International Journal of Latest Research in Humanities and Social Science (IJLRHSS)
Volume 06 - Issue 05, 2023
www.ijlrhss.com || PP. 386-395

Satisfaction with health services and its consequences on the quality of life of patients

Shems-eddine Lehmer[a], Lekbich Abdelaziz[b], Marra Youness[c], Jouad El Kaissouni[d]

[a]*Doctoral student at the Faculty of Legal, Economic and Social Sciences of Agadir IBN ZOHR University Laboratoire of Research Studies in Economics and Management Morocco*
[b]*Doctoral student at the Faculty of Legal, Economic and Social Sciences of Agadir IBN ZOHR University Laboratoire of Research Studies in Economics and Management Morocco*
[c]*Doctoral student at the Faculty of Legal, Economic and Social Sciences of Agadir IBN ZOHR University Laboratoire of Research Studies in Economics and Management Morocco*
[d]*Doctoral student at the Faculty of Legal, Economic and Social Sciences of Agadir IBN ZOHR University Laboratoire of Research Studies in Economics and Management Morocco*

Abstract: Objective: to associate satisfaction with health services and health-related quality of life (HRQoL). We conducted a cross-sectional descriptive study with 300 adult patients in 2023. We conducted a survey on: socio-demographic variables, health services (affiliation, type and satisfaction) and HRQoL (WHOQOL-BREF questionnaire). Data were analyzed from proportions and association by OR and nominal logistic regression. Results: 90% of the sample correspond to adults over 40, 51.6% men, 94.2% have health services, 66.7% public and only 12.5% have multi-risk plans , 64.6% feel satisfied with their health services but being over 40 and less than 10 years of education has a negative impact on HRQOL (OR: 1.68; p= 0.04, OR: 2 .7, p= 0.001 respectively); During the multivariate analysis, the level of patient satisfaction was influenced largely by factors such as: the level of education, the respect of previous appointments and the satisfaction with life in general. Since patients are more susceptible to the ease of making appointments, the behavior of health personnel, the delays in waiting times, it would be more judicious to assess patient satisfaction more frequently in order to improve these aspects and the image of the health facility

Keywords: health services, quality of life, public health, patient satisfaction.

Introduction

Health-related quality of life can be defined as the aspect of quality of life that refers specifically to the person's health and is used to refer to specific outcomes of clinical assessment and treatment decision-making. [1]. The concept of HRQoL includes the basic domains of physical, mental, social and emotional aspects (WHOQOL Group 1993) [2]. In these areas, the needs of human beings such as food, rest, sex, breathing, physical safety, employment, family support, health system affiliation, recognition, trust, respect, success, are evaluated to study the quality of life, self-realization, morality and creativity [3] etc. By not having these needs, the HRQoL can be compromised, as reported by numerous studies [4].

With regard to affiliation to health systems, the institutions that provide health services, by not functioning properly, can compromise the physical and mental well-being of the patient, the prognosis and treatment of diseases and even his productivity. personal and family and social, decreasing their quality of life [5]. Factors related to service provision such as access conditions [6], user attention in terms of time and quality, doctor-patient communication [7], timely delivery of drugs and clinical outcomes, infrastructure conditions [8] and user satisfaction, among others, have been associated with poorer clinical outcomes [9]. Thus, the provision of health services must meet criteria of efficiency, effectiveness, opportunity, the main objective of which is to guarantee access and quality of services, to optimize the use of resources, to promote targeted care approaches for users that ensure their biopsychosocial well-being. ten]. Law No. 09.34 relating to the health system and the supply of care organizes the current health social security system in Morocco and was mainly aimed at regulating the essential public health service and at creating conditions for access to all of the population, at all levels of care [11]. In addition to being based on the principles enshrined in the Political Constitution of Morocco of 1991 [12], for the provision of social security, it must comply with the rules enshrined in law [11]. At present, the sustainability of the health system is going through a structural crisis based on the inefficiency of operational oversight and the maximization of profit by health service providers which stems from the search for a balance between the capacity to funding and coverage [11]. Due to this situation, many services are provided with gaps and failures in their processes and compromise the quality of life of patients. For this reason, based on the declaration of universal health in Morocco, various mechanisms have been designed to guarantee health to

the entire population, in the midst of a restriction of resources that particularly affects the most vulnerable population [11].

