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Telephone attention and perceived quality in primary healthcare services in Spain

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ENG **Abstract.** The present study has a twofold objective. On the one hand, we analyze in a comparative way the level of perceived quality with respect to face-to-face and telephone primary care services in Spain during the COVID-19 pandemic. On the other hand, we studied the social and demographic determinants that may influence the level of satisfaction regarding telephone consultation. To this end, we used the Health Barometer 3357 (first wave) prepared by the Sociological Research Center (CIS) (2022). The information associated with the study variables that make up our model was analyzed descriptively and inferentially by means of ordinal regression analysis. The results, interpreted following the dimensions that articulate the SERVPERF model, indicate a lower level of telephone consultation in the categories of safety, reliability, empathy and responsiveness. In addition, patients attended by telephone have a lower level of satisfaction. However, we found no relationship between sociodemographic variables and the level of satisfaction with telephone consultation. In conclusion, we must point out the risks presented by the expansion and increase of the telephone consultation modality in primary care services and its negative impact in terms of depersonalization and quality.

Keywords: telephonic care; face-to-face care; perceived quality; primary care

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1. Introduction

The pandemic, declared by the WHO on March 11, 2020 due to the rapid expansion of the number of people infected by COVID-19, brought with it a series of recommendations addressed to the state health authorities for the adoption of measures and protocols for the surveillance and control of the disease. In Spain, the adoption of measures by the state authorities materialized in the approval of a Royal Decree of state of alarm on March 14 that implied strict measures of confinement and of paralysis and closure of social and economic activities considered as non-essential (Varela, Briones and González-Cacheda, 2024). Beyond the impact that the pandemic and the measures adopted by the different administrations had on a broad spectrum of social and economic sectors, in the present work we will focus on primary healthcare services. In general terms, we can point out that COVID-19 profoundly altered the functioning of the whole healthcare system. However, the most delicate moment is associated with the first wave of the pandemic. At that point, the level of infections and the saturation of hospital services and ICUs threatened to collapse the whole health system (Varela, Briones and González-Cacheda, 2023).

In this context, care services underwent profound organizational and care changes. In several European countries, as Ares-Blanco et al. (2021:2) point out, "measures were taken that affected health coverage, the financing system, the remuneration of healthcare providers, patient access to tests and care". We should note that the way to access primary care services became telephonic in most European countries, especially in Germany, Belgium, Denmark, Spain, France and Italy (Ares-Blanco et al., 2021). In this way, in Spain, the gateway to the health system changed its accessibility and the way of addressing the demands and needs of patients as a consequence of the epidemiological situation (de Nicolás et al., 2020). Thus, primary care centers reconfigured the model of interaction and service limiting the face-to-face modality as a measure of protection and safety (Martínez-Pillado et al., 2022).

Therefore, to circumvent the limitations imposed on personal interaction, telematic and telephonic systems were established to combine the safety of patients and professionals with the provision of primary care medical services (Vidal-Alaball and Camps-Vilà, 2021; Tranche et al., 2021). Thus, telephone assistance became widespread in Spain[1] and face-to-face care for processes not related to COVID-19 fell drastically, with face-to-face care being maintained for the follow-up of pregnancies or child vaccination. In relation to COVID-19 management, primary care at the beginning of the second wave has played a relevant role in the health systems of the different autonomous communities in Spain. The tasks of traceability, testing and contact study during the pandemic have been assumed by primary care teams, a fact that has had an impact on an increase in the overload of this service (Varela, Briones and González-Cacheda, 2023; Ares-Blanco et al., 2021; Bellmunt et al., 2020).

However, the fatigue, stress and vulnerability evidenced by the primary care system during the COVID-19 pandemic has its root causes in a long and continuous process of precariousness and resource cuts (Heras-Mosteiro et al., 2016). As emphasized by Batalla et al. (2020) the management of the pandemic has confirmed the lack of leadership and vulnerability related to the underfunding of material and human resources aggravated fundamentally as a result of the crisis that began in 2008. The long period of deterioration and cutbacks in health resources between 2009 and 2018 has been referred to by some analysts as the "lost decade" (Amnesty International, 2020). The data illustrating this statement are eloquent: between 2009 and 2018 the public health investment in the state shrank by 11.21%. This trend shows a greater intensity with respect to the investment in primary care, with a drop of 13.10% according to data from the Ministry of Health (Amnesty International, 2020).

In this context, the changes forced by COVID-19 related to the implementation of telematic systems and the expansion of telephone care are considered by some authors as an opportunity to improve entry into the healthcare system. Thus, Tranche et al. (2021) consider that these instruments can potentially be positive for increasing personalization and the time of consultation depending on the situation of each patient. Likewise, Arroyo and Díaz (2021) point out the opportunity to improve the degree of autonomy of remote assistance for people with chronic diseases or in a situation of functional dependence. Similarly, Lamata (2017) highlights the opportunity offered by devices such as mobile phones for home care. According to this research, although remote assistance is not risk-free, its proper management could reduce overloads and reduce travel.

Moreover, in a scenario marked by scarce resources, telemedicine tools have the potential to reduce service costs (Vidal-Alaball et al., 2020). On the other hand, the various modalities of remote care, including telephone care, present the risk of dehumanizing and depersonalizing healthcare because of an increase in social isolation (Fernández et al., 2022; Arroyo and Díaz, 2021), bringing to the forefront the concept of "McDonaldization" of society, coined by Ritzer (1996). Regarding the specific context characterized in the previous lines, Arroyo and Diaz (2021) presuppose a deterioration of quality in primary care assistance by telephone during the COVID-19 pandemic as consequence of the improvisation of changes and the precariousness and stress of health personnel.

