An Integrated Analysis of the Perceptions of Health Care Users, Professionals, and Managers in Catalonia[1]

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Abstract: The increased demand for health services and the inclusion of new aspects in what is culturally considered "health and health care" represent a significant challenge for the current health care system and health care practice model in Catalonia. Determining health care needs and providing the right responses to them should not only be the job of experts. Rather, it should involve the participation of all the agents who live with and in the health care system every day. The aim of this article is to point out the importance of the perceptions of the agents involved in health care for planning and decision-making in health policies. A summary of the integrated perspectives of the public, professionals, and managers from the Catalan health care system is presented. Such perspectives can reveal the agreements and disagreements concerning the dimensions of health care participants define as important: health resources, health care processes, and the relationship between professionals and users.

Table of Contents

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1. Introduction

The range of demands on the health care system is widening constantly (e.g. home health care for the elderly), and it is foreseeable that in the near future preventive strategies concerning social determinants of health will become more important than purely medical tasks. Policies must be adapted to this challenge and they must be able to offer alternatives and ways of dealing with it that are suited to these new expectations. However, this process must respect the principles of the universal guarantee of care and of fairness in access to services. Consequently, determining health care needs and providing the right responses to them should not be only the job of experts. Instead it must involve the participation of the various agents who live with and in the health care system every day. [1]

The social significance of health care is not the same for all of the agents involved. A wide range of elements shape the different positions establishing what health care is, how it is provided, and what expectations are created in relation to health and the health care system. Various everyday aspects relate to the health care system in different ways. The social meaning of health care will be different depending on whether we take an interest in professional groups (doctors, nurses, and others in direct contact with users), in management (administrative workers involved in planning and management responsibilities), or in the users of the system (patients and care-givers). That is, each of these constituencies has different experiences of health care. The interaction between these three groups therefore makes up the current state of the health care system, expressed in discourse, practices and policies. [2]

Health service planning processes are generally carried out hierarchically, handed down from the administration to the public; that is, from health administration implementing the processes within the population that receives services, and that may or may not provide a response to individuals' everyday health needs. However, when drawing up the health, social services/health, and public health plan of Catalonia, particular interest was shown from the beginning in designing the process to include the perspectives of the populations interacting with the health care system every day: the public as users (patients and care-givers), professionals, and managers (DEPARTAMENT DE SALUT, 2008). Information and data presented in this article are related to aspects of a wider research collaboration formally established among the Government of Catalonia's Department of Health, the Autonomous University of Barcelona, and the University of Girone. [3]

The purpose of the wider research project was to compare the perceptions of the public, professionals, and managers of the health care system in order to guide health planning in Catalonia, providing a qualitative methodological perspective to generate socially significant and relevant information for practitioners. Consequently, in this study we are interested in how the public, professionals, and managers understand health care in Catalonia and how this provides important information for guiding decision-making in health services planning. More specifically, experiences, perceptions, and assessments of the agents involved in the care given by the health services are identified, allowing us to generate substantive information about the key aspects, practices, and the meanings attributed to health care from the perspective of these agents, in order to systematize the strengths and weaknesses of the health care system. [4]

This article does not give a detailed explanation of the broader study's final results (ÍÑIGUEZ et al., 2007). Rather our aim to point out the importance of the perceptions of the agents involved in health care for planning and decision-making in health policies, as well as reflecting on the usefulness of qualitative methodology in health research. A summary of these perceptions of the Catalan health care system will be presented from an integrated perspective, understood as the holistic, comparative analysis of the perceptions of the public, professionals, and managers, allowing us to appreciate their agreements and disagreements concerning the important dimensions of health care defined by the participants. In this case, we will refer to health resources, health processes, and professional-user relationships. Finally, the importance of the concept of user participation in health services as a practice that forms part of the health services policy for planning and implementation is discussed. [5]

2. Theoretical Framework

The study of social reality through language is an analytical and methodological approach that has been extended to different disciplines ranging from socio-linguistics to ethno-methodology and social psychology. Its potential lies in the fact that what is said becomes one of the bases for the social construction of reality. Thus, language can be understood in terms of discourse, as an act of speaking through which symbolic constructs become real. Social agents use these constructs not only to make sense of their reality but also to give it a particular form. Therefore, however disparate different approaches to analyzing social reality through language may appear, our study selects from among them an approach to the construction of social reality made by the everyday use of symbolic and linguistic devices. [6]

Based on this, the theoretical framework of this study may be defined as eclectic. In the interest of brevity, the entire theoretical framework will not be elucidated here except for mentioning the core concepts for this article: the concept of social imaginary (CASTORIADIS, 2006), the concept of metaphor (LIZCANO, 2006) and the concept of frame (GOFFMAN, 2006; LAKOFF, 2007) [7]

CASTORIADIS (1989) speaks of social imaginary as the set of values, institutions, laws, and symbols common to a particular social group and the corresponding society. While not constituting an established reality, the social imaginary is however an institution as it represents the system of meanings that govern a given social system. These imaginaries are to be understood as historical constructs defined by the interactions of subjects in society. In that sense, the imaginary is not necessarily "real" as it is an imagined concept contingent on the imagination of a particular social subject. Nevertheless, there remains some debate among those who use the term (or its associated terms, such as *imaginaire*) as to the ontological status of the imaginary. The social imaginary is not a set of "ideas"; rather it is what enables, through a making sense of, the practices of a society. It penetrates the entire life of society, directing it and guiding it. [8]

LIZCANO's (2006) work helps us consider the systematic analysis of metaphors, the use of which is an excellent way to understanding social imaginaries given its undefined nature, leaving room only for allusion by indirect references and analogies. A metaphor is that tension between two meanings, perceiving one as if it was the other but without it actually being so. Metaphors therefore constitute the point of conflict between meanings, making them very useful for understanding how social imaginaries are established. They are in constant movement, encouraging while at the same time limiting the generation of images. It is in this dynamic process that metaphors appear. As they gradually consolidate the idea they represent, they lose this duality or intermediate point between meanings as they become consistent ideas that in turn, will move from being a perspective on things to being the things *per se*. Metaphors can be considered a type of interpretive framework forming part of the discourse of a culture and constituting a basic element for participating competently in such a culture. In analogous terms, metaphors are organizers of experience, values, and beliefs (LAKOFF as cited in FISHER, 1997). [9]

