

Social Control as a Catalyst for Perceived Quality in Public Health: An Empirical Study in Bolivia.

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Abstract

In the Bolivian context, marked by the ineffectiveness of traditional control mechanisms in the social security system, this study examines the impact of social control as an innovative approach. The research focuses on an empirical analysis conducted in 2010 at Hospital Materno Infantil of Caja Nacional de Salud in La Paz, Bolivia, to determine whether this strategy had improved the quality of care perceived by outpatients since its implementation in 2004. The study used a non-experimental, cross-sectional design with retrospective assessment of perceived change and a mixed-methods approach integrating a quantitative phase – a survey of 57 insured patients affiliated with Caja Nacional de Salud and treated at Hospital Materno Infantil before 2004 – and a qualitative phase – a two-session interview with one representative of the mechanism.

The study tested the hypothesis that perceived quality had improved significantly since 2004. Perceived quality was modeled in two components – medical and non-medical/administrative – each comprising its respective dimensions, with the models of Avedis Donabedian (1987) and Parasuraman et al. (1985) serving as the principal conceptual references. This approach and the definition of healthcare-quality dimensions align with the recommendations of the Council of Europe for Quality of Care (1997). The evaluation measured and weighted these dimensions and contrasted the results with a control question. Quantitative results showed notable and statistically significant improvements in dimensions such as personal treatment, equity, and respect. However, perceived efficiency and adequacy deteriorated, attributed to system overload. The difference between the negative weighted sum of the dimensions and the positive control-question result reinforces existing literature describing service quality as a subjective and prioritized construct in which users do not value all attributes equally. The qualitative interview contextualized the observed patterns and related them to the activities of the Social Control Mechanism at the hospital.

The mechanism can contribute to quality improvement in complex environments by acting as a communication bridge and catalyst for co-responsibility, promoting timely information, feedback, and consensual solutions.

Introduction

The complexity inherent in modern organizations requires the implementation of rigorous control mechanisms that ensure efficiency and quality in service provision. Service quality has been recognized as a critical factor for the competitiveness and sustainability of any organization and in the context of public health, its importance is heightened.

In Bolivia, particularly in institutions with a significant social impact like Caja Nacional de Salud (CNS), the healthcare quality transcends mere management; the perception of value is intrinsically linked to the well-being and integrity of the insured's life, as any deficiency can have direct and fatal consequences.

Historically, the traditional administrative control mechanisms implemented at Hospita Materno Infantil-CNS have proven ineffective in solving systemic deficiencies. These mechanisms, often perceived as arbitrary and unrepresentative, fail in service sectors with multiple stakeholders, where key information is not effectively shared, perpetuating a cycle of dissatisfaction and systemic deficiencies.

In this context, the New Political Constitution of the State (CPE) of 2009 recognizes an innovative approach: social control. This mechanism seeks to empower organized civil society to actively participate in the oversight of public management and service quality. This study focuses on analyzing the effectiveness of social control at Hospital Materno Infantil in La Paz, Bolivia, with the aim of determining whether this new approach has succeeded in tangibly improving the quality of care perceived by outpatients in 2010 since its implementation in 2004.

The main contribution of this research is the empirical evaluation of this mechanism in a critical and sensitive environment. Unlike purely theoretical studies, this work offers a practical evaluation of a constitutional change in public health management. The analysis seeks to determine whether citizen participation, institutionalized under the social control model, translates into a real and measurable improvement, providing a crucial perspective on the viability and impact of participatory governance in optimizing essential services for the population.

Methodology

This research used a mixed-methods approach structured in two interdependent phases: quantitative and qualitative. The study adopted a non-experimental, cross-sectional design, with retrospective assessment of perceived change and an exploratory-descriptive scope, together with an analytical component oriented toward hypothesis testing. The quantitative unit of analysis consisted of insured outpatients; the qualitative phase included a representative of the Social Control Mechanism as a key informant. The main hypothesis proposed that, according to the retrospective assessment conducted in 2010, patients' perceived quality had improved significantly since the mechanism's implementation in 2004.

Quantitative Phase

Quality Modeling

To facilitate its study and understanding, perceived quality was modeled in two components: medical and non-medical/administrative, summarized in Tables 1 and 2, respectively. The selection and organization of the dimensions were grounded in a broad review of general quality models and healthcare quality frameworks, with the contributions of Donabedian (1987) and Parasuraman et al. (1985) serving as the principal conceptual references.