At the level of the supply of health services, although satisfying the expectations of users of health services constitutes a complex process of intersubjectivities, the purpose of the supply of health services is no different from that of the others. types of service: satisfy users (patients and companions). In this sense, users can only be truly satisfied if the workers who provide the services are also satisfied, which makes the actions directed by the managers of these services even more complex, in order to achieve an operation that respects all the conditions necessary for achieve excellence. [13]. Increasingly important quality indicators that measure outcomes include patient satisfaction with the care received [13]. Among the implications of the process of implementing quality in health care, it can be mentioned that over the past twenty years the challenge for developed countries has been to integrate as an important component of quality health care quality, the consumer point of view [14]. Various authors have argued that a positive perception of the quality of health care translates into better medical outcomes. In this sense, most of them emphasize that for patients the healing process is not the only thing [14]. Knowing the satisfaction of patients with regard to the services offered would make it possible to assume before them positions for improving the quality of services and their adequate use. In Morocco, studies are reported where many patients are dissatisfied with certain aspects related to care in health services such as waiting times, duration of care, delivery of drugs and treatment received by staff, and indicates that depending on these variables, these services are used or not, which can compromise health status [15]; Despite the above, there are very few studies performed regarding service satisfaction and its association with HRQOL, for which it is proposed to study the impact of health service satisfaction on HRQOL in patients, seeking to know from the current model of comprehensive health care performed in the dental clinics of this institution, what are the barriers to accessing the use of health services presented by adult patients, which can compromise their well- being and commitment to the dental care provided.

Methodology

A descriptive cross-sectional study was carried out among the 300 patients treated at the CNSS clinic during the months of February to March 2023, taking into account that they met the following criteria: people who agreed to participate in the study after signing the consent enlightened, present at the dental service at the time of the survey; By including the entire study population that met these criteria, the possibility of selection bias was also reduced. The study was conducted in accordance with WTO standards (WHO/UNAIDS, 2015)

A questionnaire was designed and applied, consisting of 54 closed and coded questions, divided into three items:

1. General data: age, sex (female, male), origin (urban, rural), socio-economic category, marital status, level of education, insurance affiliation (yes, no), type of insurance,
2. Satisfaction with health services: questions related to satisfaction and use of health services such as: Based on your experience with your health insurance, do you feel satisfied and would you like to change your insurance current for another? and in general, issues related to satisfaction with the healthcare professional, administrative staff, infrastructure and service delivery process, and
3. Health-related quality of life (HRQOL): via the Whoqol-Bref questionnaire, an abbreviated version of the scale developed by the WHO [16] with an intercultural approach and containing a total of 26 questions, one for each of the 24 aspects assessed in the original WHOQOL-100, plus two questions that ask about the perception of general quality of life and general health, which are assessed separately. Each question is made up of 5 Likert-type categories. The scale provides a general score related to the perception of overall quality of life, ranging from 0 to 100, the higher the score, the better the quality of life. Taking into account the average reported by the patients (Average: 62), a threshold was established for the associations. The reliability of the internal consistency of the instrument was found by means of Cronbach's alpha, by carrying out a pilot study with 20 people chosen from the waiting room of another health establishment with similar characteristics, with the aim of evaluating the applicability of the collection instrument and the accessibility of the information of interest. The collection instrument was refined to the maximum and the researchers were trained to guarantee the proper management of information, from the delivery of the instruments to their recording in the database and thus to control information bias. The values obtained were for the satisfaction survey an alpha coefficient of 0.83 and for the quality of life questionnaire an alpha coefficient of 0.82, which are among the appropriate values for determining good reliability. The psychometric characteristics of this instrument have been reported in various surveys thanks to its validation for different specific groups, languages and countries [17]. Although at the time of the study the Whoqol-Bref had not yet been validated for the Moroccan population, the intercultural approach it had since its creation, the participation of countries from sub-

Saharan Africa and its validation in French and in Arabic have made its use in this feasible study, as other authors have done, they also report it [22].