The last concept is that of frames as basic cognitive structures that guide the perception and representation of reality resulting from social interaction processes (GOFFMAN, 2006). This includes beliefs, images, or symbols shared by a society, understanding the limited range of patterns it uses to give meaning to the world (TRIANDAFYLLIDOU & FOTIOU, 1998). Many discussions about and reflections on this concept provide opportunities for understanding what is being pursued here (DAVIS, 1975; DURHAM, 2001). However, one of the best definitions (and to our understanding most useful) is the one proposed by LAKOFF (2007, p.17):

> "Frames are mental structures shaping our way of seeing the world. As a result of this, they shape the targets we set for ourselves, the plans we make, our way of acting and what counts as a good or failed result of our actions. In politics, our frames shape our social policies and the institutions we create to carry out these policies [...]. Frames of reference cannot be seen or heard. They form part of what cognitive scientists call the 'cognitive unconscious'—structures in our minds that we cannot consciously access but which we know about because of their consequences: our

way of reasoning and what is understood by common sense. We also know about frames through language. All words are defined in relation to conceptual frames. When a word is heard, its frame is activated in the brain." [10]

Along these lines and for the purposes of this study, it is very useful to define frames of interpretation as symbolic-meaningful entities going beyond the cognitive capacity of the individual and to locate their potential for action in social agents, understood collectively and interactively. [11]

This theoretical framework is useful in the difficult task of constructing and developing health policies that match the needs expressed by the population. The limited financial resources appropriated to the health care system in the context of modern society contrasts with the growing demand for health care, whether it be understood as being integral to the welfare state or as something that has personal value. Different criteria and models can be used in this process of establishing priorities concerning health and the resulting policies. There is, however, a common aspect, which is the importance of knowledge in this whole process. This is so much the case that a related literature review referred to it as evidence-based medicine (ROSENBERG & DONALD, 1995; TOMLIN, HUMPHREY & ROGERS, 1999). This knowledge generation model is characterized by being a clinical decision-making process based on scientific and academic knowledge. The idea is, therefore, to break with a situation where clinical practice is exclusively guided by the training of health staff or the individual experiences of a few patients. An attempt is being made to turn academic and scientific production into a useful tool for health professionals' everyday medical decisions (SACKETT & ROSENBERG, 1995; STRAUS & SACKETT, 1998; BUCHAN, 2003). [12]

A second aspect that the review highlights is the need to implement a patient-centered health policy (LAINE & DAVIDOFF, 1996; BENSING, 2000; WEINER, 2004). If patients are at the center of the creation of health policy, what they think and perceive needs to considered as valid and useful knowledge for designing health services (JAESCHKE, GUYATT & SACKETT, 1994; KASSIRER, 1994). The importance of this effort to include users' perspectives is rooted in the fact that they generate benefits for themselves as patients (JAMES, COWAN & GRAHAM, 1998); it means health policy is attuned to users in terms of usability because their preferences are known (DAVEY et al., 2004); their perspectives are established as efficiency mechanisms in health resource management (STEWART et al., 2000); and the users themselves demonstrate empathy and identification with the health care system (MEAD, BOWER & HANN, 2002). However, users are not the only social agents highlighted by the literature as a group to be taken into account in generating health knowledge. In this way, interest is generated in understanding health as professional practice, not in terms of expert and disciplinary knowledge, but as social practice shared with users of the system (HAYNES, DEVEREAUX & GUYATT, 2002). This allows for aspects such as the interaction between users and professionals to be included. [13]

There is a third term justifying the use of this theoretical framework for the specific study of the health care system. This is the concept of shared decisions between professionals and users of the system (FROSH & KAPLAN, 1999). CHARLES, GAFNI and WHELAN (1997), and GWYN and GWYN (1999) have noted the explicit desire of users to be consulted concerning their health preferences and decisions. Health professionals see how, in practice, their work becomes more complex as they get forced to pay attention to aspects not considered to be technically related to medical care. Social interaction in the health field is concerned with social meanings, aspects that move away from medicine understood purely as technological know-how. [14]

Finally, the interest shown in including patients' preferences in generating the knowledge on which health policy is based generates an ideal space for the application of qualitative methodology to health care (GREEN & BRITTEN, 1998; BARBOUR, 2000). The interest in what social agents think and what their experiences mean is fully related to the study of the social semantics concerning the health care system. Empirical studies reviewed for the purposes of this study show that qualitative methodology is a specific valid form of research in evidence-based medicine (POPAY & WILLIAMS, 1998; FORD, SCHOFIELD & HOPE, 2003). Perception, opinion, and preference as concepts have evolved from theoretical versions of social imaginary, metaphor, and interpretive framework that were in turn derived from social theories. [15]

3. Research Methodology

Following the Weberian interpretive tradition in the social sciences, the qualitative research reported on in this article embraces the concept of "world" from the point of view of participants in the health care system. Its initial assumption is that social agents are the individuals who give meaning to their actions in ways that can change depending on the contextual imperatives that make such actions possible or impossible. This is reflected in GOFFMAN's (1961) psychiatric hospital research: "any group of persons ... develop a life of their own that becomes meaningful, reasonable and normal once you get close to it ..." (pp.ix-x). [16]

