaction, based on soft technologies. Furthermore, this study also aimed to analyze the aspects of health care that generated user satisfaction or dissatisfaction regarding attachment, accountability, providing solutions, expectations, relationship, comfort, and access, and to identify recommendations for local interventions. The authors made a general characterization of the population seen at the studied service, and then selected the subjects. The

study used a qualitative approach. Data were collected in semi-structured interviews, and ordered using the Collective Subject Discourse (CSD) method. The analysis reveals the importance that service users assign to the soft technologies, but also shows the need to reduce the waiting time for medical consultations and referrals, and to obtain access to medication and dental care at the same location. These factors generated great dissatisfaction among users.

Keywords: Consumer evaluation. Consumer satisfaction. Family health.

Introduction

In 1978, at the Alma Ata Conference, an international proposition was made as the key to reach the goals of international governments and organizations and the world community regarding world health: Primary Health Care (PHC) (Starfield, 2004). The main aim was to improve quality of life and contribute with world peace. Since then, PHC has referred to essential health care, which is based on scientific evidence, socially accepted practice methods, and on technologies that become accessible to individuals and families in the community by acceptable means **and at a cost sustainable to communities and countries** (authors' highlight), regardless of their development stage. (…) It is the first contact of individuals, families, and communities with the national health system, bringing health systems as close as possible to people's life and work places. Moreover, it consists of the first element of a continuous health care process (WHO, 1979).

Still regarding the process of rethinking the complex issues of the health sector, other international meetings have marked the late 20th century. Such events include the conferences in Ottawa in 1986, and Bogotá in 1992. Both events strongly emphasized on "health for all" as a fundamental human right (Brasil, 1996).

In this scenario, Brazil holds its 8th National Health Conference in 1986. This event crowned the Sanitary Reform movement, which had initiated in the country the decade before. Health is hence acknowledged as a right to all and a duty of the State. This gives health a broader concept and marks the beginning of the construction of the Single Health System (SHS), with the legitimization of the people's participation. Brazil experienced a group of administrative, political, and organizational reforms to the country's public health policies, and there has been much advancement to the legislation (Raggio et al., 1996). However, a great challenge must be overcome in order to "… *change the form by which health actions are produced and the way health services and the State organize to produce and distribute this service*" (Pereira, 2001, p.15).

From this perspective, the Family Health Program, established in the country in 1994, consists of another strategy with the purpose to

... contribute to redirect the health care model based on primary care, in agreement with the SHS principles, posing a new activity dynamics in Basic Health Units by defining responsibilities between health services and the population. (Brasil, 1998, p.10)

In fact, a public health policy strategy that would make it possible to establish what had been announced in 1978 in Alma Ata, "health for all in the year 2000", and to recognize the health care model by means of the focus on Primary Care. The authors consider that facing the battle to transform the way "health is provided" in Brazil is a challenge, since the health-disease process is considered exclusively as an individual phenomenon, centered on the client's body and founded on the biomedical perspective. Disease is the object of health work, and its resulting proceedings are the purpose of that process (Pereira, 2001).

Transforming the Health Care Model implies on (re)viewing the health work process

The present study considered the definition for Health Care Model as proposed by Merhy et al. (1997), i.e., an organization of health services based on a certain arrangement of knowledge, as well as the projects for developing specific social actions, and, yet, as a political strategy of particular social groups. Therefore, it is clear that to (re)construct changes, many work fronts are called for.

The institutional culture of the traditional, and still hegemonic, model is based on a work process in which the health care praxis is focused on curing diseases while centered on the complaint-conduct (Almeida, 1991). This conduct is characterized by a linear and mechanic rationality, founded exclusively on biological knowledge and technical and 'medicalizing' interventions. It should be emphasized that this form of care is the result of a long history period rooted on the group of dichotomies that goes through the organization of health services. Furthermore, it has been supported by the logic of the market, with the purpose to make profit, assigning people's health needs a background position.

Considering these observations, this study does not aim to deny the importance of biological knowledge and technical and 'medicalizing' interventions. Rather, the main concern is to avoid taking this as a single and unilateral issue and to understand it as a problem triggering an **action** that may answer the user's particular needs and establish emotional, cultural, and social relationships, channeling a collective perspective toward organizing the demand.