Data were analyzed using STATA 10.1 software (Stata Corp, College Station, TX, USA). Initially, descriptive analyzes assessed measures of central tendency (mean, standard deviation, and observed range) of WHO-QOL-BREF scores, sociodemographic variables, and those related to satisfaction with health services. For associations, odds ratios were used, with estimators adjusted by multiple analysis and 95% confidence intervals. At the multivariate level, a nominal logistic regression was used, including in the models the factors that had probabilities less than 0.20; models were formed from the exclusion of each of the variables in a process according to the recommendations of Greenland [23]. Moreover, the quality of fit of Hosmer-Lemeshow [24] was used, in order to demonstrate the significance of the best model from values of p>0.10.

Results

The sample consisted of a total of 300 patients, the majority of whom were mature adults over the age of 40 (90%) who attended the CNSS clinic, women (48.4%), urban origin (55%), 57% are employees; the majority have a low level of education, 70% are married.

Tableau 1. Variables sociodémographiques des patients

Age	**Effective/ frequency**	**Sex**	**Effective/ frequency**
Under 40	30 (10%)	man	155 (51,6%)
40 to 60 yearsold	125 (41.66%)	women	145 (48,4%=
60 and over	145 (48.34%)		
Place housing	**Effective/ frequency**	**Marital status**	**Effective/ frequency**
urban	165 (55%)	Single	25 (8.33%)
rural	135 (45%)	Married	210 (70%)
		others	65 (21,6%)

Education level	**Effective/ frequency**	**Socio-Professional Category**	**Effective/ frequency**
primary	120(40%)	employees	**170 (56.66%)**
secondary	110 (36.67%)	Liberal professions	**65 (21,67%)**
university	70 (23.34%)	entrepreneurs	**40 (13.33%)**
		inactive	**25 (8.34%)**

Type of health service	**Effective/ frequency**	**affilié à une assurance**	**Effective/ frequency**
public	200 (66.67%)	oui	176 (58.67%)
private	100(33.33%)	non	124 ((41,33%)

Source: Survey

According to their experiences with their health services, the population reports a level of satisfaction of 64.6% and 65.8% are calm and confident with the services offered by their health insurer; however, when asked if they would like to change their current insurance for another, the majority answered yes, with 71.7%, with an influence determinant of their choice, by other people (68.3%) (Table 2). Similarly, when questioning a characteristic process within the functioning of the Moroccan health system, such as timeliness in the processing and delivery of medical prescriptions, 52.9% expressed their degree of dissatisfaction with vis-à-vis the mechanism used by their health insurer. In the context of user satisfaction, the PQR procedure (Petitions, Complaints, Complaints) is one of the means of measuring and monitoring the quality of care, to which only 36.7% of the sample had a degree of satisfaction with the attention time of a complaint and/or claim and 35% for their suggestions. Similarly, the attention given by the administrative staff did not provide sufficient confidence and security to the study respondents (57.9%) (Table 2).

Table 2 Variables related to patient satisfaction with health services

Variables related to satisfaction with health services	**Effective/ frequency**
Are you satisfied with the health services?	
Yes	*194(64,6)*
No	*106(35,4)*
Do you feel calm and confident with health insurance?	