The study of the production of meaning and social imaginary made it necessary to adopt qualitative methodology (BOGDAN & BIKLEN, 1982; DENZIN & LINCOLN, 1998, 2000). The theoretical and epistemological bases of qualitative methodologies make them relevant for developing the study as well as being excellent tools for accessing the study's analyzed processes and practices. The possibility of doing a comprehensive and major interpretation (ENRIQUE & ALONSO, 1998) of the processes studied, as well as analyzing their specific details makes this methodology complementary to more extensive quantitative methodologies. Although this methodology requires a focus on contextually delimited areas that do not allow for universalization and/or generalization, it offers the possibility of a more detailed explanatory study. This occurs on two fronts: (1) where the methodology respects and pays special attention to the language of users, professionals, and managers (HOLLIDAY, 2004); and (2)

where the methodology takes into account the combined contexts of participants' everyday creation of meanings in relation to the construction of health care system social imaginaries (VALLÉS, 1997). [17]

The pragmatic approach to qualitative methodology has therefore been flexible. The metaphor we use to illustrate it is the French term *bricoleur* (LÉVI-STRAUSS, 1966). It is an approach making it possible to use research methods and adapt them to the emerging needs of the research project (DENZIN & LINCOLN, 1998). The subject of study of this article, as an extension of the wider project, overturns planned, linear research logic, emphasizing the movement between theoretical perspectives or the opportunistic collection of information in developing it. However, we characterize the qualitative research in this study as follows: It is interested in the *naturalness* of the situations expressed by the social agents in their own words. DENZIN (1971) uses the term *naturalistic behavior* to describe an empirical approach designed to study the social world in its own logic. Social research is based on the everyday routines of participants in the research, making every effort to understand their perspectives and then reproduce their experiences, thoughts, and language in a way that makes for a detailed and enriched study. Language not only becomes a vehicle between social agents, analyzing it also invites us to discover central and anchored symbolic logics in order to understand any social phenomenon (ÍÑIGUEZ, 2003). Finally, BRYMAN (1988) suggests two additional features of qualitative methodology that are included in this study: description and process. BRYMAN understands description as a tendency towards detail and depth in generating information. A detailed description allows researchers to mark the broadest social context for certain practices which might initially be thought to be individual ones. Social process is understood in this article as the deployment in space and time of certain social phenomena, that participants use while at the same time giving them meaning. [18]

3.1 Sampling and data collection methods

Our sampling decisions for recruiting participants did not follow random selection criteria but rather contingent and/or intentional ones. According to PATTON (1990), the purpose of qualitative sampling is "to include information-rich cases for in-depth study" (p.182). [19]

To achieve this objective three different sampling techniques have been used: typical case, political, and snowball sampling. [20]

The first sampling was carried out with typical cases within the Catalan health care system, generated by consensus among members of the research team during three working sessions. In order to be able to include the whole range of typical positions constructed and circulated concerning the Catalan health care system, a typical sample that might be characteristic and distinctive of the different agents involved in the system was agreed upon by consensus. For this reason, three basic profiles were considered:

- current users of public health care system services and non-current users; care-givers are considered as people responsible for one or more regular users of the health care system;
- professionals involved in procuring care for health service users; six typical profiles of professionals were considered: medical, nursing, psychological, social work, and social education;
- managers are administrative workers involved in the different Catalan health care system network centers. [21]

The second type of sampling, political, was carried out in order to confirm the three basic profiles generated by consensus. Political sampling is understood (PATTON, 1990) as choosing "politically important cases as one strategy for improving the chances of a project gaining attention and findings being used" (p.180). [22]

For the political sample, 11 individual interviews were conducted with people who had extensive knowledge of the Catalan health care system; these individuals will be referred to as system informants. To select these, the principal criteria considered were: having visibility, prestige, having been given credit for something that had to do with the system or in relation to it, and having a broad knowledge of the Catalan health network. The 11 system informants confirmed the profiles agreed to by the research team, although they added that more specific sampling criteria should be introduced for each type of typical informant. We summarize these in Table 1.

Informant profiles	Sampling criteria in the selection of participants
Users	Type of service currently used (according to the catalogue of services defined by the Catalan health service). They are grouped into four networks called: primary care. hospital, social services/health, and mental health
	Health situation: Chronic/acute
	With/without dependency
	Active resources for informal care and guidance
	Experience with the health care system; defined by time and the services they have used in the past. They are considered as: veterans (with more than 6 months experience with the service and/or in another service) and novices (with less than 6 months experience with the service and with no involvement with any other service)
	Age
	Sex

Informant profiles	Sampling criteria in the selection of participants
Professionals	Type of service where they currently work (according to the catalogue of services defined by the Catalan health service). They are grouped into four networks: primary care. hospital, social services/health, and mental health
	Educational background
	Experience with the health care system, defined by time and the services they have provided in the past
	Age
	Sex
Managers	Type of service where they currently work (according to the catalogue of services defined by the Catalan health service). They are grouped into four networks called: primary care. hospital, social services/health, and mental health
	Experience with the health care system, defined by time and the services they have been involved with in the past
	Age
	Sex

Table 1: Summary of the sampling selection criteria by typical informant profile [23]

Snowball sampling was used to select the final participants in the study based on the criteria and profiles from Table 1. Snowball sampling is defined by PATTON (1990) as a research technique in which the first subject contacted gives the researcher the name of another subject who, in turn, provides the name of a third, and so on. Indirect contact with the participants with the user profiles was established by consulting lists of Catalan health care system user associations that were available on the official websites of public institutions (Barcelona city council, government of Catalonia, and provincial councils). Contact with professionals was made via the different associations and official professional associations and their provincial headquarters. Finally, contact with the different managers was provided by the informants from the system already interviewed, given the fact that their knowledge of their administration placed them in a Catalan health administration gatekeeper position. [24]

3.2 Information collection and analysis

Data from this study come in the form of individual interviews (KVALE, 1996; HOLSTEIN & GUBRIUM, 2003), group interviews (MORGAN & SPANISH, 1984; KRUEGER 1988; STEWART & SHAMDASANI, 1992), and oral biographical narratives (STAKE, 1995; YIN, 2002).