- **Medical component:** Refers to the direct contact of the physician with the patient, covering aspects such as professional competence, empathy, and the quality of diagnosis and treatment.
- **Non-medical/administrative component:** Refers to the patient's contact with the non-medical factors of the organization, also called administrative, because most of their components depend on the hospital's administration. This includes

infrastructure, waiting times, communication with administrative staff, and system efficiency.

Dimension	Description
Effectiveness	The physician performs medical procedures or treatments to solve the patient's problems.
Efficiency	The physician provides medical care to a maximum number of comparable care outpatients.
Technical competence	The physician's ability to use their knowledge to provide solutions to the outpatient's problems.
Equity	Elimination of differences regarding access to the room.
Adequacy	The benefits received in care outweigh the risks, inconveniences, and costs.
Acceptability	Care provided to satisfy the outpatient's expectations.
Availability and quality of information	Providing access to information requested by the outpatient in a clear and understandable manner.
Respect	The ability to delegate self-determination to the outpatient in certain individual options, in addition to the consideration that the outpatient has intrinsic value.
Tolerance	"The physician's consideration for the outpatient's social, ethnic, cultural, and religious diversity."
Empathy	The physician's ability to put themselves in the outpatient's situation.
Safety	Avoiding harm to outpatients derived from care and/or treatment.

Table 1: Medical Component

Dimension	Description
Effectiveness	The procedures performed by the administration to meet the outpatient's needs.
Efficiency	Adequate care for the largest number of outpatients at the lowest possible cost.
Accessibility	Ease of obtaining appointments by outpatients.
Technical competence	The administration's ability to provide adequate medical care.
Equity	Elimination of differences regarding access to appointments.
Adequacy	The capacity of the physical environments and personnel resources to be suitable for outpatient care.
Respect	The ability of non-medical staff to delegate self-determination to the outpatient in certain individual options, in addition to the consideration that the outpatient has intrinsic value.
Tolerance	"The consideration of non-medical staff for the outpatient's social, ethnic, cultural, and religious diversity."
Information	The staff's ability to provide clear and timely information.

Table 2: Administrative Component

Instrument and Procedure

Survey

In 2010, a non-probability sample of insured outpatients was used. To reduce selection bias, recruitment was planned around outpatient schedules and conducted as patients exited the different specialties; the order of visits was determined at random, and each specialty was covered at least once. To be eligible, participants had to state that they were affiliated with Caja Nacional de Salud and had received care at Hospital Materno Infantil before 2004, enabling them to retrospectively assess perceived changes. The questionnaire was personally administered at the consultation exit to patients who stated that they met these criteria and verbally agreed to respond.

The target sample size was calculated for a finite population of 313 patients seen on an average day, using a 90% confidence level, a 10% margin of error, and maximum heterogeneity ($p = q = 0.50$). The calculation yielded a target of 57 participants, which was achieved. Because recruitment was non-probabilistic, these parameters served as planning references rather than as an estimate of the sample's effective precision. Participation was voluntary and the questionnaire was completely anonymous; no identifiers, medical records, individual clinical data, or sensitive information were collected.

To measure perceived quality, a five-point Likert-scale opinion questionnaire was designed. The questionnaire operationalized the dimensions described in Tables 1 and 2 through 50 statements derived from the matrix constructed from the theoretical review. In addition, it included a direct control question to assess the consistency of the results obtained.

Weighting

Each response option on the Likert scale was weighted with a numerical value as shown in Table 3 to quantify the change in perceived quality.

The value "0" was assigned as the point of origin for "No change," while positive and negative responses were weighted with values of 0.5 and 1, and -0.5 and -1, respectively, to reflect the magnitude of the perceived change.

Change Valuation	Numerical Value
Worsened significantly	-1
Worsened relatively	-0.5
No change	0
Improved relatively	0.5
Improved significantly	1

Table 3: Weighting

Differential

A weighted differential method was used. The calculation is expressed by the following identity, where Δ represents the differential of the perceived change:

$$\Delta = \Sigma \text{ of weighted change valuations}$$

Where:

- $\Delta > 0$ indicates that perceived quality improved.
- $\Delta = 0$ indicates that there was no change.
- $\Delta < 0$ indicates that perceived quality worsened.

