



# Patients and health care professionals: Partners in health care in Croatia?

Milan Milosevic<sup>1\*</sup>, Hana Brborovic<sup>1</sup>, Jadranka Mustajbegovic<sup>1</sup> and Anthony Montgomery<sup>2</sup>

<sup>1</sup>University of Zagreb, School of Medicine, Andrija Stampar School of Public Health, Zagreb, Croatia

<sup>2</sup>Department of Educational and Social Policy, University of Macedonia, Thessaloniki, Greece

**Objectives.** To explore quality in hospitals from the patients' and health care professionals' perspective in line with Act on the Protection of Patient Rights.

**Design.** A qualitative study using a focus group design and semi-structured interviews.

**Methods.** Three focus groups among health care professionals were conducted with 51 participants: 24 nurses and medical technicians, 15 physicians, 12 residents, followed by additional interviews (20 nurses and medical technicians, 10 physicians, and 2 residents). Twenty patients were interviewed at the time of their discharge from the hospital. Collected data were analysed using thematic analysis.

**Results.** Patients identified waiting for medical treatments/procedures as the most concerning factor, followed by changes in administration procedures and admission in hospitals. From the physicians' and nurses' perspective, the main topics were inadequate resources to work with and inadequate working environment. Residents emphasized administration and lack of adequate equipment in contrast to other health care professionals. Both patients and health care professionals identified similar organizational and administrative issues impacting on service delivery.

**Conclusions.** Health care providers and patients equally recognize the factors that impact upon quality of care. This problem is beyond the health care professionals' possibility to solve, which is the main source of stress and burnout that influence the quality of care. These factors cannot be overcome, by either health care professionals or patient organizations working alone. Greater partnership between health providers and patient associations is needed.

## Statement of contribution

### *What is already known on this subject?*

- Healthcare providers and patients have the same goal: good quality of care and safety.
- Croatia has undergone significant socio-economic and political changes, which have affected the organization of the health care system.
- The patient experience is positively associated with clinical effectiveness and patient safety.

\*Correspondence should be addressed to Milan Milosevic, School of Medicine, Andrija Stampar School of Public Health, University of Zagreb, Rockefellerova 4, 10000 Zagreb, Croatia (e-mail: milan.milosevic@snz.hr).

**What does this study add?**

- From the perspective of patients and health professionals the main concern regarding quality of care is the organization of work in hospitals.
- Croatian patients and health professionals show considerable agreement with regard to the administrative problems in hospitals.
- Solutions that include only efforts on the part of the health care worker will fail.

Health care professionals and patients have the same goal: to have a good quality of health care. Twenty years ago, Donabedian defined the quality of care as the kind of care, which is expected to maximize an inclusive measure of patient welfare, after taking into account the balance of expected gains and losses associated with the process of care in all its segments (Donabedian, 1989a,b; Donabedian, Eisenberg, Gellhorn, Lohr, & Veatch, 1989). The term 'quality of care' integrates the concepts of access to care and effectiveness of care, which is further divided into clinical and interpersonal effectiveness (Campbell, Roland, & Buetow, 2000). However, the degree to which definitions and conceptualizations of quality of care have successfully accounted for the needs of patients has been questioned (Montgomery, Todorova, Baban, & Panagopoulou, 2013).

**Health care in Croatia**

The following study will evaluate to degree to which the perspectives of both health care professionals and patients are compatible in Croatia. As one of the first transition countries in Central and Southeast Europe, the Republic of Croatia, through comprehensive health service legislation, has made a significant step forward in aligning its standards in the protection of patients' rights to those that exist in the developed countries. In this regard, an important landmark in terms of quality of care was the 2004 Act on the Protection of Patient Rights (Official Gasette, 2004). The actions of the Croatian Ministry of Health (MoH) in developing such rights were noteworthy in that this legislation represented input from the following stakeholders: the Croatian Medical Association, the Croatian Medical Chamber and patients' associations, and members of the International Alliance of Patients' Organizations. Thus, great effort was expended to embed the role of patient associations within the health legislation process since 2004. This historical note is an important precursor to appreciating our analyses of patients as partners in health care.

In the last 10 years, to pursue effective improvements in health care performance, Croatian health institutions have placed great emphasis on the need to change organizational culture (psychosocial stress at work, workplace harassment, working overload, and administration) to improve personal productivity (implementation of new technologies and computerization in the health care system) and to prevent occupational injuries and diseases and to improve overall quality of care for patients (Bubas, Milosevic, & Delic-Brkljacic, 2008; Golubic, Milosevic, Knezevic, & Mustajbegovic, 2009; Knezevic & Belosevic, 2006; Knezevic, Golubic, Belosevic, Milosevic, & Mustajbegovic, 2010; Knezevic *et al.*, 2011; Milosevic *et al.*, 2011).