	System informants	Professionals	Managers	Users and care-givers
eGroup interviews		11		12
Individual interviews	11	7	13	26
Biographical stories				2
Total participants	11	98	13	124
Total number of participants: 246				

Table 2: Summary of data collection methods used and participants [25]

All the generated information (individual interviews, group interviews, and biographical stories) was digitalized and transcribed, forming a single body of data. The participants' agreement to take part in the study was recorded digitally at the beginning of each individual or group interview or biographical narrative. Participants' identities were not revealed. ATLAS.ti was used to analyze the data [26]

The challenge of any analytical process is to give the data meaning, reduce its volume, identify significant patterns in line with the research project objectives, and to effectively communicate the essence of what is revealed by the data (RUIZ OLABUENAGA & ISPIZUA URIBARRI, 1989). There are many approaches to analyzing qualitative data that are congruent with this objective. However, analytical practice also teaches us that few studies remain faithful to a single type of analysis. We could not avoid this pragmatic approach; therefore our analysis process is characterized by the use of thematic analysis along with some of the key aspects of grounded theory and frame analysis. [27]

The thematic analysis carried out in this study made it possible for us to uncover the most important synergistic themes from the principle Catalan health care system agents. In this article the themes of health resources, health processes and information, and communication and interaction in the health care system have been selected. This type of analysis

> "is a useful approach for answering questions about the salient issues for particular groups of respondents or identifying typical responses [...]. It is essentially a

comparative process, by which the various accounts gathered are compared with each other to classify those themes that recur or are common in the data set" (GREEN & THOROGOOD, 2006, p.177). [28]

We reached a second point in the analysis process when the clarification of the three themes selected by agents (users-care-givers, professionals, and managers) began and through the application of the principles of grounded theory (GLASER & STRAUSS, 1967; STRAUSS & CORBIN, 1994). This perspective is congruent with the objectives of this study as it allows us to: (1) take into account the heterogeneity of meanings and their links with the everyday lives of the agents of the Catalan health care system for each of the themes; (2) incorporate meanings emerging from agents during data collection; (3) obtain the meanings of practices and specific examples through what is enunciated by the agents themselves; (4) pay attention, as an element of analysis, to unique and, therefore, atypical cases. [29]

Finally, an analysis of frames (RITCHIE & SPENCER, 1994) was carried out in an integrated way to relate the specific aspects of the three themes of users-care-givers, professionals, and managers of the Catalan health care system.

"The aim of policy development is not at the forefront, and generally grounded theory, given that we can't say at the beginning what we will find out, or even who we are going to include in the sample, is not easy to sell to policy- and practice-minded funders" (GREEN & THOROGOOD, 2006, p.184). [30]

As this is a study commissioned by the Catalan government this type of analysis has allowed us to systemize and present the information so that it is useful and comprehensible for the professionals who will use the results of the research to plan future health services. Consequently,

"What moves framework analysis beyond a sophisticated thematic analysis is the final stage of looking at relationships between codes. This is what is known as mapping and interpretation, so a key tactic is to use diagrams and tables to physically explore the relationships between the concepts and the typologies developed from them. [...] Framework analysis in general has an overt policy orientation, with an end point of developing practical strategies on the basis of analysis" (GREEN & THOROGOOD, 2006, p.186). [31]

We have therefore generated tables that integrate the commonalities, differences, and discrepancies between users, professionals, and managers for each of the themes that emerged: health resources, health processes, and communication and interaction in the Catalan health care system. [32]

4. Results

One of the main aims of this article is to point out the importance of the perceptions of the agents involved in health care for planning and decision-making in health policies, as well as reflecting the usefulness of qualitative methodology in health research. Consequently, offering a succinct summary of some of the results obtained that allows readers to get an approximate idea of the scope of the research takes precedence over an exhaustive presentation of the results. These details are available in the project's complete report (IÑIGUEZ et al., 2007). [33]

We will focus on each of the themes identified—health resources, health processes, and professional-user communication—configuring the perception users, managers, and professionals have of the health care system. For each of these themes, and using illustrative tables, we will present a summary of the results related to the integrated perspective of the Catalan health care system agents. We understand *integrated perspective* to mean the holistic, comparative analysis of the perceptions of the public, professionals, and managers that allow us to reveal their agreements and differences concerning the dimensions of health care which they themselves define as important. [34]

4.1 Health resources

4.1.1 Health resources: Users

Users' perceptions of the resources of the health care system are characterized by complaints about the contrast between the high level of technological resources and the scarcity of other resources.

> "There isn't enough time to provide care, public health resources are very limited in this respect, so you can't have even slightly personalized care with patients because I know that sometimes with a patient, being able to talk to them a bit and allowing him/ her to express can sometimes sort out a lot of things" (GU03:88 208:208). [35]

The shortage of professionals is associated with the perception of restrictive policies and cutbacks in resources. Gaps in material and organizational resources are associated with the strain this represents both for users and for the system. It is pointed out that the desirable amount of time for interaction between users and professionals is not guaranteed because of these failings. [36]

This diagnosis refers not only to the quantity of resources, but also to their quality and organization. In fact, the structure and organization of care is considerably more complex; which means that, in conjunction with the lack of resources, a confusing context for users is generated, leading to dysfunction and negative effects concerning care, real and perceived control, and satisfaction.

> "Even the GPs I have had for ... 30 years!! ... And ... well, they've normally been quite nice but ... now they're under strain, or I don't know if more is being demanded of

them as ... they give worse care! In more of a hurry! With appointments! I don't know. You don't ask more from them than you should. If you say a prescription it should be a prescription, not two!" (GU09:8 16:16). [37]

4.1.2 Health resources: Professionals

Health care cannot be understood without professionals. They are not only the workforce, they are also people linked to others through practices that are not merely procedural. In this sense, the staff and its management form one of the mechanisms that promote or impede the proper functioning of the system. Professionals' perceptions on this issue are:

- The lack of staff leading to considerable gaps in health care; the perception that the increase in needs to be covered means more work but has not led to an increase in personnel.
- The perception that current contract conditions, together with staff turnover, the temporary and precarious nature of jobs, still have a much more negative effect on health care.