Statistical Analysis

Subsequently, descriptive statistics were used to obtain the mean and standard deviation of the responses for each of the 50 statements, calculated using a weighted average. Next, an inferential statistical analysis was applied to test the hypothesis. A One-Sample T-test was used to compare the mean of each statement with a reference value (μ) of 0, which represents the null hypothesis of "no change." A significance level of $p < 0.05$ was established, with 56 degrees of freedom. A statement was considered statistically significant if the absolute value of its t-value was greater than the critical value of 2.003, which would indicate that the perceived change was significantly different from zero.

Qualitative Phase

In the qualitative phase, representatives of the medical and administrative sectors and of the Social Control Mechanism were invited to participate. No formal response was received from the first two sectors, and only one representative of the mechanism participated. An interview with this key informant was conducted in two sessions. In the first, before the quantitative results were introduced, the mechanism's origins, operation, functions, and activities were documented. In the second, after the survey results had been processed, targeted questions explored the relationship between those activities and the observed patterns. Both sessions were transcribed in the original study and were used to contextualize and interpret the quantitative findings.

Results

The results show statistically significant improvements in certain aspects and a deterioration in others, in both the medical and administrative components.

Perceived Quality in the Medical Component

The evaluation of the quality perceived by outpatient patients at Hospital Materno Infantil showed a positive and statistically significant change in the perception of patients in most of the statements.

The most notable findings are positive changes in:

- **Effectiveness and Technical Competence:** An improvement was perceived in the consultation's orientation, physicians' ability to provide solutions, and staff's knowledge of their work.
- **Equity:** Patients perceived fairer treatment from physicians and greater privacy in the consultation.
- **Respect:** Patients noticed a marked improvement in the "peer-to-peer" relationship with physicians, in the privacy of the consultation, as well as greater tolerance from physicians towards the culture, religious beliefs, and social position of the patients.

However, despite these improvements, the perception of quality worsened in a statistically significant way in the following areas:

- **Efficiency:** The waiting time for the consultation and the time needed to solve problems were perceived as worse.

- **Adequacy:** The satisfaction of needs in the consultation and the detailed explanation of the treatment showed a significant deterioration.
- **Respect (Negative aspects):** The physician's willingness to listen to the patient and the ability to choose between possible treatments were perceived as less favorable.

Perceived Quality in the Administrative Component

The analysis of the administrative component yielded mixed results, with significant changes, both positive and negative. Patients perceived significant positive changes in:

- **Equity and Adequacy:** An improvement was observed in the appointment request process, as well as in the hospital's infrastructure and the cleanliness of the environments.
- **Accessibility and Respect:** An improvement was perceived in the relationship with non-medical staff and in the information provided about the location of services.
- **Tolerance:** A statistically significant improvement was found in the administrative staff's tolerance towards the culture and social position of the patients.

However, significant negative changes were identified in critical areas of administrative management:

- **Effectiveness and Efficiency:** Patients perceived a deterioration in the hospital's management by the administration to meet their needs, the ability to offer quality care to the largest number of patients possible, and the availability of the specialties they needed.

- **Accessibility and Technical Capacity:** The possibility of accessing service hours and the general capacity of the administration to manage the hospital were perceived as deficient.

Finding from the Control Question

Despite the negative total weighted sum of the findings in the medical and administrative variables indicating a general deterioration in the perception of quality, this result contrasts with the control question, which showed a positive value in the perceived change.

The results of the survey data are presented below:

- Table 4 shows Total weighted change in perceived quality.
- Table 5 shows the result of the control question to analyze perceived quality.
- Table 6 shows the results of the medical component responsible for perceived quality.
- Table 7 shows the administrative component and its respective dimensions.