We should point out the absence of empirical studies that allow us to know the impact on perceived quality because of the implementation of the telephone interaction model at primary care in Spain during the COVID-19 pandemic. Regarding the scarce published literature we should mention, firstly, Vidal-Alaball and Camps-Vilá (2021)[2]. In this case, the research points to a high degree of patient satisfaction. However, we should bear in mind that such a statement is based on the results of an Internet survey published in a press release. Secondly, we will dwell on the work of Almalky and Alhaidar (2021) who analyze the level of satisfaction with "tele-psychiatry" from the patients' perspective through a questionnaire applied to 141 patients. In this case, the results point to a high level of satisfaction. The research found

[1] The pandemic accelerated the expansion of telephone consultations in primary care services. However, the extension of telephone consultations predates the appearance of COVID-19 (Vidal-Alaball and Camps-Vilà, 2021). As an example, Modroño et al. (2016) point out that 16% of the consultations performed in in 2015, at an urban primary care office were carried out by telephone. After the pandemic, its use has increased in Spain.

[2] In any case, the research points out that telephone consultation is especially recommended in the following cases: "preparation of first face-to-face visits, non-critical updates of medication plans, resolution of doubts about treatments and therapeutic plans, communication of analytical and test results with non-critical results and in follow-up visits" (Vidal-Alaball and Camps-Vilá, 2021: 1).

no relationship between the level of satisfaction and the sociodemographic characteristics among the people consulted. To complete the state of the question, we will point out the research carried out by Zammit et al. (2020) which provides results and conclusions drawn from a questionnaire administered to 100 otorhinolaryngology patients between April and June 2020. These would be the following:

> "This study showed significant improvement in patient satisfaction and an increased telephone consultation preference through the use of a structured consultation model. The potential benefits in terms of infection control and impact on out-patient work-load may see telephone consultations persist in the post-coronavirus era" (Zammit et al., 2020: 1).

In any case, the sample used and the scarcity of research on the subject advise us to take this conclusion with caution. In order to improve our knowledge of this issue, we will develop a research project with a double objective in the following lines:

1. to analyze in a comparative way (by telephone or face-to-face) the level of quality of primary care services and the key factors involved in this perception,
2. to analyze the social and demographic determinants that may influence satisfaction with the telephone consultation and other key factors for the correct interaction in the provision of the service.

In the next section we will get into the different various theoretical and conceptual elements relevant when interpreting and analyzing the data on which this research has been carried out.

2. Public management and public services in the 21st century: conceptual elements

In this section we will address the theoretical and conceptual framework related to our object of study. We consider it necessary to contextualize the research in the exact evolutionary moment of public management paradigms. In this way, we will try to establish a general framework from which to approach and analyze quality in public primary healthcare services. In this regard, it should be recalled that in current public management these types of services are consolidated under the label of *neo-public* models (Denhart and Denhart, 2015; Criado, 2016).

According to Pastor, Sánchez and Mairal (2020: 144), *neo-public* theoretical approaches seek to "democratize public action and recover the identity of governments and public administrations, the essence of their existence as state institutions that exercise public power and manage the interests of society as a whole with the aim of guaranteeing the freedoms and rights of citizens and ensuring social cohesion and inclusion". In addition, according to Belmonte and García (2020), the postulates and the vision of these new management models would seek to dignify the role of public administrations through a return to neo-Weberian guaranteeism combined with various elements of the *new public management* linked to participation, transparency or the incorporation of innovative solutions linked to technology.

If we focus on the idea of a *new public service*, we should point out that this idea is articulated through a new conception and relationship between government, public administration and citizens through the modification of their traditional roles. In this way, the aim is to overcome the vision that establishes the role of clients or the administered of the citizenry in their relationship with public administrations through empowerment and participation. These transformations should not diminish the importance of values such as effectiveness or efficiency in the provision of public services; however, these principles should be articulated under the deliberative, democratic and public interest logics (Osborne, 2020).

It seeks, in short, to enhance the value of public services, even reversing management models based on privatized provision, overcoming traditional and *neo-managerial* models (Belmonte and García, 2020). In any case, the idea of *new public service* presents communicating vessels and similarities with the concept of *servuction* (Oslzak, 2013). This focuses on citizen participation in the design of public services and in the production of public services (Peters and Pierre, 2005). It also focuses on the extension of citizens' rights before the public administration (Criado, 2006). Thus, like *neo-public* currents, the idea of *servuction* has tried to overcome the shortcomings of the classical bureaucratic model, related to procedural hegemony and depersonalization in the provision of services (Ramió, 2017).

Along with these masterful guidelines of the main paradigms of public management, the idea of incorporating quality as an essential approach that places the citizenry in a leading role has been installed in the public sector since the 90s of the 20th century. This quality, as an approach incorporated from the private sectors mainly in the United States under the influence of Japan ("Total Quality"), is precisely—in terms of the constant search for the alignment of public services with citizenship (Mazzucato and Kattel, 2020)—the ultimate cause of the need for research on the perception of quality, in our case focused on telephone care in public health services.