The authors agree with several other researchers (Nascimento, 2004; Mehry, 2002; Pessini, 2000) regarding the mode of production in health care, in the sense that, to (re)construct the prevailing praxis, care would have to be produced as the purpose of the health work process.

"Care is what opposes carelessness and disregard". Boff (1999, p.33) defines care as an *"attitude of occupation, concern, responsibility, and affective involvement with others".*

The term *care* covers health practices that involve many considerations. For health practices to establish *care* as the final product implies that services comprehend the following: welcoming, responsibility relationships, autonomy of the subjects involved, health needs, solutions, commitment, social and economic aspects, and public policies; in other words, integrality.

According to Pessini (2000, p.236), *"caring is more than an isolated act, it is a constant attitude of occupation, concern, of taking responsibility and becoming tenderly involved with others".* It should be recalled that the act of caring implies the act of curing, because the biological aspect still exists. However, as stated by Silva Júnior et al. (2003, p.123): *"it is difficult for health professionals to deal with emotions; they rather deal with disease, in which the rationality of biomedicine establishes a reference and intervention points for the identified 'lesions' and 'dysfunctions'".* This search to (re)construct health practices, considering health care production as the purpose of the health work process, already implies the need to incorporate other tools in the process of health service production. In this sense, soft technologies should also consist of health service production tools.

Soft Technologies in Health

Mendes-Gonçalves (1994) does not restrict the meaning of technology to the set of material work instruments. Rather, this concept also addresses knowledge and its material and non-material results in the production of health services, stating that technologies bear the expression of the relationships established between men and the objects with which they work.

Mehry (2002) includes to the referred definition of technology the knowledge used to produce unique products in health service, as well as the knowledge required to organize human

and inter-human actions in production processes. This author classifies technology in three types: hard, soft-hard, and soft technologies. This way of addressing the technologies present in health work is presented by Mehry, with emphasis on the fact that hard technologies refer to equipment, the machines that involve dead work, fruit of other production moments; hence, they comprise well-structured and materialized knowledge and actions, which are finished and ready. Soft-hard technologies refer to the grouped knowledge that guides work. That is, the norms, protocols, knowledge produced in specific areas, such as clinic, epidemiology, administrative knowledge, and others. The main characteristic is that they comprise captured work, but with the possibility of expressing live work. Soft technologies are those produced during active live work. They condense interaction and subjectivity relationships, allowing for welcoming, attachment, and accountability to occur, in addition to making subjects autonomous. Mehry et al. (1997) affirm that it is necessary to make changes in the work process focused on the process of making soft technologies effective, as well as their forms of working with other technologies. In this sense, changes would be strengthened if soft technologies were incorporated into the work process, and in the encounters between workers, and between workers and users.

These technologies are needed in health processes, and, from this perspective, the authors agree with Pereira (2001), who states that there should not by any hierarchy in the values of the different technologies. Their importance depends on the situation. However, one must not forget that every situation requires soft technologies.

The purpose of the present study was to evaluate the quality of the care provided in the selected service, focused on user satisfaction, and based on soft technologies.

Evaluation from the perspective of satisfaction

According to Contandriopoulos et al. (1997), *evaluation* is an activity as old as the world. A literature review shows that there are many concepts regarding *evaluation.* These authors also state that "*This brief review on the state of knowledge shows that it would be **vain** to propose one universal and absolute definition for evaluation* (p.31, our highlight)". They also propose one widely accepted definition that could be adopted today, which states that to **evaluate means to value an intervention or any of its components, with the aim to help to make decisions.**

Therefore, the improvement to service delivery in the health system should be the main motivation to perform an evaluation (Hartz, 1997). From this perspective, the present study 'listens' to what users have to say, because though their statements are certainly not uniform nor constant, they will present social phenomena, individual and collective expectations, as well as economic, political, and cultural factors that will surely affect service outcome (Oliveira, 1998).