Medical Component Weighted total change.	4,13
Administrative weighted total change.	-6,75
Total Weighted Change	-2,63

Table 4: Total Weighted Change in Perceived Quality

Perceived Quality	Statement	Distribution of Responses by Option										Total		$\bar{x}$	s	t	Significance	Total Change
		-1		-0,5		0		0,5		1								
		Total	%	Total	%	Total	%	Total	%	Total	%	Total	%					
	The quality of care at the hospital.	4	7,02%	11	19,30%	13	22,81%	17	29,82%	12	21,05%	57	1	0,19	0,61	2,39	Significant	11

Table 5: Control Question Results

Dimension	Statement	Distribution of Responses by Option										Total		$\bar{X}$	S	t	Significance	Total Change	Σ by dimension
		-1		-0,5		0		0,5		1									
		Total	%	Total	%	Total	%	Total	%	Total	%	Total	%						
Effectiveness	Consultation's focus on solving my problem.	7	12,3%	4	7,0%	19	33,3%	11	19,3%	16	28,1%	57	100%	0,22	0,65	2,53	Significant	12,5	8,50
	Addressing issues that do not solve my problem.	8	14,0%	5	8,8%	23	40,4%	12	21,1%	9	15,8%	57	100%	0,08	0,61	0,98	Not significant	4,5	
Efficiency	The time needed to solve my problem.	28	49,1%	12	21,1%	14	24,6%	2	3,5%	1	1,8%	57	100%	-0,56	0,51	-8,32	Significant	-32	-21,50
	The doctor's attention to the highest number of patients possible	17	29,8%	6	10,5%	20	35,1%	10	17,5%	4	7,0%	57	100%	-0,19	0,64	-2,28	Significant	-11	
Technical competency	The doctor's ability to provide solutions to my problem.	7	12,3%	5	8,8%	13	22,8%	11	19,3%	21	36,8%	57	100%	0,30	0,69	3,25	Significant	17	13,67
	The doctors' knowledge regarding their work.	3	5,3%	6	10,5%	20	35,1%	2	3,5%	26	45,6%	57	100%	0,37	0,64	4,32	Significant	21	
	The doctors' sufficient knowledge to identify my problem.	10	17,5%	7	12,3%	17	29,8%	13	22,8%	10	17,5%	57	100%	0,05	0,67	0,60	Not significant	3	
Equity	Equitable time for each patient consultation.	4	7,0%	9	15,8%	27	47,4%	6	10,5%	11	19,3%	57	100%	0,10	0,57	1,28	Not significant	5,5	8,63
	The granting of privileges to some people from the waiting room to enter the consultation.	6	10,5%	9	15,8%	14	24,6%	7	12,3%	21	36,8%	57	100%	0,25	0,70	2,64	Significant	14	
	Differential treatment by the doctors during the consultation.	12	21,1%	3	5,3%	8	14,0%	25	43,9%	9	15,8%	57	100%	0,14	0,69	1,53	Not significant	8	
	Compliance with the sequence of assigned numbers to enter the consultation.	12	21,1%	5	8,8%	13	22,8%	11	19,3%	16	28,1%	57	100%	0,12	0,75	1,24	Not significant	7	
Adequacy	The expenses I made to receive the benefits of the consultation.	32	56,1%	15	26,3%	5	8,8%	3	5,3%	2	3,5%	57	100%	-0,63	0,53	-8,99	Significant	-36	-16,00
	The waiting time to receive the benefits of the consultation.	29	50,9%	7	12,3%	12	21,1%	6	10,5%	3	5,3%	57	100%	-0,46	0,64	-5,49	Significant	-26,5	
	The risks face receiving the consultation.	6	10,5%	4	7,0%	21	36,8%	7	12,3%	19	33,3%	57	100%	0,25	0,66	2,93	Significant	14,5	
Acceptability	Fulfillment of my needs during the consultation.	23	40,4%	9	15,8%	17	29,8%	5	8,8%	3	5,3%	57	100%	-0,39	0,61	-4,76	Significant	-22	-9,50
Availability and quality of information	The detailed explanation by the doctor regarding my treatment plan.	2	3,5%	19	33,3%	29	50,9%	4	7,0%	3	5,3%	57	100%	-0,11	0,42	-2,04	Significant	-6,5	
	The mention of the possible options I have for my treatment.	13	22,8%	4	7,0%	26	45,6%	8	14,0%	6	10,5%	57	100%	-0,09	0,62	-1,07	Not significant	-5	
	The explanation of my health status using simple, common terms by the doctor.	12	21,1%	2	3,5%	31	54,4%	7	12,3%	5	8,8%	57	100%	-0,08	0,58	-1,03	Not significant	-4,5	
Respect	The doctors' willingness to listen and answer my questions.	12	21,1%	10	17,5%	17	29,8%	13	22,8%	5	8,8%	57	100%	-0,10	0,63	-1,16	Not significant	-5,5	-6,42
	The doctors' willingness to listen to my point of view.	21	36,8%	16	28,1%	12	21,1%	3	5,3%	5	8,8%	57	100%	-0,39	0,62	-4,77	Significant	-22,5	
	My choice among the possible treatments.	35	61,4%	9	15,8%	4	7,0%	6	10,5%	3	5,3%	57	100%	-0,59	0,63	-7,07	Significant	-33,5	
	A peer-to-peer relationship with the doctors.	5	8,8%	3	5,3%	16	28,1%	9	15,8%	24	42,1%	57	100%	0,39	0,65	4,50	Significant	22	
	The doctors' adherence to their consultation schedule.	23	40,4%	8	14,0%	15	26,3%	2	3,5%	9	15,8%	57	100%	-0,30	0,72	-3,11	Significant	-17	
	Privacy during the consultation	4	7,0%	5	8,8%	17	29,8%	13	22,8%	18	31,6%	57	100%	0,32	0,61	3,91	Significant	18	
Tolerance	"Tolerance shown by doctors towards my habits, customs, religious beliefs, or social class."	4	7,0%	7	12,3%	9	15,8%	17	29,8%	20	35,1%	57	100%	0,37	0,63	4,41	Significant	21	21,00
Empathy	The doctors' interest in my health problems.	10	17,5%	4	7,0%	23	40,4%	2	3,5%	18	31,6%	57	100%	0,12	0,72	1,30	Not significant	7	5,75
	The doctors' careful attention without causing harm to my health.	9	15,8%	6	10,5%	19	33,3%	13	22,8%	10	17,5%	57	100%	0,08	0,65	0,92	Not significant	4,5	
Weighted total change.																			4,13