We thus find ourselves in a global context of citizens' demand for quality in public services, as an unavoidable requirement in the current idea of the so-called *new public services* marked by the fact that the relationship between the public sector financing circuit (via taxes), and the return demanded in the form of results and quality is increasingly present—let us recall the validity of the principle of "legitimization by results or performance" (Carrillo, 1996). According to Van Ryzin and Del Pino (2009), citizenship is based, in short, on the understanding that they should receive the same level of quality, care and service as they receive in the modern market for any private service. In fact, today's societies are even more critical of the results generated by public management (Figueroa, 2012), evoking the theory of the multiplier effect of failures in the public sector and the general distrust that they eventually provoke (Downs, 1967).

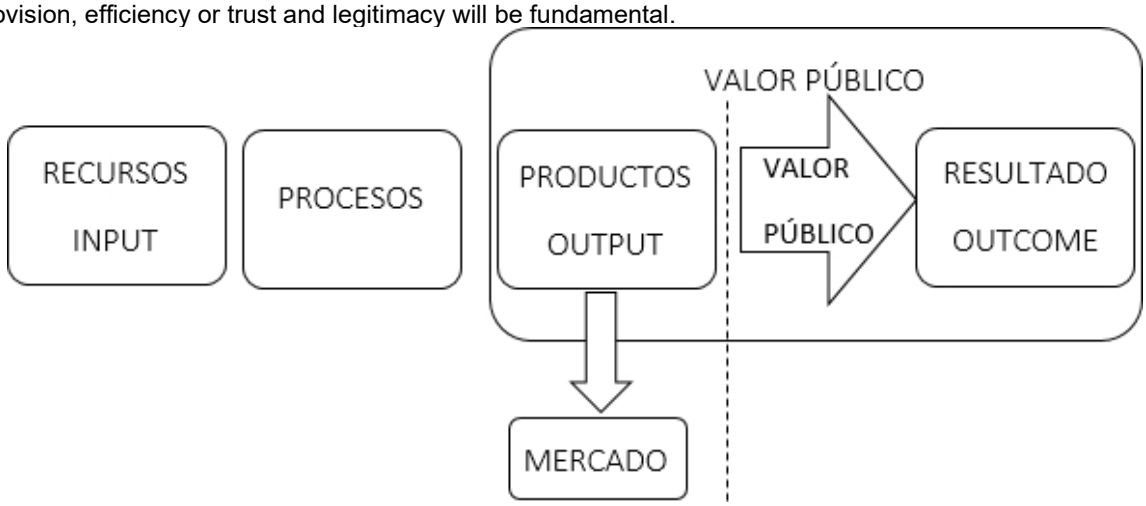
Denhart and Denhart (2015), as pioneers of the concept of the *new public service*, have introduced into the debate the nuance between the idea of serving the citizens and not the "clientele" (transcending the outdated, individualistic and commercialized concept of client, more typical of business marketing) and understanding that the perception of quality concerns all types of people, because the client is society as a whole, and no one can be left behind, as could happen in a private service. In this perspective, following Villoria (1996), if the concept is not adequately adapted to the public framework, we would find ourselves reinforcing a dangerous trend for the democratic system as a whole. This

trend is the destruction of the citizen as the depositary of the duty and right to participate in the essential decisions of the society in which he lives, and its replacement by a mere client or consumer of services generated by the State.

This new conception of public service also introduces the idea that responsibility is not simple and that therefore the point of contact (the "street level bureaucracy") with the citizenry would be the public personnel—in our research mainly health personnel—as the key link in the transmission of quality. Moreover, precisely this new theoretical approach emphasized importance of "human treatment", overcoming the efficiency obsession of the old New Public Management ideology introduced by Hood (1991), which left values such as equity, justice, representation or participation out of the public agenda (Pollit, 2007; Keating, 1997). In this sense, this research tries to offer criteria to health professionals on how to adjust the treatment of health service users, following the idea of adaptability of professionals to users worked by Baltazar and Olimpio (2023) in the field of social services.

Taking advantage of a "window of opportunity" such as the COVID-19 pandemic crisis to consolidate new technologies and new forms of interaction with citizens may not be a bad strategy. In fact, it is one of the ways in which innovation can enter sectors with as much resistance to innovation as the public sector. However, it is important to remember Moore's (2008) central idea that there is no innovation properly speaking if "public value"—defined as the value created by the public administration and the government through services, laws, regulations and other actions—is not provided. In this sense, public value, following Parrado (2023: 23-41), is an end of public institutions, it implies "the merit of what is created and sustained by public administrations on behalf of the general interest" (Parrado, 2023: 25) and has to be taken into account when studying in depth the healthcare models that can be adapted to each country and even to each level of administration (Mateos, 2017).

Precisely, whether or not the telephone service provides this "public value" is, in some way, a central element in this research. And in this measurement, Moore's (2013; 2008) dimensions referring to the achievement of results, quality provision, efficiency or trust and legitimacy will be fundamental.



Public value creation flow. Image extracted from Serra (2014)

However, in the line followed by this study, if what is investigated is the difference between face-to-face and telephone attention, the results, once the existing bibliography has been analyzed, are very scarce, which reinforces the need for this line of research.

At a state level, as a framework object of this research, it is worth mentioning the fact that the State administration has long incorporated the logic of quality in its reports, documents and institutional websites (MPTFP, 2017). In fact, a first intensive bibliographic analysis on the research topic allows us to state that reports on the perception associated with the quality of healthcare received are frequent—Annual reports of the National Health System available online since 1993 (Informes anuales SNS, 2021).