  "The relationship is ... er ... it's quite frequent ... we do a lot of coordination, but sometimes this coordination is not what we would want, is it? There's no ... What would you call it, let's see ... Equity with ... How can I explain it to you? There are a lot of professionals working in the network who do not agree with or who have something against employment integration, either because of salaries or because of the performance issue. And, of course, it's difficult to coordinate with these people if they don't have the same criteria" (SMPP03:44-44).

- Complaints over the waste of professional competencies due to actions and tasks not directly related to care.

  "The economic criteria of the hospital manager guides when patients should leave the hospital and go home. This has more relevance than the clinical criteria of a doctor, a psychologist, a nurse or from a group of professionals who know better about patients' lives. It takes me out of my nerves and it is happening so often" (GSMP02: 600-611). [38]

4.1.3 Health resources: Managers

Managers offer a perspective on health resources that is focused on the perceived gaps in both financial and human resources, considering the needs that are necessarily covered. This diagnosis of the use of these resources is related to the monitoring carried out and with what should be done to optimize their management. They also refer to a lack of time to address management issues and its repercussions.

  "I think hospitals are dimensioned to care for the general population—the demands of the population 15 or 20 years ago; a demand, let's say, related to a primary system

> with lower public expectations than we now have. The problem that we mainly have with this (system) is that it grinds to a halt" (HPGI:48 110:110). [39]

With respect to the lack of financial and material resources, it has been shown that there is a lack of investment in infrastructure and that there are dysfunctions in monitoring and evaluation policies. This leads to complaints, inequalities, and, in all cases, an inefficient distribution of the available resources. There is also a call for the clarification of the health model to systemize and prioritize users' expectations and demands, providing guidance for the list of services that can be provided effectively. [40]

The lack of human resources is largely due to two reasons: insufficient financial appropriations and employment conditions that are often inadequate or in fierce competition. This situation leads to declining motivation among professionals and reduces the attractiveness of the system for competent professionals.

> "Eh! ... if you're talking about professionals, they are very demotivated. There needs to be such a radical change, as we've managed to turn the professionals into a proletariat and work more on a more economic basis like supply and demand. That's why we've got too much supply and we can choose how we want them, because they've been converted into a proletariat, with low wages, etc...." (ISO8:12 27:27). [41]

The failings in time management result from both, the lack of professionals and the erratic organization of functions and tasks. The quality of the service offered to users and the ease with which they can access the health care system depend on an adequate number of professionals and a well-functioning organization.

Users	Professionals	Managers
A) Visibility and deficits		
Participants make the "informal" and private resources provided by the public for health care invisible. Only very overworked principal caregivers, some nursing staff, (health/social services network, and the mental health network) see a complementary aid relationship between the formal and informal health care systems.		
They see the activity as carried out mainly by medical staff and more by men than by women. This happens equally at all levels of care and particularly in primary care.		
Users particularly value and seek nursing staff as a reference point while they are using the system.		
All participants perceive that resources (staff and health care services) have increased.		

Users	Professionals	Managers
		Managers share this idea but they see it as impossible to achieve. New formulas must be sought with the arguments that costs cannot be increased. It has to be accepted that the system has reached the limit of what can reasonably be expected. Only a minority of managers continue to propose optimizing resources as a single solution to current deficits.
B) Strains		
All participants agree that the main effect of this lack of resources leads to strains concerning responsibility, waiting times and/or work. This has different implications.		
Users see the strains in: (1) waiting to receive care, (2) the complexity of itineraries/routes throughout the health care system and (3) the unavoidable need to reconcile care for dependents with working life. They see the strain on professionals derived from the over demand for services and the pressure the system exerts on them.		
	Professionals do not always see the strain on users, but rather the *pressure* of having to work harder and do the job *worse*. The maximum strain situation affects junior hospital doctors, as they are the most vulnerable (lower status, more dependent).	

Users	Professionals	Managers
		Managers see their strain as a consequence of feeling that they are almost the only ones who have to oversee the optimization of resources (controlling costs). There are two solutions for resolving the problem: (1) pressuring/persuading users and professionals to include interest in control on their agendas and (2) extending the role of the different professionals contracted and getting them to include new functions (so as not to increase hiring).
	Medical staff experience new responsibilities as a strain and loss of professional identity. They literally think that "they do enough" for patients. But nurses consider them as an opportunity to improve their status, autonomy and/or professional development.	
C) Over-use		
Participants mention over-use when they are referring to the use of additional tests in diagnosis and the use of emergency services.		
Users see the use of additional tests as a sign of good health care and they do not consider this overuse.		
	Professionals recognize they are over-using the service but they consider this necessary given current conditions under which health care has to be carried out (lack of time and user pressure).	

Users	Professionals	Managers
		Mangers believe there is over-use, partly because of the current conditions in which care is given and partly because of excessively and unnecessarily defensive and technocratic practices by medical staff.
D) Inequalities		
Participants see the differences and inequalities between regions for the provision/catalogue of services very clearly. Those affecting waiting times for surgery, social service/health care (palliatives and home care support) and mental health care are most visible.		

Table 3: Health resources: Agreement and discrepancies [42]

4.2 Health processes

4.2.1 Health processes: Users

Users' perceptions in relation to health processes are articulated based on time and coordination of itineraries/routes throughout the health care system. Users perceive that when they approach the system they enter a context full of paths they need to follow, where there is no one to explain them. The result of this is that they are saddled with more responsibilities than they ordinarily should have, leading to disorientation and helplessness. Whether they can face these situations successfully or not is tied to learning from what takes place during their experience within the system. Meanwhile, the processes within the system take too long. This is a specific dysfunction with very negative effects due to the fact that users' time is one thing and the system's time is another.