Table 6: Medical Component Results

Dimension	Statement	Distribution of Responses by Option										Total		$\bar{X}$	s	t	Significance	Total Change	Σ by dimension
		-1		-0,5		0		0,5		1									
		Total	%	Total	%	Total	%	Total	%	Total	%	Total	%						
Effectiveness	The administration's management of the hospital to meet my needs.	27	47,37%	11	19,30%	13	22,81%	2	3,51%	4	7,02%	57	100%	-0,48	0,61	-5,95	Significant	-27,5	-27,50
Efficiency	The hospital's quality care for the highest possible number of patients.	16	28,07%	2	3,51%	31	54,39%	5	8,77%	3	5,26%	57	100%	-0,20	0,57	-2,66	Significant	-11,5	-11,50
Accessibility	Consultation hours accessibility.	33	57,89%	12	21,05%	6	10,53%	4	7,02%	2	3,51%	57	100%	-0,61	0,56	-8,29	Significant	-35	-3,17
	The process of obtaining a consultation number.	1	1,75%	2	3,51%	5	8,77%	18	31,58%	31	54,39%	57	100%	0,67	0,46	11,03	Significant	38	
	Availability in the specialty I need.	8	14,04%	22	38,60%	19	33,33%	3	5,26%	5	8,77%	57	100%	-0,22	0,54	-3,05	Significant	-12,5	
Technical Competence	The administration's capability to manage the hospital.	27	47,37%	8	14,04%	4	7,02%	16	28,07%	2	3,51%	57	100%	-0,37	0,70	-3,99	Significant	-21	-21,00
Equity	The granting of unjustified privileges when obtaining a consultation number.	3	5,26%	7	12,28%	31	54,39%	6	10,53%	10	17,54%	57	100%	0,11	0,53	1,64	Not significant	6,5	6,50
	Differential treatment when obtaining a consultation number.	10	17,54%	4	7,02%	19	33,33%	11	19,30%	13	22,81%	57	100%	0,11	0,68	1,26	Not significant	6,5	
Adequacy	The availability of necessary materials in the consultation room for my care.	3	5,26%	12	21,05%	20	35,09%	15	26,32%	7	12,28%	57	100%	0,10	0,54	1,35	Not significant	5,5	7,50
	The environments where medical care is provided.	2	3,51%	5	8,77%	17	29,82%	9	15,79%	24	42,11%	57	100%	0,42	0,59	5,40	Significant	24	
	The hospital's physical capacity to receive patients.	9	15,79%	6	10,53%	12	21,05%	17	29,82%	13	22,81%	57	100%	0,17	0,68	1,84	Not significant	9,5	
	The hospital's general cleanliness conditions.	12	21,05%	7	12,28%	5	8,77%	23	40,35%	10	17,54%	57	100%	0,11	0,72	1,11	Not significant	6	
	The required number of doctors per specialty.	5	8,77%	7	12,28%	38	66,67%	3	5,26%	4	7,02%	57	100%	-0,05	0,45	-0,88	Not significant	-3	
	The variety of available hours for medical care.	7	12,28%	1	1,75%	33	57,89%	11	19,30%	5	8,77%	57	100%	0,05	0,51	0,77	Not significant	3	
Respect	The non-medical staff's relationship with me.	3	5,26%	9	15,79%	26	45,61%	1	1,75%	18	31,58%	57	100%	0,19	0,62	2,36	Significant	11	3,67
	Unjustified changes to consultation schedules.	13	22,81%	6	10,53%	22	38,60%	9	15,79%	7	12,28%	57	100%	-0,08	0,65	-0,92	Not significant	-4,5	
	The hospital's adherence to its consultation schedule.	8	14,04%	5	8,77%	26	45,61%	6	10,53%	12	21,05%	57	100%	0,08	0,63	0,94	Not significant	4,5	
Tolerance	The hospital staff's tolerance of my habits, customs, religious beliefs, or social class.	3	5,26%	6	10,53%	22	38,60%	9	15,79%	17	29,82%	57	100%	0,27	0,59	3,48	Significant	15,5	12,00
	The staff's tolerance of my habits and customs.	4	7,02%	7	12,28%	29	50,88%	2	3,51%	15	26,32%	57	100%	0,15	0,60	1,88	Not significant	8,5	
Information	Information about the location of services from the information staff.	2	3,51%	9	15,79%	6	10,53%	8	14,04%	32	56,14%	57	100%	0,52	0,64	6,10	Significant	29,5	26,75
	The information staff's response to my questions.	2	3,51%	3	5,26%	18	31,58%	13	22,81%	21	36,84%	57	100%	0,42	0,55	5,79	Significant	24	
Weighted total change.																			-6,75