Yes	*197(65,8)*
No	*103(34,2)*
Do you want to change your current insurance for another?	
Yes	*215(71,7)*
No	*85(28,3)*
Who influenced the choice of your current insurance?	
own decision	*95(31,7)*
Others	*205(68,3)*
Of all the services offered in your insurance, which presented the most disadvantages:	
General services	*176(58,7)*
Critical services	*124(41,3)*
Is the process for assigning appointments adequate?	
Yes	*172(57,5)*
No	*128(42,5)*
Is the care provided by your insurance appropriate?	
Yes	*167(55,8)*
No	*133(44,2)*
Are all the services offered provided satisfactorily?	
Yes	*165(55)*
No	*135(45)*
Are the processing and delivery times for medical orders satisfactory?	
Yes	*141(47,1)*
No	*159(52,9)*
Do you receive timely diagnostic tests (clinical lab, cytology, etc.)?	
Yes	*208(69,2)*
No	*92(30,8)*
Are the institutions where you are cared for comfortable and clean?	
Yes	*235(78,3)*
No	*65(21,7)*
Is the information provided to the user clear?	
Yes	*202(67,5)*
No	*92(32,5)*
Is the delivery of medicines prompt and complete?	
Yes	*168(56,2)*
No	*132(43,8)*
Do the medical staff clarify your concerns?	
Yes	*191(63,7)*
No	*109(36,3)*
Is there timely attention to complaints and claims?	
Yes	*110 (36,7)*
No	*190(63,3)*
Attention to suggestions?	
Yes	*105(35)*
No	*195(65)*
Does the care provided by administrative staff provide confidence and security?	
Yes	*174(57,9)*
No	*126(42,1)*
Do you feel safe with the care provided by your insurance?	
Yes	*189(62,9)*
No	*111(37,1)*

Table 3.Univariate analysis between the total HRQoL score (WHOQOL-BREF) and sociodemographic variables in patients

Variables	HRQOL (total score) OR (IC 95 %)	p		HRQOL (total score) OR (IC 95 %)	p
Age			Level of education		
Young adults (≤ 44 years old)			Low level of schooling	2,7(1,53-4,76)	0,001*
mature adult and	1,68(1,01-2,8)	0,04*	High level of education		
Older (≥ 45 years old)			Marital status		
Sex			Married		
Women	0,91(0,54-1,53)	0,73	Single	1,07(0,64-1,78)	0,79
Male			type of occupation		
Origin			Formal economic activity		
urban	1,18(0,64-2,17)	0,57	Non-formal economic activity	1,54(0,90-2,61)	0,11
complementary health services			Has health services		
Yes			Yes		
No	0,73(0,34-1,58)	0.43	No	1,56(0,52-4,65)	0,42
Socio-Professional Category			Type of health services		
employees	7,4(0,91-60	0.06	private		
Liberal professions			public	1,07(0,64-1,81)	0,77
entrepreneurs					
inactive					

For the quality attribute regarding timeliness, the process of assigning appointments (57.5%), delivery of medication (56.2%) and delivery of diagnostic tests (69.2%) were reported as favorable results in the context of the characteristic related to the possibility that the user has to receive one or more services without generating delays putting their life or health at risk. (Table 2).

By associating socio-demographic variables and those related to satisfaction with health services with total HRQOL scores, it turned out that it was only associated with being over 45 years old. (OR: 1.68; p= 0.04), low level of education (OR: 2.7; p= 0.001) and late delivery of medical results (OR: 1.88; p=0.03) (Tables 3 and 4), but when running the multivariate analysis, the model that best explains the compromised HRQoL includes the following factors: low level of education (OR: 3.04; p= 0.00), dissatisfaction with the comfort and cleanliness of health services (OR: 2.13; p= 0.02) and dissatisfaction with the care provided by the administrative staff of the hospital. institution (OR: 1.75; p = 0.04) (Table 5).

Table 4.Univariate analysis between total HRQOL score and variables related to satisfaction with health services in patients.

Variables related to health insurance satisfaction	**Total HRQOL score OR(IC95%)**	**p**
Are you satisfied with the health services?		
Yes		
No	1,37(0,80-2,33)	0,24
Do you feel calm and confident with health insurance?		
Yes		
No	1,53(0,89-2,61)	0,11
Do you want to change your current insurance for another?		
Yes	1,20(0,68-2,11)	0,51
No		
Who influenced the choice of your current insurance?		
own decision		