It can therefore be affirmed, based on the series of perception studies available, that in the Spanish case a good valuation is maintained (even at international level according to the Global Health Service Monitor, 2021), along citizen support despite the deterioration linked to the various general crises of the public service system (Guillén and Luque, 2019) and despite the worsening of the service that has been highlighted in the introduction. In addition, healthcare spending itself was prominently the one that citizens pointed out as the most important of all public services (no less than 60% of respondents pointed out this type of service among all, legitimizing its financing) (IEF, 2013).

The Spanish healthcare system was still considered—until very recently—in an international comparative perspective, one of the best in the world; especially if we analyze that public spending is lower than that of the large OECD countries (Schütte, Acevedo and Flahault, 2018; Tandon et al., 2010; Rico, Freire and Gérvas, 2007). The Bloomberg Report goes so far as to rank Spain as the healthiest country in the world (also analyzing lifestyle or eating habits) as shown in the Bloomberg Healthiest Country Index (2019). We will see in the following pages, in a current picture, what impact intense introduction of telephone care in the health service has had on this perception of healthcare quality, which is favorable from the outset but pessimistic for the future (Global Health Service Monitor, 2021). The implementation of telephone care has already been experimented but has received an abrupt and "reactive" acceleration in its implementation with the arrival of the COVID-19 pandemic and the restrictions imposed on face-to-face contact.

2.1. The idea of quality as applied to public health services

Based on the theoretical approach discussed in the previous section and the importance given to the quality of public services, we will specify the idea of quality applied to medical care, although some categories can be observed in similar

studies on quality in social care, such as those of Socías and Andujar (2023). Thus, the concretization of the *servuction* paradigm to the primary care setting would involve the elements that we will describe, and whose result would have an impact on the satisfaction of patients' needs (Román, 2012):

1. Patient participation in the production of the service.
2. The attention of health personnel.
3. The physical support necessary to produce the service.
4. The primary healthcare service as the result of the interaction of the three elements mentioned above.

Having pointed out the above, and following Donabendian (1984), we will try to measure the outcome of primary healthcare services according to the support used. In this way, we will determine the satisfaction and benefits to the patient or to the user (who may not be a patient but a mere user monitoring his physical condition). The previous delimitation of our scope of analysis may be completed based on the ideas of Pedraza et al. (2014) and the considerations of the WHO (2009). The aforementioned works point to the alignment of the quality of public services with factors such as efficiency, institutional perception, final results and, of course, the satisfaction of users' needs based on their expectations (or "extrinsic quality") (Williams, 1994).

In this logic of quality, this article addresses the importance of communication and the support used with service users, shifting the focus from intra-organizational quality (processes, internal structures, procedural flows, etc.) to external quality. To aspects as apparently simple as the fact that the person attended understands what they are told and can be understood by the public professional, who will have to make a greater effort in communication and interaction (Lovell et al., 2022). As Fernández et al. (2022) point out, in their case for the telematic relationship, the difficulty of understanding, technical language or the absence of linguistic options may be some of the barriers that can also be mentioned in the case of telephone care.

In addition to the classic dimensions of the most validated quality questionnaires, it is necessary to point out the impact on expectations and levels of satisfaction of other more "classic" explanatory factors in most statistical analyses, both descriptive and inferential: we refer to factors such as sex, level of education or age of the respondents. Following authors who specialize in studies of the perception of the quality of public services, such as Montaña and Ramírez (2002), we have deemed it necessary to include these factors because of their potential explanatory capacity for the responses analyzed.

However, it is worth mentioning that in addition to the usual biases in any quantitative social research, it is necessary to point out the existence of factors specific to the public sector that determine the construction of citizen perception of public services (Montaña and Ramírez, 2002). Among these, we can point to our own and others' experiences of contact with the service, the different needs or roles played (patient, close relative of a patient, companion...), as well as the general perception of the public, which in the collective imagination is given by a mixture of political actors, the State, public administrations and civil servants in general.

For the transition from approaches articulated through a higher level of abstraction, such as the *new public service* or the concept of *servuction*, to other more empirical approaches related to the perception of quality by primary care patients, it is necessary to refer to instruments of international scope such as the SERVQUAL (Parasuraman et al., 1998) and SERVPERF (Cronin and Taylor, 1994) models. The SERVPERF model implies that the expectations shouldn’t be taken into account, but the user experience should be, and is considered the most appropriate for measuring perceived quality, in addition to providing reliability due to its simplicity to the research, understanding this perception as an evaluative perception of the performance of the attributes of the service (Díaz, 2005: 35). And in the understanding that, as such a service, healthcare is an intangible, which cannot be seen, felt or liked, until we have to make use of it.

In addition, it is important to remember the consensus, both in the previous methodological tools and in the literature on the subject (Pedraza et al., 2014), that quality measurement must be based on a multidimensional approach. This is, therefore, to establish that perceived quality responds to different dimensions, in an aggregation of the same that provide us with a final perception of quality of the users on the healthcare received. These dimensions, some of which are addressed in the SERVPERF questionnaire (Luna-Pérez, 2017) have been adapted to the specific design of our research articulated on a Sociological Research Center (CIS) survey and oriented to specifically know the impact on quality in primary healthcare services of telephone care. Following the multidimensional approach to quality, we have used a series of variables that have their correspondence with the dimensions collected in the SERPERF models pointed out by authors such as Luna-Pérez (2017: 2), and that we will see in detail in the following pages:

- Tangibility: physical facilities, equipment and personnel appearance.
- Reliability: ability to perform the promised service reliably and accurately.
- Responsiveness: willingness to assist customers and provide prompt service.
- Safety: the knowledge and courtesy of the employees and their ability to inspire trust and confidence.
- Empathy: care, individualized attention that the company provides to its customers.