> "P1: Then, when you have a chronic problem, when you've spent years in hospital, you gain experience. Then you know what you mustn't do, you know you've got to do something else. The doctors know you've done that and you go on" (EPU03:5 36:36). [43]

4.2.2 Health processes: Professionals

Professionals' perceptions in relation to health processes are articulated around arguments related to teamwork and coordination. Teamwork is seen as a very important element, as a way of inspiring and basing actions and professional practice, as a *modus operandi* and as an indicator of the effectiveness of professional practice. Coordination is understood as something requiring a minimum of consensus, one that serves as a constructive common base; but working on a team is often considered sufficient to know how to tackle a difficult task. So, teamwork means sharing knowledge and practices and being willing to

carry out joint action where the action of caring is more important than who practices it. [44]

In their view, satisfaction or dissatisfaction with employment conditions, the precarious nature of jobs, involvement in the activity, and other aspects strongly influence the chances of coordination while being less influential when it comes to teamwork. However, professionals have expressed the idea that professional practice policies have not allowed for coordination. In fact, they highlight insufficient coordination as the most outstanding feature of their activity. They indicate the complexity and heterogeneity of the context, the unequal relationships between primary care and hospital professionals, and the effects of expectations and previous experiences of coordination as principal coordination difficulties.

> "I mean, if you find there are the same criteria, or that they value work as an important tool, well you can work along the same lines and coordinate. But, of course, if you've already got a circuit that doesn't ... that thinks that they're poorly paid.. or that the workers are being rather exploited ... if there are professionals who think that, and that this feeling is put across to the worker and, of course ... that takes off and then ... The information is a bit disjointed and the process doesn't continue" (SMPP03: 136-136). [45]

Finally, the lack of coordination can be seen at the different levels of operational independence and action of care viewpoints, even though continuity is a user care requirement. The disconnect caused by the lack of coordination often leads professionals to refer to their activity in *civil servant* terms, as a way of summing up the fact that applying illness/user specific procedures takes precedence over providing care (the focal point of the system). [46]

4.2.3 Health processes: Managers

Managers' perceptions stress the need to establish a different model. A model is proposed that prioritizes the health care user in the system, substituting a management model that focuses on professionals with one that is user-focused. Additionally, they stress the need for the system's adaptation to needs defined by the current situation, including those related to levels of care that currently impede coordination and other operational aspects.

> "Theoretically everything is very coordinated, everything is the same system but, of course, here in Catalonia we have a system with a lot of autonomy for the centers which is very good for some things, but we've reached a point where this autonomy has gone far enough and become a bit of a mess" (HPGI:23 49:49). [47]

In the view of managers, coordination is a central element of the system for the organization of services and for professional practice. Coordination must be compatible with autonomy. The characteristics of interpersonal relationships, such as competition or lack of trust seem to have a very negative effect on any attempts at coordination. Meanwhile, problems associated with the lack of

coordination are principally related to the greater number of users (e.g. chronic patients) who need to deal with a very large number of professionals, as well as the loss of primary care (community health centers)[2] contact and control suffered when users get into the hospital network.

> "But, with elderly people what happens is that they start with one specialist, after six months a second one appears, after a year a third appears and they end up having four specialists and a GP who writes them out prescriptions" (ISO6:8 33:33). [48]

From this point of view, coordination encompasses care services, the levels or parts of the system, as well as professionals. Managers mention different critical points in situations such as care integration or referral. Problems arising from a lack of knowledge among professionals at one level about professionals at another level are highlighted as features of their perceptions, particularly in terms of hospital network professionals knowing little or often being misinformed about primary care services.

Users	Professionals	Managers
A) Processes and routines		
Participants agree that the processes involved in health care have to be well-defined, easy to understand, and known by the different agents.		
	Professionals show ambivalence as they want fixed processes involving little bureaucracy not involving interactivity with professionals of equal or higher status. At the same time they want a degree of autonomy and the use of their professional judgment. They ask for breaking down processes so that all their components can be specified and carrying out avoiding professional relationships, as if they were merely functions of each professional role.	

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2   Primary care is a term used for the activity of a health care provider who acts as a first point of contact for all patients. Continuity of care is also a key characteristic of primary care. Primary care involves the widest scope of health care, including patients of all ages, patients of all socioeconomic levels, and geographic origins, patients seeking to maintain optimal health, and patients with multiple chronic diseases.

Users	Professionals	Managers
		Managers maintain two central interests when it comes to processes: optimization and increasing efficiency. Users' needs and satisfaction are not central, as they will be dealt with as a direct result of improving treatment, which they place outside the duration of the consultation; this is how the needs of professionals—largely medical staff—and of the system come to be central in designing processes.
Users want simple, integrated processes designed to focus on their needs; and they always want the guidance of a professional (given the high level of anxiety originating in health problems and the uncertainty involved in the care processes dictated by the system). This means that: (1) the system has to have professional teams managing complex cases and (2) the public must have the chance to learn to manage their care itinerary/*routes* throughout health care system.		
B) Coordination and information systems		
	Professional and managers reduce the notion of coordination to links between information systems and case management with clear referral criteria (and they are not sure about the integration of professionals and services). In this way they associate it with a standardization of practices and relations between services and systems, as well as with the homogeneous implementation of protocols and procedures.	

Users	Professionals	Managers
		It is a question of sharing clinical and financial information in order to prevent duplication of care (additional tests) and of users and professionals collaborating to control costs
	Professionals believe that this means sharing clinical information and scientifically validated procedures for action (for efficiency reasons and to reduce potential conflicts arising from relationships with colleagues). And sharing with users information about established care itineraries (so as not having to provide a response to their constant demands for guidance); and about their health situation (so as to try to improve their compliance with treatment and with the rules for use of services).	
For users coordination means there is no duplication or gaps in care. And it can be seen when information circulates and is shared between the professionals providing care. Users do not want to be the only people with the knowledge and records of all points that make it possible to have a continuous overall view of what is going on.		