Others	0,60(0,34-1,04)	0,07
Of all the services offered in your insurance, with which you had the most problems:		
General services		
Critical services	0,85(0,51-1,43)	0,56
Is the process for assigning appointments adequate?		
Yes		
No	1,55(0,92-2,59)	0,09
Is the care provided by your insurance appropriate?		
Yes		
No	1,45(0,87-2,43)	0,15
Are all the services offered provided satisfactorily?		
Yes		
No	1,36(0,81-2,27)	0,23
Are the processing and delivery times for medical orders satisfactory?		
Yes		
No	0,85(0,51-1,42)	0,55
Do you receive diagnostic test results (clinical lab, cytology, etc.) in a timely manner?		
Yes		
No	1,88(1,03-3,13)	0,03*
Are the institutions where you are cared for comfortable and clean?		
Yes		
No	2,16(1,15-4,05)	0,01*
Is the information provided to the user clear?		
Yes		
No	1,31(0,76-2,26)	0,32
Is the delivery of medicines prompt and complete?		
Yes		
No	1(0,59-1,66)	1,00
Do the medical staff clarify your concerns?		
Yes		
No	1,37(0,81-2,33)	0,23
Is there timely attention to complaints and claims?		
Yes		
No	0,86(0,51-1,47)	0,60
Attention to suggestions?		
Yes		
No	0,94(0,55-1,60)	0,82
Does the care provided by administrative staff provide confidence and security?		
Yes		
No	1,84(1,09-3,09)	0,02*
Do you feel safe with the care provided by your insurance?		
Yes		
No	1,48(0,87-2,5)	0,14

*Variables with statistical significance. Source: authors

Table 5. Multivariate model between WHOQOL-BREF score, socio-demographic variables and variables related to satisfaction with health services in patients

Variables	**Total HRQOL score**	
	OR (IC95%)*	**p**
Level of education		
Low level of schooling	3,04(1,69-5,47)	0,001
High level of education		

Are the institutions where you are cared for comfortable and clean?		
Yes		
No	2,13(1,09-4,17)	0,02
Does the care provided by administrative staff provide confidence and security?		
Yes		
No	1,75(1,01-3,04)	0,04

*Value of model: X2: 23.77, p=0.001

Discussion

This study found some factors related to dissatisfaction with health services that negatively impact health-related quality of life (HRQOL). One is age, finding that being over 40 is a risk for HRQoL. It must be taken into account that patients over the age of 60 correspond epidemiologically to a population that presents care needs given the reduction in functional capacities [25]. This ability is largely determined by lifestyle factors in adulthood, such as smoking, alcohol consumption, level of physical activity and diet, and can decline so abruptly that the outcome may lead to premature disability [25]. This puts this population at risk and justifies promotion and prevention activities on the part of health institutions that even reach workplaces [26] and generate healthy spaces, given their limited access conditions to services in due to the limited time available to attend medical appointments and attend these types of preventive programs. If in the midst of these limitations there are gaps in the provision of health services, a worsening of health conditions is generated and would have an impact on the quality of life of the patient, his family and even on social and economic productivity. from the country.

Similarly, the low level of schooling represented a risk for the HRQOL, results whose interpretation coincides with those reported by Salas et al. 2010 [22], where the high level of schooling and the perceived satisfaction with health services are directly linked, which would lead to a better use of these, translating in the long term into a positive impact on the QVLS. It must be taken into account that having a few years of education does not encourage habits such as reading and interest in information that allow this type of population to understand more easily the functioning of the system. current health; When this lack of knowledge and misinterpretation of system norms and rules occur, misperceptions and erroneous myths are generated regarding health care that compromise service utilization and therefore their HRQoL [27].

Regarding satisfaction with health services, just over half of the patients in the study felt satisfied with the services that matter despite the fact that in the multivariate model it is shown that they do not feel unsatisfied with the comfort and cleanliness of the facility where services are provided and disagreement with the care provided by administrative staff who do not offer confidence and security when offering information and advice has a negative impact on the HRQOL. This coincides with what was reported by Massip et al; in Havana, Cuba [28], who consider in their review that, when talking about satisfaction, it is important to take into account the distinction between general satisfaction, referring to the degree of patient satisfaction with health care received, and specific satisfaction, which is the degree of satisfaction with the use of a specific service, or with specific aspects of the services received, observing this difference in this study, counting patients with general satisfaction with the services but with dissatisfaction with a specific service received. Similarly, Massip et al; reports that in the studies reviewed on satisfaction and quality, it is concluded that in general users are generally satisfied with the services they receive, but when they address more specific topics such as information, treatment or friendliness, this satisfaction decreases [28], also coinciding in this aspect with the results found in this study. Therefore, carrying out this type of survey is considered a very valuable tool since it provides information on the degree of patient satisfaction in terms of the treatment received and in the reorientation of the objectives set by health institutions that lead to the formulation of improvement projects.