Table 1. Theoretical quality dimensions and study variables

Variables	Description	Quality dimensions
Modality of attention	Modality of medical care.	Tangible element
Overall satisfaction	Level of satisfaction with medical care (last 12 months).	Overall satisfaction
Trust	Confidence and security transmitted by the physician.	Security
Time	Time dedicated by medical staff to each patient.	Responsiveness
Monitoring	Knowledge of medical history and monitoring of health problems.	Reliability
Information	Information received regarding the medical problem addressed.	Responsiveness and empathy
Expression	Telephone medical consultation. The ideas can be expressed as well as in a consultation.	Reliability
Comprehension	Telephone medical consultation. The doctor's instructions can be understood in the same way as in a face-to-face consultation.	Reliability
Telephone satisfaction	Degree of satisfaction with medical consultation by telephone (last 12 months).	Overall satisfaction

Source: own elaboration

Table 1 shows in greater detail the most commonly used and validated dimensions of quality, supported by the SERVQUAL and SERVPERF questionnaires used in our study. In this way, the variables listed in Table 1 correspond to dimensions of analysis addressed in the aforementioned reference models[3].

Having pointed out the main theoretical and conceptual elements related to the ideas of public service and quality, we will try to answer the following research questions related to our object of study and our unit of analysis:

– Are there differences in the perception of quality by users of public primary care services according to the type of consultation received (telephone/face-to-face)?
– What factors related to service delivery could be involved in determining the perceived quality according to the type of consultation received (telephone/face-to-face)?
– Are there social and demographic determinants involved in the perception of quality in telephone healthcare services

3. Materials and methodology

To answer the research questions posed, in the following lines, we have developed an empirical analysis based on the Health Barometer number 3357 (first wave). This cross-sectional study was carried out by the Sociological Research Center (CIS) in collaboration with the Ministry of Health of the Government of Spain. Its "objective is to obtain information on the perception that citizens have of the functioning of the public health system and the impact of measures linked to public health policies, to analyze the knowledge and attitudes of the majority of citizens when faced with health problems" (CIS, 2022: 1). The interviews were carried out by means calls to fixed and mobile telephones, taking as a reference the population of both sexes of legal age residing in Spain. The selection of individuals was carried out through the application of sex and age quotas. To carry out the interviews, a random selection was made, resulting in 33.5% of the interviews being carried out by landline telephone and 66.5% by mobile telephone between March 18 and 25, 2022[4]. The questionnaire, of national scope, has taken 50 provinces and 930 municipalities as sampling points. The first wave of Health Barometer number 3357 is nationally representative, and the results obtained show a cross-section that reflects the situation of the country during the period in which the interviews were carried out. In total, the sample size reaches 2,358 surveys (N=2,358). The sampling error for a confidence level of 95.5% is ±2.1%.

Table 2. Study variables

[3] In any case, we should clarify that the model constructed does not follow the orthodox pattern of the SERVPERF and SERVQUAL models, since it has been based on a CIS survey.

[4] The questionnaire was executed after the peak of the 6th wave of COVID-19 in Spain.

Variable	Description	Values	Min.	Max.
Modality of attention	Modality of medical care.	0=Presential 1=Telephonic	0	1
Overall satisfaction	Level of satisfaction with medical care (last 12 months).	1=Very bad 2=Bad 3=Regular 4=Good 5=Very good	1	5
Trust	Confidence and security transmitted by the physician.	1=Somewhat unsatisfactory 10=Somewhat satisfactory (Scale 1-10)	1	10
Time	Time dedicated by medical staff to each patient.	1=Somewhat unsatisfactory 10=Somewhat satisfactory (Scale 1-10)	1	10
Monitoring	Knowledge of the medical history and monitoring of health problems.	1=Somewhat unsatisfactory 10=Somewhat satisfactory (Scale 1-10)	1	10
Information	Information received regarding the medical problem addressed.	1=Somewhat unsatisfactory 10=Somewhat satisfactory (Scale 1-10)	1	10
Expression	Telephone medical consultation. The ideas can be expressed as well as in face-to-face consultation.	1=Strongly agree 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree	1	5
Comprehension	Telephone medical consultation. The doctor's instructions can be understood the same way as in a face-to-face consultation.	1=Strongly agree 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree	1	5
Telephone satisfaction	Degree of satisfaction with medical consultation by telephone (last 12 months).	1=Very satisfied 2=Satisfied 3=Somewhat satisfied 4=Slightly satisfied 5=Not at all satisfied	1	5
Sex		1=Male 2=Female	1	2
Age		Between 18 and 24 years old Between 25 and 34 years old Between 35 and 44 years old Between 45 and 54 years old Between 55 and 64 years old Between 65 and 98 years old	18	98
Educational level	Educational level attained.	1.-No schooling 2.-Primary education 3.-Secondary education (1st phase) 4.-Secondary education (2nd phase) 5.-Higher education 6.-University studies	1	6

Source: Independent variables: modality, gender, age, educational level; Dependent variables: overall satisfaction, confidence, time, monitoring, information, expression, comprehension, telephone satisfaction.