Table 4: Health processes: Agreement and discrepancies [49]

4.3 The professional-user relationship

4.3.1 The professional-user relationship: Users

Users' perceptions are very clear; they include information transmission processes, communication typologies, as well as the way professional-user interactions take shape. [50]

Users perceive communication from health care providers as deficient, when this information relates to their specific health problem. They often give details of very inadequate or potentially harmful information, and communication practices, which are associated with the position given to users in the health care system. These perceived deficits and problems make users feel displaced, ignored, and even invalidated agents making decisions about their own health.

> "I mean, there is like ... like a kind of middle ground ... which is what ... which is what we are supposed to occupy ... where you say, well, you're the doctor and you're the one who knows and so, tell me and let's see ... the thing is that I'm the patient and I'm the owner of this body and so ... there are certain decisions which I have to make, aren't there? And it's as simple and as difficult as that ... but it's very hard ..." (GU06:46 156:156). [51]

In relation to interaction processes, users define them in terms of agent positions (users, caregivers, and professionals) that are different and marked by a strong asymmetry. In this sense it can be concluded that recognizing users as persons and competent agents, considered in ethical, moral, and political terms, or as individuals with a voice is not always guaranteed by the health care system.

> "And it was the ... the endoscopy, at the endoscopy they put the tube in and they hadn't finished putting the tube in, they pulled the tube backwards and said 'Oh! If what you've got is thrush right up into your mouth, what you've got is AIDS', and she went away—'Get dressed and you can go'. And she went and I got dressed. That's how I found out I had AIDS" (GU04:148 377:377). [52]

Users allude to bad experiences such as feeling mistreated or ignored and others who relate having received differential treatment by the same professional, depending on whether the visit took place in a public or private sector site. A very important element is the credibility professionals confer on users and how it influences the care they consequently receive. This is why the effects of a lack of credibility often delegitimizes users, frequently causing them to suffer at the hands of professionals charged with attending them. At the same time, users also value aspects found in health professionals, their commitment, responsibility, competence, consideration, positive disposition, modesty, and trust/empathy.

> "And this is fundamental, they need to listen to you, to guide you, to take you ... to educate you, to know what you've got to do and learn to control things and, when you come to see them, if you've done it wrong to tell you 'Listen, this doesn't work' but if

you've done it right they should also tell you (what doctors should be like)" (GU07:42
107:107) [53]

Health care users allude to and assess a number of their own behaviors that they
perceive as being negative or positive. The former are withdrawal,
powerlessness, helplessness, disorientation, deception, and fear while the latter
are politeness, responsibility, treatment adherence, and a willingness to
collaborate or confront. They also perceive that some of the behaviors they have
to enact when they approach the system are asking for help, being polite, acting
responsibly, adhering to treatment, collaborating, confronting, being proactive,
being demanding, drawing attention, demanding fairness, and complaining. [54]

4.3.2 The professional-user relationship: Professionals

Professionals' perceptions of their relationship with users are articulated in
relation to the type of interaction the professional maintains with users in terms of
the perception of this interaction, the consequences of the type of relationship,
some aspects of self-perception, and the effects of sociological changes. These
perceptions indirectly speak to communication and interaction competencies with
users. [55]

The professionals establish differences between dealing with users as "sick
people" or even people suffering from a particular illness or disorder, making it
more difficult to consider them simply as people. This difference in treatment is
perceived as an important factor for the operation of the system and professional
practice. [56]

Professionals' perceptions recognize that users seek certain interlocutors within
the system who are more accessible and perceived as being capable of
entertaining joint decisions.

> "Because he's very busy. They tell you 'You could be a doctor, with everything you
> know' and you tell them 'No, I'm a nurse and I'm happy with that' and the people tell
> you 'I can explain things better to you, because ... well, I don't know'. The thing is they
> give different care, training like everyone. People are starting to know about the work of
> nurses, so now is our time, now is the time to move forward" (GAPP02: 533-533). [57]

The relationship development between professionals and users can be explained
in terms of the conditions where their activity is carried out. The pressure
professionals feel as they attempt to fulfill the institutional agenda, deal with the
volume of demand, as well as developing a professional role characterized their
point of view. Thus, professionals directly or indirectly establish differences
between doctors and nurses. A specific aspect is the image created of specialists
as a repository of higher knowledge compared to general practitioners (GPs).
The effects of this characterization are exemplified in the case of the GP. GP's
are often confused by users with medical staff working at the level of hospital
care. Users think that primary care is a secondary extension of hospitals care.

> "The image, eh? Not reality, because it's not what I think. But the image is that in primary care doctors have a good life, that they go home for lunch, that they finish at 3 and that it's very relaxed. I've heard my manager say 'When I'm retired I want to be a GP'. I've heard this and he said it in a forum where there were 15 doctors. The perception is sort of a few grannies coming in with a cold or a sore throat, and that it's all like that. I think that shows utter ignorance of primary care, don't you?" (GAPP01:935-935) [58]

Finally, two societal changes appear to have a considerable effect on users' perceptions of the quality of care. One is the aging of the population, which is generating great pressure on practitioners. The other is the increase in the immigrant population from outside Spain with characteristics that translate to considerable demand for care: communication difficulties because of the language, and the fact that professionals have a dependent relationship with assistants from outside health care in order to do their jobs. [59]

4.3.3 The professional-user relationship: Managers

With respect to perceptions of behavior and the characteristics of the professional-user relationship, the main aspects highlighted by managers make particular reference to new demands and their link with training and participation needs.