Likewise, although the vast majority feel satisfied, many would like to change insurance and a large part of them have not participated in the choice of the insurance company and have been influenced by other people, among which the employer has a great influence. The free choice of health promotion entities must be understood as the right to free choice, in accordance with the law [11] and its amending laws such as law 1122 of 2007 [30] and 1438 of 2011 [31], which he member has to choose between the different Health Promotion Entities, which one will manage the provision of his health services. It must be taken into account that one of the criteria to be fulfilled for the application of the principle of free choice relies on the supply of administrators and providers of health services, which obliges service providers to improve their quality and possibly their efficiency. Despite legal guidelines, a frequent behavior is the taxation of health insurance companies by the employer [29].

The comfort perceived by the patients, as well as the cleanliness of the establishment providing the service, play a key role in the patient's external perception of the services to be received, the quality of care and

the prognosis of the treatment. These factors are reported by some studies as one of the factors generating the most dissatisfaction, in particular discomfort in waiting rooms and disagreement with the cleanliness of sanitary services [32]. Here it was not specifically explored in which area of the facility providing healthcare services they were dissatisfied with regards to comfort and cleanliness, but information is provided for healthcare facilities to investigate these aspects. and work to improve them. Whether or not the service is used and its impact on HRQoL may depend on this. Similarly, not feeling confident in the administrative staff can generate restlessness, insecurity and uncertainty in the patient about the resolution of his health problem and his commitment to his quality of life. in the long term, because depending on this factor, it can also compromise the appropriate use of health services [33]. Here is one of the factors that showed a negative impact on HRQOL, contrary to what was reported by Morales et al; where most patients were satisfied with this factor [32]. It should be taken into account when choosing administrative staff that they not only have knowledge in the field, but also communication skills and emotional intelligence that promote good relations with patients.

Another of the factors that showed a negative impact on HRQoL, although not included in the final model, is the timely delivery of diagnostic test results (clinical laboratory, etc.), a factor that is also reported with perceived dissatisfaction by patients in other studies [34-36]. Failure to comply with actions to access services in an agile and timely manner has effects on the user at the family, professional, economic and social levels, among others, disabling not only him, but also his family. This situation generates processes of inequity, as reported by several researchers [34-36] and would compromise the HRQoL, since the results of clinical examinations and laboratory tests are not available in real time, the treatment of diseases and leads to their possible complications as confirmed by the study of Seva [37], where patients, not having their results in a timely manner, resort to palliative medicine, pharmacies or local doctors and beyond all that Even legal measures and withdrawal actions are resorted to where the patient, although they feel ill, forego care, compromising their well-being and quality of life [37]. Health facilities have an obligation to be affordable, equitable, sustainable and of high quality; and they are responsible for the functions of promoting, restoring and improving individual and collective health [38], for which these results are expected to serve as a guide for many institutions in the pursuit of excellence in the health system. health and the guarantee of the fundamental rights of the individual such as the right to health as established by the Moroccan Constitution [12].

Untimely delivery of medication was another aspect that was reported with dissatisfaction in the study. Within the framework of the rights established in the benefit plan, the delivery of medicines and supplies formulated by health professionals within the framework of the overall process of care, constitutes a process of great importance not only for the quality characteristics corresponding to the relevance, continuity and security for the user of the health system, but also from the economic point of view of the member, when the "disbursement" for the purchase of a service or a drug to restore his state of health is so important expensive, which is why an access barrier is created [34]. The process established for this purpose points to a history of complex procedures and incomplete sending of formulas, both in terms of quantities, presentation and type of drug itself, which has generated continuous monitoring of the opportunity to its delivery, understood as a sanitary quality process [39].