As can be seen in Table 2, a total of twelve study variables have been selected, eight of which collect information on five and ten-level scales regarding perception and satisfaction with the medical care provided in the primary care service. The first of the variables shown in Table 2 collects dichotomous information on the type of medical care received, telephone or face-to-face. To complete the investigation, three predictor variables have been incorporated to analyze the degree of satisfaction with telephone care in primary healthcare services. As shown in Table 1, the social and demographic variables reflect the gender, age and educational level of the individuals in the study sample.

For the analysis of the information synthesized through the study variables, we will first present various descriptive statistics showing the percentage and measures of central tendency and dispersion related to the models of care and to the perception and satisfaction of the people consulted. In addition, we will show the measures of central tendency and dispersion of the variables that show sociodemographic information of three scale variables that allow us to know the perception and satisfaction with the medical care provided through telephone devices. After that, in order to analyze the relationship between the variables, we will run an ordinal logistic regression model. In this way, firstly, we will calculate the probability to predict the perception and satisfaction of citizens with respect to primary care services according to their typology (telephone and face-to-face). Then, we will analyze and try to predict the levels of satisfaction and perception regarding telephone attention according to age, sex and educational level. Statistical significance was established at a value of $p<0.05$. The Stata 15 package was used for the statistical treatment of the study variables.

4. Research results

In this section we will show the results expressed through the variables described in the previous section. To this end, we will prepare three tables presenting descriptive information. To complete the study, and with the aim of answering the research questions formulated, we will analyze the relationship between the different variables collected in this research.

Table 3. Overall level of satisfaction according to the type of service received (telephone or in person) (%)

	On-site	**By telephone**
Very good	36.6	24.1
Good	50.7	48.5
Regular	11.1	21.3
Bad	1.1	3.8
Very bad	1	2.3

Source: Own elaboration

Table 3 shows a significant difference (12%) in the level of satisfaction in favor of the face-to-face modality regarding the evaluation and degree of satisfaction related to the modalities of healthcare. On the other hand, we can observe a significantly higher figure for the telephone modality for the "regular" response (21.3% vs. 11.1%). For the rest of the levels observed, face-to-face medical care also shows a higher rate of satisfaction. Thus, the proportions shown in Table 3 paint a picture that is significantly more favorable to face-to-face medical care.

Table 4. Evaluation (Likert scale) of several key variables (trust, time, monitoring, information) of medical care as a function of modality (telephone and face-to-face) (%)

	Trust		Time		Monitoring		Information	
	Face	Tel	Face	Tel	Face	Tel	Face	Tel
1 (Totally unsatisfactory)	1.61	4.82	2.37	4.17	2.80	4.65	1.94	4.98
2	0.97	1.77	1.94	4.17	1.08	2.57	1.08	2.25
3	1.18	1.77	2.26	7.06	2.15	2.57	1.72	2.41
4	1.83	3.69	4.84	9.15	3.33	7.38	2.58	4.33
5	5.59	7.06	8.92	13.80	7.85	9.79	6.24	10.27
6	6.34	9.79	9.14	13.96	8.28	12.52	8.17	11.72
7	11.61	16.69	15.70	13.16	10.75	16.69	13.66	16.85
8	22.26	20.55	22.69	17.98	23.33	19.42	22.26	21.19
9	20.65	16.21	13.66	7.38	16.24	11.72	17.31	12.20

10 (Totally satisfactory)	27.96	17.66	18.49	9.15	24.19	12.68	25.05	13.80

Source: Own elaboration. Face: Face-to-face. Tel: Telephone.

Similarly, Table 4 shows a higher degree of satisfaction with the face-to-face medical consultation modality. This fact can be observed through the values of four variables that allow us to evaluate and compare the quality of face-to-face and telephone medical care service. In the first place, the people attended in person say they feel a greater level of confidence. Furthermore, in relation to the time invested in providing the medical service, the perception of those attended in person is again more positive than that of those contacted by telephone. The tendency is confirmed by observing the values collected through the variables that inform us about the follow-up and monitoring of health problems and the quality of the information received in the medical consultation. As can be seen in Table 3, this difference is evident for the four variables analyzed, especially in the extreme levels of the scale measuring citizen satisfaction.

Table 5. Ordinal logistic regression

Modality of attention					
	Coef	SD	Z	95% CI	
Overall satisfaction	0.72***	0.10	7.24	0.52	0.92
Trust	-0.65***	0.09	-7.04	-0.83	-0.47
Time	-0.88***	0.09	-9.51	-1.06	-0.70
Monitoring	-0.72***	0.09	-7.88	-0.90	-0.54
Information	-0.72***	0.09	-7.85	-0.90	-0.54

Source: Own elaboration. Independent variable: modality of care; Dependent variables: overall satisfaction, trust, time, monitoring, information, expression, understanding.
* p<0.05; ** p<0.01; *** p<0.001

To complete the comparative analysis related to the perception and quality of face-to-face and telephone medical care, Table 5 shows the results of the ordinal logistic regression analysis performed. The data showing the relation between the study variables allow us to predict a higher rate of overall explicit and implicit satisfaction (trust, time, monitoring, information) among those who receive face-to-face medical care. The results show a statistically significant level for the five dependent variables analyzed (see Table 5).