By assuming that health care quality consists of objective (represented by knowledge/technical actions) and subjective (represented by relationship aspects) dimensions, the authors of the present study defend that health service production should be based on care and not on procedures. Malik and Schiesari (1998) stated that any discussion regarding quality carries an implicit or explicit notion of evaluation. They also state Donabedian (1990), and refer to three dimensions for health service quality: *technical performance*, that is, applying medical knowledge and technology to maximize benefits and reduce risks; *interpersonal relationships*: the relationship with patients; and *amenities*: comfort and esthetics of the facility and equipment at the service location. Satisfaction can exist or not in any of these dimensions. What rules is if the user's expectations were perceived and answered.

In 1990, Donabedian defined the concept of quality and stated seven attributes, or pillars, over which quality lies: efficacy (the best that can be done, in the most favorable possible conditions); effectiveness (to achieve the best, regardless of conditions not being ideal); efficiency (maximum effect, lowest cost); acceptability (associated with the user's expectation: conformity with the services and patient and family's aspirations and expectations); optimization (creating more favorable conditions to solve problems); legitimacy (users accepting and approving of the health services); equity (effort to reduce inequalities).

According to Uchimura and Bosi (2002), the subjective dimension of service and program quality – here it includes the evaluation of user satisfaction – is a territory that remains little explored. Furthermore, it certainly holds " *many aspects to be unveiled, since it belongs to the world of changes, of the profound and private* " (Uchimura & Bosi, 2002, p.7).

In this study, the authors agree with other researchers that associate satisfaction with psycho-cultural factors, which are believed to be capable of affecting the user's perception toward the service, and would therefore affect their judgment regarding the care that was provided. The authors, however, also believe that by changing the form by which care is produced, using quality and not only quantity, responsibility and not only dependency, using care and not only reserved techniques, satisfaction will be the final outcome of the health work process.

Methodology

This is a descriptive study; a *case study with a qualitative approach*, using semi-structured interviews for data collection.

This study was performed in a city in Northern Sao Paulo State, 313 km from the capital. The city has 543.885 inhabitants (SEADE: 2005), of which 99.47% live in the urban area. The municipality is divided into health districts and is competent for Full Municipal System

Management, according to the Health Care Operational Norm [*Norma Operacional de Assistência à Saúde*] (NOAS/ 2002), the latest norm issued by the Health Ministry.

The studied health unit, named Sumarezinho Basic and District Unit [*Unidade Básica e Distrital do Sumarezinho*], belongs to the West District area and is under the technical and administrative responsibility of the Teaching Health Center of the Ribeirao Preto College of Medicine (University of Sao Paulo). The studied Family Health Center (FHC) is one of the five centers of the aforementioned Teaching Health Center. The health team working there is composed of one physician, one nurse, two nursing auxiliaries, and five community health agents. Since it is a Health Unit of a teaching, research, and care institution, it counts on the work of five Community and Family Medicine residents, groups of undergraduates of the medicine, dentistry, nursing, and other courses that require internship; as well as postgraduates from several units of the Ribeirao Preto Campus, working on their field research. This means that the health care provided at this unit is performed by other people besides the minimum work team.

The studied FHC received people of varied areas, since at the same time it covers three slums of the city's west sector, it also covers an area of "higher standard" inhabitants from one of the neighborhoods in that area. Of the five micro-areas belonging to the Center, only micro-area 2 is composed exclusively of families at risk, because these families live in a slum. The other micro-areas consist of families of different social classes, which results in health conditions that are also very diverse.

The team has 836 families registered in the Basic Care Information System [*Sistema de Informação da Atenção Básica* –SIAB; February 2004], which represents approximately 3000 people. The research subjects are 18 users who used the service at least once. All subjects were at least 18 years old, and belonged to families that were selected at random from a proportion in each respective micro-area, determined according to the total number of registered families. Only one

respondent per household was considered, the person who first answered the interviewer or the person who was responsible for the service user and agreed to participate in the study. When there was more than one person in these conditions, they would point themselves who would participate in the research, since only one person per family using the studied service would be interviewed.

Data were obtained using the Collective Subject Discourse (CSD) method, a qualitative approach proposal designed by Lefèvre et al. (2000). The CSD is a legitimate, though not the only way to understand the social representations revealed by verbal discourses presented by this population. To organize and tabulate the discourses, four "*methodological figures*" were used, which are indispensible to perform an analysis and interpretation of these thoughts or statements: key-expressions, central idea, anchorage, and collective subject discourse.