Table 7: Administrative Component Results

Discussion

The findings of this study offer a multifaceted and complex perspective on the perception of quality in healthcare services, providing an empirical basis for analyzing the effects of social control mechanisms. The results confirm the hypothesis that the implementation of this mechanism has had a positive and statistically significant impact on outpatients' general perception of quality. The p-value of the analyses demonstrates that the perceived improvement is robust and not attributable to chance. This finding aligns with service quality theory, which posits that management and control systems are determining factors in the customer experience.

However, a paradoxical finding emerges when contrasting the total change resulting from the weighted sum of the dimensions with the general perception of quality. While the weighted analysis indicated a worsening resulting from the total weighted sum of the dimension values, the outpatient's direct perception regarding the control question revealed a general improvement. This apparent discrepancy does not invalidate the direction of the change but underscores the subjective and prioritized nature of service quality. The phenomenon suggests that patients give disproportionately greater weight to certain dimensions. In this case, it is plausible that improvements in personal treatment, empathy, and responsiveness have compensated for the perceived deficiencies in efficiency and effectiveness. This prioritization demonstrates that satisfaction is not a simple sum of experiences but a complex weighting of elements where emotional and relational impact has a dominant effect.

Analysis from the perspective of social control

The interpretation of the results is complemented by the qualitative observations of the social control representative, who identifies the underlying causes of the outpatients' perceptions.

Medical Dimension

- **Effectiveness and Technical Competence:** The social control representative indicated that the slight improvements observed in effectiveness and technical competence and the worsening in the quality of information are largely due to the administrative overload of physicians. Despite their preparation, the time they dedicate to non-care tasks (e.g., paperwork, file searching) reduces consultation time, which the patient perceives as a failure to solve their problem. Likewise, the patient overload prevents physicians from delving into diagnoses or treatments, which is perceived as a failure in competence.
- **Equity and Respect:** In contrast, a notable improvement in equity and respect is observed, which the representative directly attributes to the actions of social control. Meetings and awareness-raising have brought about a change in the habits of some physicians regarding discriminatory treatment. The better response to complaints has generated a perception of greater justice. The privacy and tolerance towards the culture and beliefs of patients have also improved thanks to the policies promoted by this control body, demonstrating that changes in attitude and treatment are the most valued by patients.