> "It hasn't adapted well enough or quickly enough to the problems arising: elderly people, for example, or dependency ... The health care system that has been designed is a system for sorting out a broken arm or curing an infectious disease or ... of course it is! You don't cure chronic disease or degenerative illnesses in elderly people. At best you make sure they don't get worse. And the whole machinery designed for an acute system is not efficient for a chronic system, and it's expensive" (ISO1:11 30:30). [60]

According to managers, there has been a recent change in the characteristics of users who have become more demanding, although the extent of their demands can vary according to their social and cultural levels. Managers are also aware that, from a user's point of view, a good professional treats people well, and that in addition to asking for information users also want to participate in decision-making. [61]

Managers offer quite a positive assessment of users' demands and requirements. However, they question the degree to which the system should respond. Along these lines, they question the possibility of actually satisfying everyone. As managers they point out the need for clarity on what the system can offer and question the consequences of the model the system is moving towards. In addition, managers see the need to educate users about their *can't wait culture*; one that turns them into *bad* service users, such as when they walk into the emergency room without having a strict need that corresponds to the service.

Users	Professionals	Managers
A) The value of the information and the relationship		
Users want professionals to value and seek the information they might give at consultations and; to stop expecting users to be a source of information with value for professionals. Users want to know about their health situation, understand the options of care the professional is considering for their case. To interpret this need for information of users, it is necessary to take into account the fact that the knowledge they are seeking is gradually generated/developed in a relational context based on previous knowledge and that this learning occurs in a situation of limited rationality due to the anxiety involved in the situation. It is a position from which there is a constant need to understand, to have the opportunity for reassurance and/or to confirm that they are doing whatever is considered appropriate to achieve the objectives. Thus, it is not only a need for particular pieces of information at one point in the process which may or may not be understood.		
	Professionals and managers want users with competence equal to their own to understand health-related information. They value the information users have about what is happening to them unequally. They all see that this relationship is crucial for generating user satisfaction, but not all of them see it as essential for good practice (e.g. for therapeutic effectiveness or efficiency) in all cases.	

Users	Professionals	Managers
	Professionals see themselves as obliged to a gradual distancing from users that leaves them when giving information as representatives of the system.	
B) Need for extension versus need for limits on the relationship		
Placing limits on care is largely seen as the equivalent to placing limits on the time of the relationship. The difference is that for managers setting these limits is necessary, but for users it is not. Professionals are divided on this issue and nursing staff largely share with users the fundamental value attributed to relationships in care.		
The relationship is the most important thing for feeling well cared for. That is, it is an indicator which, from users' point of view, can be used as an index. The relationship is where the other values of health care, such as a good diagnosis and the effectiveness of the treatment, are given to them.		
	Professionals and managers agree that isolated, effective responses can be given to many demands without paying attention to relationships. For a significant number of professionals, this is not considered good practice, above all in the primary care (community health center), social services and in health and mental health networks.	
C) Collaborative relationship versus caring relationship		
Tradition and inertia help to reproduce in encounters a paternalist-type of caring relationship. But participants agree in seeing that in theory it would be desirable to establish a collaborative relationship, largely characterized by the user's full participation in decision-making and a complementary role in providing care. Despite this, only the active members of users' associations and a minority of professionals and managers do anything effective to make this kind of relationship possible in everyday practice.		

Users	Professionals	Managers
Participants emphasize the respectful relationship with users; a relationship that includes respect for their decisions, and consideration of their point of view and autonomy. Participation refers to: (1) enjoying recognition and opportunities for action within the system (recognition of their competence); (2) being able to make a collaborative contribution; and (3) becoming effective agents in the system.		

Table 5: The professional-user relationship: Agreement and discrepancies [62]

5. Discussion

In this last section we will highlight the innovative aspects of this research and the conclusions that can be drawn from them, covering the innovative conceptual and methodological contributions it offers, particularly the notion of health agent participation and the usefulness of qualitative methodology in health care system research. [63]

Introducing user participation as a constitutive element of health care involves questioning current health care system design, planning, and implementation practices. That is, it means contemplating a change in the form of user participation, from being perceived as a fleeting opportunity, to one that considers it an integral part of health planning. [64]

A participative approach requires positioning users as active agents for change in the process of improving public health and health care provision to citizens A participative model means that the other agents in the health care system (professionals and managers) should be positioned in a relationship that values the position of each patient as a legitimate knowledge source of living conditions and health. This means it is necessary to understand each patient's individual needs without losing sight of the holistic concept of the health care system (BERG, 1999; HAGE, 2000). That is, recognizing patients' needs and perspectives as a valid resource for clinical practice rather than considering them a problem or source of difficulty for the general operation of the health care system (ASHWORTH, LONGMATE & MORRISON, 1992; KIRK & GLENDINNING, 1998). [65]

Based on the work of KONING and MARTIN (1996), additional practical aspects can be derived from the concept of participation: (1) clearly defining the roles and functions of participants; (2) understanding the notion of power shared among

participants; (3) incorporating the local knowledge of each of the participants; (4) and considering the possible diversity of opinions about future expectations in the participation process. [66]

One of the keys to the success of user participation in the health care system is generating knowledge about their specific health needs. In this way, adopting qualitative methodology involves taking on the importance of analyzing and interpreting the meaning people give to their actions and the actions of others, as well as contemplating the complementary nature of description and comprehension. These assumptions are very useful in health policy research and are particularly important when scientific studies deal with health policies that place the patient/user at the center of planning (SATURNO HERNÁNDEZ 1995; MATURANA & CORBELLA, 2000). [67]

As we see it, a qualitative perspective is an important element in measuring the quality of care received by users (WENSING & GROL, 1998). This is demonstrated in studies by BATALDEN (1998), WENSING and ELWYN (2002), and others that reveal certain specific elements in: (1) providing information for users, (2) elucidating patients' preferences at each point of their care plan, (3) providing user feedback on the health care system, and (4) designing health resources and services in accordance with the needs expressed by users. [68]

Consequently, our research can be seen as a qualitative methodological contribution to the development of health policy planning in Catalonia (DE LA PUENTE & FUSTÉ, 2008), providing ideas and issues for future research in the design of health services based on how users, managers, and professionals perceive the Catalan health care system (ÍÑIGUEZ et al., 2008). [69]

Acknowledgments

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