After obtaining the data, 61 collective subject discourses were outlined. For the analysis, the discourses were ordered according to the similarity of ideas, and thus four broad themes emerged: "the expectations", "the reality we have", "producing soft technologies", and "the suggestions". The CSDs were ordered in these broad themes so as to achieve the study's objectives.

Results and discussion

In the **first theme**, the expectations, the aim was to find the meaning that users assigned to health, since it is understood that this would allow to collect the subjective perception they had of reaching their expectations. It is important to remember that, according to that explained by Souza and Pereira (1999), the patient's idea of health will affect their judgment over quality. Tanaka (2005)[2] and Santos & Lacerda (1999) state that when evaluating health service quality, especially regarding satisfaction, one should know the patients' needs and desires.

In this study, the interviewer began by asking the interviewees what health meant to them, and the result was a number of discourses with diverse ideas. The first idea that emerged was that, although health is inherent to people's lives, when asked "what health is", they find it hard to express their ideas:

Health means we have health, right? It is being healthy, ... Oh my, how can you tell if you are healthy, it's hard, right?...I never thought about what being healthy means! CSD 5

Another emerging view is centered on the biological aspect, as the absence of disease, where health is associated to the presence of the doctor and medication:

The medicine I need. CSD 9

We hope to find the doctors. CSD 12

It does not take long to be seen. CSD 13

These users' expectations also show health as being the service itself, and the service being associated with "good health care":

Health is a place you can go when you need to, and you are well cared for there. CSD 1

There are, however, other factors associated with health, which make it a broader concept. The view presented in this discourse shows that service users present other expectations regarding the health they should have:

If it is not physical... it is harder to find out, ...we don't have good physical health, I don't know if it is because of the food, the lack of exercise, we are missing out on these qualities .... a job, you know (...). If we have those things, then you have normal health.

But, if you don't, then it's hard, right?... health depends on many factors you know, health includes mental health, spiritual health, and physical health,... taking good care of yourself, not taking drugs, not drinking alcohol. Oh... it's having...good development you know, having a stable life, a good life at home you know, filled with harmony and peace, an unhealthy person isn't happy, they have no happiness in life, right? Indeed, health includes a lot of things! CSD 6

... doctor, I don't know, someone who would, like, analyze you closer, who..., gives you more attention, more priority in the care they deliver,..and the doctor should really solve our problem, right? He should listen to us first, so we can tell him what the problem is,(...) .You go to the doctor and he doesn't examine the way you live, he doesn't pay attention to you, he just takes a look at you and sends you home,... how should he know what's wrong with me?... CSD 10

According to Stenzel et al. (2004), satisfaction results from judgments regarding several attributes, which includes providing solutions to the demands, as well as access, health care quality, and the conditions of the facility. These authors also cite Vaistman et al. (2003), when referring to the users' perception regarding the health practices at the services develops by associating at least four dimensions: individual subjectivity, the society's culture, the relationship network established through history, and the situation of a particular context or the immediate experience.

These discourses showed that service users are able to report their need of being cared for by professionals who do not reduce them to fragments of their physical body, and rather see them as whole beings. Users deem this characteristic of good medical/health praxis: *"the doctor has to examine the person, see what's going on, in order to see what the person does or doesn't have,..."* - CSD 8.

The **second theme – the reality we have -** verified what exactly happened during service practices at the studied Center. At this moment, the interviewees answered questions about the service, how their appointment was processed, the workers at that location, and their answers provided an idea of how, or even if, the production of care took place.

The first item analyzed *was access*, and, according to Starfield (2004), it is the form by which people experience the characteristic of service accessibility. Primary Health Care has a unique characteristic, which is first-contact care: every time there is a health demand that enters the system through primary care, there is a better chance of granting better quality in referring the solution to the user's need. This better chance is also associated with the relationship established between users and health professionals, problem solution and the continuity of health care.