Dissatisfaction was also reported with regard to the attention time for a complaint and/or a claim, corroborating what was expressed by J El Kaissouni 2023 for the case of Morocco, which states that petitions, complaints, claims and requests are still in force are progressing despite the regulations that exist in Morocco to control them [34]. It is important to remember that the public health system [30] must fully guarantee the health of the population, both individually and collectively. Likewise, the National Health Superintendence of Morocco is the entity responsible for strengthening the mechanisms for monitoring the areas of the EAPB (administrative, technical, scientific, economic, among others) and must guarantee the respect of users' rights in the health system and enforce the duties of the various players in the system.

Although this study has limitations such as the volume and selection of respondents and not representative of the Moroccan population and those corresponding to the type of study, it adds to the scientific evidence provided on the factors that influence patient satisfaction. with regard to health services. and that can compromise their human development and quality of life that allow adequate feedback in the provision of these services and knowledge of the aspects to be improved.

In conclusion, the low level of education, presenting dissatisfaction with the comfort and cleanliness of health services and the attention provided by administrative staff generates a negative impact on the HRQoL.

Bibliography

[1]. Cleary PD, Mc Neil B J . Patient satisfaction as an indicator of quality care. Inquiry1988;25(1):25–36.
[2]. Group TW. Development of the World Health Organization WHOQOL-BREF quality of life assessment. The WHOQOL Group. Psycho Med 1998; 28(3):551–8.

[3]. Alvarez LFB. The Culture of Consumption and its Relationship with the New Computer Technological Trends. Teckne 2016; 3(1):35-38.
[4]. Taenzer P, Bultz BD, Carlson LE, et al. Impact of computerized quality of life screening on physician behavior and patient satisfaction in lung cancer out patients. Psych oncology 2000;9(3):203–213.
[5]. Abodunrin O, Akande T, Osagbemi G. Awareness and perception toward referral in health care: A study of adult residents in llorin, Nigeria. Annals of African Medicine 2010; 9(3):176-180.
[6]. Contreras D, Gómez O, Puentes E, Garrido F, Castro M, Fajardo G. Waiting times for surgical and diagnostic procedures in public hospitals in Mexico. Public health Mex 2015; 57(1):29-37.
[7]. Chirino A, Hernández E. Affective communication and management of emotions in the training of health professionals. Educ Med Super 2015; 29(4):872-879.
[8]. Almeida R, Bourliataux S, Martins M. Satisfaction measurement instruments for healthcare service users: a systematic review. Public Health Cad 2015; 31(1):11-25.
[9]. Rahmqvist M. Patient satisfaction in relation to age, health status and other background factors: a model for comparisons of care units.Int J Qual Health Care2001;13(5):385–390
[10]. Diaz C, Zapata Y, Aristizabal JC. Access and satisfaction with curative services: analysis of cases in affiliates of the contributory regime and affiliates of the subsidized regime in a stratum 2 neighborhood Cali, Colombia. Rev Gerenc Polít Salud 2015; 14(29):155-178.
[11]. Law 100 of 1993: By which the comprehensive social security system is created and other provisions are issued. (Official Gazette 41148, of 23/XII/1993).
[12]. Columbia. National Constituent Assembly. Political Constitution of Colombia 1991. Chapter 2. Social, economic and cultural rights. Article 48 and 49. (Constitutional Gazette No. 116, of 10/VII/1991)
[13]. Larsen DL, Attkisson CC, Hargreaves WA, Nguyen TD. Assessment of client/patient satisfaction: development of a general scale. Eval Prog Plann1979;2(3):197–207
[14]. Wolf MH, Putnam SM, James SA, Stiles WB. The medical interview satisfaction scale: development of a scale to measure patient perceptions of physician behaviour. J Behav Med 1978; 1:391–401.
[15]. Delgado M, Vázquez M, Moraes L. Quality in health services from the meaning frameworks of different social actors in Colombia and Brazil. Rev public health 2010; 12(4):533-545.
[16]. The WHOQOL group: development and gener- al psychometric properties. Soc sci med 1995; 41:1403-9.
[17]. Moreno A, Faerstein E, Werneck G, Lopes C, Chor D. Psychometric properties of the Abbreviated instrument of Avaliando de Qualidade de Vida of the World Health Organization of the Pró-Saúde Study. Public Health Cad 2006; 22(12):2585-97.
[18]. Yao G, Wu Ch. Factorial Invariance of the WHOQoL-Bref among disease groups. Qual Life Res 2005; 14:1881-8.
[19]. Izutsu T, Tsutsumi A, Islam A, Matsuo Y, Sayuri H, Kurita H, et al. Validity and reliability of the Bangla version of WHOQoL-Bref on an adolescent population in Bangladesh. Qual Life Res 2005; 14:1783-9.
[20]. twenty.
[21]. Jenkinson C, Coulter A, Bruster S. The Picker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries. Int J Qual Health Care 2002; 14:353–358.
[22]. Urzúa A, Miranda-Castillo C, Caqueo-Urízar A, Mascayano F. Do cultural values affect quality of life evaluation? Soc Indic Res 2013; 114:1295-1313.
[23]. Attkisson CC, Greenfield TK. The UCSF client satisfaction scales: I. The Client Satisfaction Questionnaire 8. In: Maruish, ed. The use of psychological testing for treatment planning and outcomes assessment. 2nded. London: Lawrence Erlbaum Associates,1999;1333–1346.
[24]. Greenland S. Modeling and variable selection in epidemiologic analysis. American journal of public health 1989; 79(3):340-349.
[25]. Hosmer DW, Lemeshow S. Applied logistic regression 2nd edition. New York: John Wiley and Sons Inc; 2000
[26]. Merlo J. Contextual Influences on the Individual Life Course: Building a Research Framework for Social Epidemiology. Psychosocial Intervention 2011; 20,109-118.
[27]. Garcia JC. Health promotion in workplaces: an opportunity to develop. Av. Enferm 2009; 27(1):124-129
[28]. Sánchez G, Niño C, Estupiñán C. Factors associated with timely treatment of women with breast cancer supported by a non-governmental organization. Biomedical 2015; 35(4):505-512.
[29]. Massip C, Ortiz RM, Llantá M del C, Peña M, Infante
[30]. The evaluation of health satisfaction: a challenge to quality. Rev Cub Public Health 2008; 34 (4): 0-
[31]. España D, Jaimes C. Criteria or determining elements of the free choice of Eps and Ips in Bogotá D.C. by users of the contributory scheme. Rev Gerenc Polít Salud 2010, 9(19):179-215.