The standard of health care in Croatia is generally good (Croatian Institute for Public Health, 2006a,b), with the better quality of health care services present in the cities and larger towns. In 2010, Croatia spent 7% of its gross domestic product on health care down from approximately 8% in 2008 (World Bank, 2011). Croatia ranked around the 50th in the world in life expectancy with 73 years for men and 79 years for women, and it had a low

infant mortality rate of 6 per 1,000 live births (World Health Organization, 2012). In the period from 1990 to 1999, Croatia underwent socio-economic and political changes, which also affected the organization of the health care system. The system has been transformed from a national health insurance model with a high level of solidarity to a public–private mix. However, Croatia is still reforming key structural elements of government; this includes state pensions, state subsidies, privatization of the state portfolio, and the Croatian health care system. The Croatian health care system has severe budgetary issues, which can affect the supply of medication in publicly run health care facilities in Croatia. Since 2006, the Croatian MoH has been tackling the accessibility, fairness, and equality of the health care system, which feature in the overall strengthening of the Croatian health sector (Croatian Institute for Public Health, 2006a; Mittermayer, Huic, & Mestrovic, 2010).

The new Act on the Protection of Patient Rights (Croatian Association for the Promotion of Patients' Rights, 2012) represents one more step on the road to the legal protection of human rights. It is still facing practical implementation issues for improving the position of patients in the health system (Babic-Bosanac & Dzakula, 2006), but Commissions for the Protection and Promotion of Patient Rights have been established on the county level with representatives from the government and active patient organizations as members (Croatian National Institute of Public Health, 2010). Professional medical ethical codes also provide rules of patient rights protection, while patient organizations may participate and actively oversee the implementation of the law in this area (Code of Medical Ethics & Deontology, 2008). However, a more complete picture of quality issues in the hospital can be aided by eliciting information from all stakeholders. Typically, the media (understandably) skews their focus towards the experience of patients but the obligations of health care professionals. Thus, there is a need for researchers to account for the experiences of both groups.

### ***Health care professionals and patients: Comparing perspectives***

Exploring the perspective of patients in how health care is delivered is desirable on ethical, utilitarian, and empathic grounds. Defining a successful patient experience is demanding task but should include the following elements: hours and access that are convenient for patients (same-day appointments, after-hours availability for urgent needs), adequate medical consultation and services, staff knowledge, the physician's professionalism (bedside manner), patient safety, and patient education opportunities (American Medical Association, 2013).

Encouraging patient ownership of their medical journey leads to improved patient safety, clinical effectiveness, better adherence to medication and treatment (Berwick, 2009; Street *et al.*, 2009; Thom, Hall, & Pawlson, 2004; Vincent & Coulter, 2002). Indeed, a recent systematic review of the area (Doyle, Lennox, & Bell, 2013) concludes that patient experience is positively associated with clinical effectiveness and patient safety and supports the case for the inclusion of patient experience as one of the central pillars of quality in health care. Indeed, the authors of the review state, 'Clinicians should resist sidelining patient experience measures as too subjective or mood-orientated, divorced from the "real" clinical work of measuring and delivering patient safety and clinical effectiveness'. Collating patient experience and comparing it with health care professionals experience are important, especially when the evidence indicates that perspectives on understanding and effort can vary considerably (Granger, Sandelowski, Tahshjain, Swedberg, & Ekman, 2009). Moreover, there are considerable discrepancies with regard

to views on professionalism in medicine. For example, Green, Zick, and Makoul (2009) using focus groups (FGs) to explore professionalism with patients, resident physicians, attending physicians, inpatient nurses, and outpatient nurses across different specialties found large differences regarding behaviours such as reviewing charts before seeing patients, seeking second opinions, and comfort and cleanliness. Identifying and recognizing the gaps/agreements in perception between health care professionals and patients can help health care organizations to more effectively understand quality of care.

The present research is connected to a larger international project concerning organizational culture, job burnout, and the improvement in quality and safety in hospitals (FP7-HEALTH, 2009) (see Montgomery *et al.*, 2013 for full discussion). The project is based on a conceptual framework that entails mixed-methods approaches to understanding these relationships (Montgomery *et al.*, 2011) and that has an action research orientation (Koch & Kralik, 2006). The objective of this study was to explore quality of care in hospitals from the perspective of both the patients and health care professionals.

## Methods

### Participants

During October and November 2010, FGs were conducted in two hospitals in Croatia: one general county hospital from the eastern part of Croatia that mainly covers rural areas and one clinical hospital from an urban setting (City of Zagreb). Besides their location, coverage area, and type of hospital (clinical vs. general), there were not distinct differences in the total number of employees, number and types of departments, working hours, and total patient turnover. The rationale for recruiting participants from two hospitals was to minimize urban–rural and regional influence that can impact on quality of care.

The eligibility criteria for participants from the health care professionals group were that they had to be employed in selected hospitals at the time of investigation for at least 6 months. Patients who were included in this study were chosen from different departments regarding their diagnosis (chronic disease) and duration of hospitalization (at least 1 day of hospitalization). Patients were selected the day before discharge from the hospital, in agreement with the heads of each department and the chief nurse. The sampling method for health care professionals was purposive and the sample size was defined on pragmatic grounds. Efforts were made to include a range of health care professionals from surgical, non-surgical, and emergency medicine departments. The number of patients was linked to the actual daily patient turnover regarding their diagnosis (chronic disease) and duration of hospitalization.