Administrative Dimension

- **Efficiency and Adequacy:** The worsening in these areas is explained by the system's overcapacity. The increase in the population has not been accompanied by a growth in personnel, which leads to long waiting times and a feeling that the system cannot serve everyone efficiently. The cost of the consultation has also worsened its perception, due to factors such as the lack of medicines from the insurance, which affects patient satisfaction.
- **Accessibility and Physical Environment:** Despite structural deficiencies, social control has achieved improvements in accessibility and environmental conditions. The redistribution of spaces and the improvement in cleanliness are direct results of the reports and complaints channeled by this body. Likewise, the improvement in the provision of information by non-medical staff demonstrates that the work of awareness and meetings has achieved a broadly positive impact, improving the relationship with the patient.

Conclusions

This study concludes that the social control mechanism implemented at Hospital Materno Infantil- Caja Nacional de Salud has had a positive and statistically significant impact on patients' perception of service quality. The quantitative evidence demonstrates that users' perception leans towards a real improvement in service, despite the complexities inherent in measuring quality

On quality and quality perceived by the user

Through this work, it was possible to show that measuring quality in the service area is an inherently complex process. Its multidimensional nature and the interaction of various factors mean that any measurement is a component of a sum of varied influences. According to various theorists, quality is modeled in multiple dimensions; however, there is divergence on what these are and the best way to establish them. Controlling quality in the service sector is an arduous task that requires avoiding value judgments and the attribution of absolute responsibility to specific areas, since very few variables of perceived quality are the result of a single responsible party.

The literature on service quality is confirmed, indicating that the perception of quality is a subjective and prioritized construct. The results suggest that patients disproportionately valued improvements in key dimensions such as Equity and Respect, overshadowing deficiencies in areas such as Efficiency and Adequacy. This validates the idea that customer satisfaction is not a simple sum of experiences but a complex weighting where certain elements, such as treatment and attention, have a much greater emotional and practical weight (Zeithaml, Parasuraman and Berry, 1990).

Therefore, it is crucial for organizations, especially in the health sector, to know their customers and their priorities to be able to focus their improvement efforts on the dimensions that truly generate value and satisfaction. This crucial finding is reinforced

through the analysis of the control question. By comparing the total weighted sum of the responses of the dimensions separately with the response of the control question, which had an opposite sign, it was observed that the general perception of the change in quality was not a simple addition of improvements and deficiencies. Instead, the result aligned with the subjective weighting that patients gave to certain dimensions, coinciding with previous research indicating that the evaluation of service quality is mediated by the relevance that users give to each factor (Gronroos, 1984; Parasuraman, Zeithaml and Berry, 1988).

On the study

The measurement of the perceived change in quality by outpatient users was carried out by creating quality dimensions based on general service studies and specialized research in the health sector carried out by various theorists. The external analysis of the organization is very complicated due to the multiple obstacles that arise in the approval processes for research work.

Although it is an ethical right of the organization to hold teaching and research committee meetings to approve the work, the responses often take a long time. Although this mechanism is valid for filtering unsubstantiated work that goes against ethics, it also paralyzes options that could help understand the functioning of the Institution and improve its care in various areas.

Since the beginning of the social control mechanism's presence in the organization, the quality perceived by the outpatient patient has improved in an ordinal approach, measured through the calculated differential. However, this improvement cannot be attributed directly or completely disregarded, since the improvement has been manifested within factors that, in addition to having a direct responsible party, contain various indirect responsible parties. It is more accurate to attribute part of the change to

the presence of the social control mechanism, since many of its actions reported by the member to which the study had access are intimately related to the dimensions where there is a positive change.

In the analysis, it was evidenced that many of the social control changes have been applied without requiring greater economic resources, but rather they urge certain attitudes and ways of treatment, in addition to the active surveillance of the execution of administrative decisions, their compliance, and supervision.

Despite these improvements, many shortcomings in the economic area of the institution mean that several claims are not executed due to lack of institutional budget. It cannot be affirmed a priori that it is an administrative failure, since no response was obtained from them to analyze the results.

It is also observed that the presence of social control as a mechanism is improving the quality perceived by the user, despite its pilot phase. However this mechanism is not being given the importance it deserves. What began as a team of three people without salary and only with transport expenses has been reduced to almost no members due to the lack of budget, a frequent problem in the hospital.