One CSD clearly showed the user's satisfaction regarding the place where the center is located:

> Oh, it is good... really close to home ... (...). Because it isn't too far for us to go (...) I think the location is good...(...). CSD 38

The quality of the facility is another attribute of the service that can be subjectively evaluated by the users in terms of their satisfaction. It is observed that the first discourse could be translating the state of accommodating to things in life, quite as if it were "like this anyway "; it is so common for public health facilities to lack maintenance that it becomes obvious, so people are unable to recognize it as good or bad:

> (...) The other things are just like at other health units. We get used to it! I was uncomfortable in the beginning, you know? But now I'm used to it, I have no complaints! If I don't have to stay out in the rain, or under the sun, it's just great! CSD
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It is also important to consider if satisfaction regarding the relationships, "feeling at home at the Center", could be responsible for the users feeling that it is good just the way it is. This is because their expectation has been "decoded" and solved: they received good service, they were welcomed, and thus the condition of the facility is not considered so important.

> Oh, for me it's normal, you know? There's no need for changing anything... (...). I think it's good, you know? I don't think it needs any rebuilding. CSD 41

Other discourses emerged, which showed that dissatisfaction was also present. A first discourse presented the view of health toward treating diseases, in which the need of having a building like a hospital was the user's expectation:

> It's more like a house, you know? It's not a building, it's .. like, it should be more like a hospital: with a wider door,...a building like,... like an emergency room or health units, you know? CSD 4

The "*building*" stated in the above discourse holds an image of hospital architecture, which is determined by the norms standardized by the country's institutions, with normalizing functions. However, perhaps a less-improvised architecture should be considered, one that would allow or even strengthen the change in the health care model.

In the process, the factor "delay" to receive care, be seen by a doctor, or undergo procedures and exams was discussed with the interviewers, and the CSDs showed satisfaction at some moments and dissatisfaction at others.

Starfield (2004) presents the time issue in the following way: most emergencies should be seen to in one hour, in about 90% of cases; acute conditions should take no longer than one day to get an appointment, also 90% of cases; regarding routine procedures, follow-up visits should be

scheduled for one week, in 90% of cases; and, finally, the waiting time at the Unit should be less than thirty minutes, in 90% of cases. In fact, there is still a long path to be pursued before achieving these goals, as shown in the discourses below:

> I got an appointment, but it takes long, they schedule it for after two or three months, because there's always someone ahead of you. CSD 19

> I've waited 5 hours,.. from noon until 5 pm just to be seen, for example I go in the morning and they tell me to come back in the afternoon,...if I go without an appointment it takes a while, you know? I have also been seen as soon as I got there! There were many times I needed an unscheduled consultation and they saw me immediately,...we wait for our turn. CSD 29

The CSDs showed how this time occurred at the Unit, and how time was "relative", that is, what took long for one person might not be long for another. Subjects also reported that the service took long, but it was good anyway. It appears that "good service" justified the delay:

> Well... it is still far from that goal, you know? It's average, you know? And should it take so long ... at least the doctor I was seeing? But anywhere you go, it takes long to see the doctor,... so we have to understand... for me, it's good! CSD 18

The **third theme**, in fact, was just a part of the process, since the authors understand it as an evaluation of the satisfaction, but considering the presuppositions of the present study. Here, the emphasis is on the issue of soft technologies, thus this section analyzes the CSDs referring to relationships.

The first idea that emerged from the CSDs, regarding the differences of the services, addressed the relationships as "serving well" or "good service". This is in agreement with Mehry

(1998), who stated that the health crisis from the users' view regards the lack of responsibility and interest in their health:

> The center offers really good service! We have friends here, you know? I felt that the nurses are very considerate, they talk with us, treat us well,... (...). ...you're treated with more love than in other places, because they already know you. Nurses and doctors treat us differently... their care is totally different. Fortunately, we always feel welcomed! CSD 49

> People here are really considerate... And the thing we like the most is to be treated well, just like we treat them, right? They treat us really well... CSD 20

This discourse also shows the human-to-human treatment: *"treat us just like we treat them, right?";* and *"people who take care of us"* (Mishima et al., 2004), people who welcome others but also need welcoming. Welcoming places are places for exchanging human things, *"I give you and you give me"*.

Franco and Magalhães Junior (2003) state that clinical practice translated into acts of listening and speaking, in which diagnosis takes on the dimension of care, has been lost over time and was replaced with the prescriptive act and a brief relationship between professionals and users. Today, an attempt is made to recover the production of care, since this is the only way to work with the health/disease process to produce, in the services, true health in its broader concept.