[32]. Congress of the Republic of Colombia. Law 1122 of 2007: By which some modifications are made in the General System of Social Security in Health and other provisions are issued. Bogotá D.C.: Congress of the Republic of Colombia; 2007.
[33]. Law 1438 of 2011: By which some modifications are made in the General System of Social Security in Health and other provisions are issued. (Official Gazette 47957, January 19, 2011). Law approved.
[34]. Linder- Pelz S, Struening EL. The multidimensionality of patient satisfaction with a clinic visit. J Comm Health 1985;10:42.
[35]. Medeiros F, Araújo G, Albuquerque A, Clara I. Treatment in a Basic Health Unit: user satisfaction in focus. Rev public health 2010; 12(3):402-413.
[36]. Schwartz CE, Sprangers MA. An introduction to quality of life assessment in oncology: the value of measuring patient-reported outcomes. AmJManagCare2002;18 (Suppl): S550–S559.
[37]. Franco S. Between business and rights. Rev Cub Public Health 2013; 39(2):268-284.
[38]. Mishima S, Campos A, Matumoto S, Fortuna C. Client satisfaction from the perspective of responsiveness: strategy for analysis of universal systems. Rev Lat Am Enfermagem 2016; 24: e 2674
[39]. Seva I, Flores M, Martínez F. Self-medication prior to pharmaceutical indication in flu or cold. Vitae 2014; 21(1):30-37.
[40]. Mejía A, Sánchez AF, Tamayo JC. Equity in access to health services in Antioquia, Colombia. Rev Public Health 2007; 9(1):26-38.
[41]. Woodward CA, Ostbye T, Craighead J, Gold G, Wenghofer EF. Patient satisfaction as an indicator of quality care in independent health facilities: developing and assessing a tool to enhance public account-ability. AmJMedQual2000;15(3):94–105