Table 6. Evaluation of interaction and satisfaction with telephone medical consultation as a function of various sociodemographic variables.

	Expression					Comprehension					Satisfaction				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sex															
Mean	1.5	1.5	1.5	1.6	1.5	1.5	1.6	1.6	1.6	1.6	1.5	1.6	1.6	1.6	1.5
p50	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1
SD	0.5	0.5	0.5	0.5	0.5	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
iqr	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Age															
Mean	53.6	51.6	53.2	50.4	46.5	51.9	50.3	61.3	50.7	47.4	53	50.7	48.2	50.6	52.1
p50	54	52	49	51	45	52	51	63	51	47	53	51	48	49	52
SD	14	16	16.8	16.5	15.7	14.9	15.6	17.6	16.9	15.9	14.9	15.8	16.3	16.9	16.3
iqr	21	24	32	25	24	22.5	24	26	26	21	22	22.5	25	28	23.5
Educational level															
Mean	4.6	4.5	4.7	4.5	4.9	4.7	4.6	4.4	4.5	4.7	4.5	4.7	4.7	4.5	4.4
p50	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
SD	1.4	1.4	1.4	1.4	1.3	1.4	1.4	1.5	1.5	1.3	1.5	1.4	1.4	1.4	1.4
iqr	2	3	2	3	2	2	2	3	3	2	3	2	2	3	3

Source: Own elaboration

With respect to the relationship between the sociodemographic variables examined with the degree of satisfaction

with telephone care and the key elements for the correct provision of health services linked to expression and comprehension, no major differences are observed in Table 6, which shows various descriptive statistics. In this way, we can see a similar level with respect to the capacity for expression and comprehension between men and women who received medical care over telephone. Similarly, the perception regarding the quality of service is similar for both sexes. The tendency noted regarding the relationship between sex and the three dependent variables observed is repeated for the educational variable. Thus, no significant differences are observed according to the level of education attained. Finally, we can observe that younger people show greater difficulty in understanding and expressing themselves in medical consultations made by telephone. This difference with respect to age is reduced for the variable that reflects the level of satisfaction with telephone medical care (see Table 6).

Table 7. Ordinal logistic regression

	Expression					Compression					Satisfaction				
	Coef	SD	Z	95% CI		Coef	SD	Z	95% CI		Coef	SD	Z	95% CI	
Sex	0.03	0.11	0.28	-0.1	0.2	0.02	0.11	0.79	-0.1	0.2	-0.00	0.10	-0.0	-0.2	0.2
Age	-0.1*	0.00	-3.44	-0.0	0.0	-0.00	0.00	-1.90	-0.0	0.0	-0.00	0.00	-1.7	-0.0	0.0
Edu	0.02	0.04	0.57	-0.0	0.1	-0.07	0.04	-1.86	-0.1	0.0	-0.07	0.04	-1.8	-0.1	0.0

Source: Own elaboration. Independent variables: sex, age, educational level; Dependent variables: expression, comprehension, satisfaction.
* p<0.05; ** p<0.01; *** p<0.001

As can be seen in Table 7, the ordinal logistic regression analysis performed shows only a statistically significant relationship between the variables age and expression. Thus, we can predict only a higher probability of dissatisfaction among younger people when expressing their views and needs in primary healthcare services performed through telephone consultation.

5. Discussion

The present research has been structured and articulated through a double objective. First, we have tried to investigate and analyze in a comparative way, the quality and the key factors that configure the citizen perception of the provision of primary care medical consultation services in person and by telephone. Secondly, we have addressed the social and demographic factors that may influence the level of satisfaction with the telephone healthcare model. Through the determination of these objectives, the research seeks to improve knowledge in an area that has been scarcely explored in the field of public management. The main findings point to a series of limitations and challenges for the implementation of new forms of medical care in primary care linked to information and communication technologies. Furthermore, it is relevant to point out that the results of the present research contradict the statements presented in the scarce and limited research related to our object of study published to date (Almalky and Alhaidar, 2021; Vidal-Alaball and Camps-Vilá, 2021; Zammit et al., 2020).

With respect to the first research question, the data presented in the study show, in general terms, a drop in the quality of medical care provided by telephone devices. Thus, the descriptive statistics in Table 3 show a comparative drop of 12 points in the most positive evaluation to the detriment of telephone medical care. The increase in dissatisfaction can be seen in the increase of more than 10% in the number of people who rate the care received over the telephone as average. The tendencies shown by the descriptive statistics are confirmed by the results associated with the ordinal regression analysis performed. It is sufficient to observe the statistically significant figures for the overall satisfaction variable analyzed according to the type of medical care. These results allow us to predict a higher level of satisfaction among people who are attended in person. Contrary to the results presented by Almalky and Alhaidar (2021), Zammit et al. (2020) and Vidal-Alaball and Camps-Vila (2021), in which telephone care is linked to a high level of satisfaction among individuals, we can affirm that this modality of medical care has a negative impact on the quality perceived by the citizens who go to their primary care center.