The **forth theme** pointed out the users' suggestions to improve the service. The aim here was to not only gather data regarding actions to be performed with social participation, but also to analyze, at this moment, the population's satisfaction and dissatisfaction regarding the needs that were raised previously.

One of the stated issues is having a 24-hour service at the Center. It is worth remembering that, maybe at this moment, what users are really trying to suggest is that the "good service" they have received, in fact, should be present in every health care location. Hence, a reflection is called for – health care quality is what really matters to users, as well as, unquestionably, the responsibility of the workers caring for their health. The discourse states:

> Just like the Cuiabá Health Center, 24 hours. The service should also be available on Saturdays and Sundays, so we wouldn't have to go all the way down there, and...having...providing... an emergency room here, with more services. I think it would be good, right? CSD 57

Another suggestion that users presented is to interfere in the time issue: the time waited for exams, how long it took to be seen, to solve their demands. The delay, as mentioned before, is a reason for great irritability and dissatisfaction for those using the service at the Center. Since the service is provided through good relationships, at the end users are pleased with the solution they achieve. "Time" should be a concern for the health team regarding the provision of service, because it is far from having the expected quality in this sense. Users, however, suggest that more doctors would solve the issue:

> Oh, I was going to tell straight to him that they need more doctors there, you know? (...) If they had more, it would be better, right? Our situation would be improved, then there would be no delays... I think they need more doctors! CSD 59

Family Health teams also count on dentists, and the interviewees remember this professional as having an essential role in their health:

> There is a dentist at the Center, but it is as if there wasn't one, you know? To tell the truth, you have to go to the Cuiabá Center to get dental services,.. here, the dentist just

looks at you and sends you to the Cuiabá Center! Well, that makes is complicated, you

know? It does! It there was a place, a dental service here, wouldn't it be easier? CSD 61

Users also state there is a need to improve the access to medication. Providing medication could be the factor responsible for the idea that users have of access to service, with better welcoming and providing a final solution to their problem:

There should be medication here at the Center, right? It's difficult,... because there isn't a pharmacy here, you know?(...). Oh,...if there was one here, it would be much better. CSD 26

According to Halal et al. (1994), user satisfaction is associated with getting the prescribed medication at the same service location where they were seen. The authors of the present study believe that having access to the medication and making it available at the unit would be the best and easiest way for users to get the medication.

Conclusions

The present study aimed to evaluate user satisfaction/dissatisfaction, mainly regarding soft technologies. The results prove that, in fact, the studied service users consider the way they are treated very important, and value the incorporation of these technologies in the health service production environments. They demonstrate strangeness when people do not greet them or call them by their names. They also point out forms of service, at different moments of the work process, and value actions that show that workers recognize them as human beings. Users also appreciate the commitment that workers at the Center have in obtaining the services they need. The study also shows the appreciation that users have regarding the form that workers establish a relationship with them, a welcoming relationship, with aspects associated with attachment,

commitment, health accountability and autonomy. In this sense, the authors feel authorized to state that soft technologies generate satisfaction, when focused on health care practice.

The study also made it evident that users claim for a service that offers the technology resources needed to solve their problems in the biological aspect; the stress deficiencies of personal and even structural resources, like the lack of drug distribution and having no dental equipment, or yet the delay in performing exams. This reinforces the need to make different technologies available (hard, soft-hard, and soft) in health production processes.

Another aspect that merits reflection is the working hours, since users suggest a 24-hour service. Perhaps this observation triggers a re-evaluation of the current work hours. This system answers to whose needs? Could it be reviewed without the need to indicate uninterrupted working hours?

The fact that users are satisfied by the implementation of soft technologies did not make them blind or unable to report their dissatisfactions with the work process or with the lack of investments to answer the needs of those who justify the implementation of the service. This circulation through the paths of satisfaction and dissatisfaction shows that, with no doubt, there is still a need for many investments. Furthermore, there is a need to incorporate the practice of evaluating everyday activities, with a view to implement changes in the perspective of the guiding principles in Primary Health Care and to strengthen the Single Health System, making users the central object of the work process.

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