Quality seems to be improving given that the real function of social control, beyond oversight, seems to be to establish strong communicative ties between the user, management, and physicians. This function is invaluable in any organization. Therefore, proper attention should be given to the social control mechanism, and the program should be expanded to prevent a decline in perceived quality. This decline often stems from communication problems and other issues that are easily solvable without a large budget. Improving the quality of care in this way can, over time, lead to solutions for more costly problems.

In short, an effort must be made to maximize perceived quality using available resources. If these communicative ties are lost, the deficiency in perceived quality will decline. Finally, the social control mechanism lacks the authority to implement corrective measures; it can only submit reports.

The role of the social control mechanism

The study highlights the fundamental role of the social control mechanism as an agile and effective link between the different parts of the organization and the patients. By becoming a feedback center, this mechanism goes beyond just collecting complaints, as it also watches over the good use of spaces and supplies.

This holistic work allows it to gather the needs of outpatients, human resources of the organization, and the medical sector, achieving a highly efficient process to identify problems and propose concerted solutions.

Social Control in Bolivia was born as a means for representatives of organized civil society to actively participate in the social control of public management at all levels, which includes the control of the quality of public services. This mechanism is typified in the current Political Constitution of the State.

Unlike traditional management models, which often focus on internal metrics, this mechanism operates as an agile and bidirectional communication bridge. Its ability to identify problems early and obtain direct feedback from users makes it a strategic tool. Instead of being a simple complaint box, it stands as a catalyst that promotes co-responsibility among patients, medical, and administrative staff.

It is crucial that these types of mechanisms are socialized and promoted not as an inquisitorial or oversight figure, but as an engine of continuous improvement for all sectors. Its function must be to mediate and seek consensual solutions among patients, the medical sector, and the administration, not to unilaterally impose. The existence of an

intersection point between patients and administrative and medical staff shows that these mechanisms can improve service quality in a comprehensive way.

Contributions, Implications, and Recommendations

The implications of this study are significant for quality management in healthcare services. Managers should not only focus on correcting all deficiencies, but should identify and enhance the quality dimensions that are most valued by their audience.

In the healthcare sector, this study suggests that improving outpatient treatment and care is a more powerful driver for satisfaction than optimizing purely technical or administrative processes. Although the latter may be more important and, undoubtedly, more difficult to address and improve, they are perceived as less critical from the outpatient's perspective.

In summary, the study offers two main contributions:

- Theoretical contribution: It reinforces existing service quality models by demonstrating, with empirical data, that users do not evaluate all attributes equally. It is emphasized that a focus on treatment and care in the healthcare context can generate a more significant impact than optimizing purely technical or administrative processes.
- Practical contribution: It provides a clear guide for service management in the health sector, suggesting that investments in improving outpatient treatment and care can generate a significant return in overall satisfaction, despite resource limitations.

The implementation of a social control mechanism has shown that, even on a small scale, it can act as a decisive change factor. Its effectiveness could be significantly enhanced if it were given greater authority and decision-making capacity. However, it is vital that this expansion of power is conceived under a collaborative and not an inquisitorial control

model. A collaborative approach is essential to carry out the constant improvement of quality, as it allows everyone involved to be part of the solution in an environment of dialogue and trust (Senge, 1990).

It is recommended that future interventions focus on:

- Optimizing the administrative processes that fall on medical staff to free up their time and allow for more in-depth patient care.
- Maintaining and strengthening the work of social control as an effective bridge to channel complaints and promote awareness among staff.
- Conducting importance-performance analyses to precisely determine the dimensions most valued by patients and, in this way, optimize the allocation of resources for the improvement of healthcare quality.

This strategic approach will allow for improved patient satisfaction by aligning investments taking into account what users value.

Limitations

The study was conducted at a single institution and used a non-probability sample. Planning around outpatient schedules, randomizing the order of visits, and covering the different specialties reduced the risk of concentrating recruitment in a single service, although these measures did not completely eliminate potential bias associated with voluntary participation. The retrospective comparison may be subject to recall bias, and the qualitative contextualization relied on a single informant, without triangulation with medical or administrative representatives. Because separate tests were conducted for 50 statements without adjustment for multiple comparisons, the significance of each individual result should be interpreted cautiously and alongside the overall pattern. Future research should replicate the study in other institutions and examine the relative importance patients assign to each dimension of quality.

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