To specify the specific factors that can negatively impact perceived quality, we have tried to answer the second research question. To this end, we have started from the association and linkage of the study variables that make up our model with the items that make up the SERPERF model (Luna-Pérez, 2017; Cronin and Taylor, 1994). First, we should observe how the variable trust appears related to the modality of care received. The results allow us to predict a higher level of trust among patients attended in person. Thus, telephone medical care in primary care services would be less able to transmit security and trust to users. In the same sense, the perception of the duration of the medical consultation time is greater among those who receive face-to-face care. Thus, the time variable, related to the responsiveness of primary care services, appears to be associated with face-to-face care. Thirdly, the variable analyzed collects information on the monitoring and knowledge of the patient's medical history. In this case, the statistical tests performed allow us to predict a higher level of satisfaction among patients attending the medical center. These findings show a greater erosion in the reliability transmitted by telephone medical care services. Finally, the information received by patients is more likely to be of lower quality among those seen by telephone. These results suggest a negative impact on service delivery in terms of empathy and responsiveness.

The negative impact of telephone care shown by the variables that make up the model results in a drop in the perceived quality of primary care services in each of the SERPERF model dimensions analyzed (Luna-Pérez, 2017). In the same way, the overall satisfaction variable presents more discrete values for the telephone care modality. By observing the data and indicators, we can conclude that the modality through which medical care is provided matters in primary care services. In this case, far from bringing "public value" (Moore, 2008) in terms of quality, efficiency, trust and legitimacy, this innovation extended more intensively in wake of the COVID-19 pandemic, seems to be degrading healthcare services in terms of quality, reducing responsiveness, levels of trust, safety, empathy and reliability. Beyond the COVID-19 context, the increase in telephone consultation in primary care seems to be a response linked to the deterioration that health services have been suffering since the economic and financial crisis of 2008. The precariousness and underfunding in terms of financial and human resources suffered throughout the "lost decade" (Amnesty International, 2020; Batalla et al., 2020) has given rise to innovations, such as telephone consultation, which allow professionals and public organizations to "muddle through" (Lindblom, 2010), neglecting the quality of public services and leaving citizen satisfaction levels in the background.

The findings and results we have been discussing place primary care services in the opposite direction to the dynamics and characteristics established prescriptively by the theories linked to the *new public services* (Belmonte and García, 2020) or by the concept of *servuction* (Oslzak, 2013). Although telephonic devices contributed to maintaining health services in a context of physical distancing as a consequence of COVID-19, their expansion and generalization could be aggravating the depersonalization features that characterize the classic bureaucratic model on which public organizations and services are hegemonically based. On the other hand, the implementation of telephone assistance in primary care services cannot be disassociated from the economic vision linked to the new public management through which the cutback of public services resources during the "lost decade"[5] was managed. On the basis of the data handled, the implementation of telephone care services carried out in Spain should be radically rethought based on the reinforcement of primary care systems in terms of human resources, while intelligently introducing information and communication technologies, trying to take advantage of the opportunities they offer to improve quality, efficiency, efficacy and effectiveness, fleeing from economistic simplifications (Brugué, 2022; Ramió, 2022). As Arroyo and Díaz (2021) point out, telephone and digital devices can contribute to increasing the degree of autonomy and assistance to certain groups. Furthermore, as Lamata (2017) points out, although remote assistance involves risks, telephone devices could help reduce travel and certain overloads.

Finally, and in connection with the second objective of our research, we found a similar level of satisfaction with telephone consultation regardless of age, sex or educational level. The results are consistent with the findings presented by Almalky and Alhaidar (2021) and could be related to the level of maturity and complexity of telephone technology. Unlike digital communication and information technologies, which are more complex and recent, the use of the telephone as a mass communication tool dates back to a longer period of time. To complete the analysis of the association between sociodemographic characteristics and the level of satisfaction with the telephone consultation, we focused on two variables that contributed to explaining performance in the interaction established between doctor and patient in primary healthcare services: expression and comprehension. In this case, the statistical analysis performed shows that younger people show a higher degree of limitation of the telephone channel as a means of expressing their ideas compared to the face-to-face consultation modality.

The main limitation of this research is associated with the specific context in which the fieldwork for the elaboration of the Health Barometer 3357 was carried out. The interviews were conducted after the peak of the 6th wave of the COVID-19 pandemic. The circumstances related to that context and its counter-intuitive results may have conditioned the response of the people consulted. To overcome the aforementioned limitation, we consider it necessary to deepen the object of study addressed through future research. On the other hand, the findings linked to the sex variable present the limitations intrinsic to the binary method through which this category was constructed in the questionnaire implemented by the CIS.

6. Conclusion

The findings of the present study show a loss in the quality of telephone consultations in primary care services compared to face-to-face consultations. The people consulted report a lower level of general satisfaction when they are attended over the telephone. In addition, the perception of the citizens consulted indicates a drop in the levels of trust and a degradation in terms of medical consultation time, monitoring and follow-up, and information received. Following the SERPERF model, it can be concluded that the expansion of telephone consultation has a negative impact on levels of safety, reliability, empathy and responsiveness. These results may have an impact on an increase in depersonalization in the provision of public health services. In general terms, the sociodemographic variables used to study the level of satisfaction with the telephone consultation do not allow us to make predictions based on sex, age or educational level. However, we found a higher level of dissatisfaction in terms of communicative expression among younger people. We consider that the analysis and interpretation of this finding should be addressed through future research.

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[5] It should be recalled that the antecedents of the implementation of telephone consultation predate the pandemic. On the other hand, the end of the pandemic, far from marking an end to it, has led to an increase in this modality of medical care.

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