Three FGs among health care professionals were initially conducted in each hospital. Recorded data are combined together giving a total number of 51 participants: 20 nurses and 4 medical technicians (group 1), 15 physicians (group 2), and 12 medical residents (group 3). The majority of health care workers were women (34; 66.6%) with an average age ( $\pm SD$ )  $37.8 \pm 10.2$  years (range from 21 to 59 years). The average age of male health care professionals was  $41.5 \pm 9.3$  years (range from 23 to 64 years). There was no statistical differences in average age between female and male health care professionals (independent *t*-test,  $t = 1.245$ ,  $p = .219$ ). Participants came from the following departments: 18 (35.3%) in internal medicine departments, 8 (15.6%) orthopaedic surgery, 8 (15.6%) gynaecology, and 17 (31.3%) emergency ambulance. FG discussions and interviews were recorded, transcribed, and stored in a secure location. Interviews ranged in length from 30 min to 1.5 hr.

In the days following the FGs, 63% of the sample (32 health care professionals) agreed to participate in an additional in-depth interview (18 nurses, 2 medical technicians, 10 physicians, and 2 medical residents). The purpose of this additional in-depth interview was to provide health care professionals with an opportunity to expand further on the issues and questions raised in the FGs.

Twenty patients were individually interviewed with the same questions that had emerged from health care professionals FGs at the time of their discharge from the hospital. Eleven patients (55%) were females with an average age  $44.5 \pm 13.4$  years, range from 23 to 67 years. The average age for male patients was  $45.1 \pm 14.8$  years, range from 24 to 70 years, without no significant difference compared with women (independent *t*-test,  $t = 0.089$ ,  $p = .930$ ). Patient average length of stay in hospital was  $7.5 \pm 3.4$  days.

### **Design**

This is a qualitative study using both FGs and interviews. The methodological approach utilized was one which sought to bridge the gaps between patient and health care professionals' perceptions. The theoretical background to the research was a relational one that seeks to explore how patient and health care narratives are actively negotiated (Waring, 2007, 2009). Thematic analyses were employed to inductively identify issues that are experienced throughout the system. In this instance, such an approach was more appropriate than an occupational health psychology (e.g., Karasek Job-Demand-Control) or patient cognitive model (e.g., illness perceptions model) to capture the nuanced interplay between patients and health care professionals.

### **Procedure**

Participant information sheets and the study as a whole were approved by the ethics committees of the selected hospitals. Health care professionals were recruited individually by an interviewer during their working shifts, and patients were invited to participate while waiting to be seen by their health care professionals. The interviewer gave each participant an explanation of the research and asked for her or his voluntary and anonymous participation.

As already mentioned in the introduction, this research is connected a larger international project concerning organizational culture, job burnout, and quality of care in hospitals (ORCAB). The international ORCAB team developed qualitative methodologies for FG and interviews with health care professionals and patients, which were adapted to the specifics in each country (for a description of the ORCAB project methodology, see Montgomery *et al.*, 2013, from this series). Semi-structured interviews were designed to include topics that emerged from the FG discussions. The interviews explored quality of care in more depth (including providers and patients' perspectives/expectations).

### **Analysis**

Participant responses to an open-ended question about their working conditions were subject to thematic analysis (Braun & Clarke, 2006). The aim of the open-ended question was to explore each participant's own framework of meanings, to allow greater freedom of expression, and to prevent bias due to limited response ranges elsewhere. Specifically, each item was studied repeatedly and was given equal attention during the analysis

process, which was thorough, inclusive, and as comprehensive as possible. A pre-existing coding frame was not utilized. Rather, relevant extracts from the data set were collated to form themes. Themes were then checked against each other and against the original data set to ensure that they were coherent, consistent, and distinctive. The process was predominantly inductive, in that the themes identified were strongly linked to the data themselves and therefore were data-driven. An interpretive process was used to organize and summarize the data to identify patterns and attempts to theorize the significance of the patterns, their broader meanings, and their implications in relation to similar research. The extracts were also checked to ensure that they matched the analytic claims. During the analysis process, the researcher continually considered whether the analysis provided a convincing and well-organized representation of the data and the topic. Candidate themes were reviewed and refined to create map of major themes and sub-themes (Braun & Clarke, 2006).

## Results

Several major themes emerged from the qualitative data for patients and health care professionals groups. The following is a description of the themes identified in their responses, as well as verbatim examples of patients and health care professionals' responses that illustrate them.

### Patients

For patients, the following are main concerns related to the *organization of work and financial issues*: (1) waiting for medical treatments/procedures as a most concerning factor ('we wait too long for regular tests', 'I waited for this examination 2 months', 'we are tired from waiting for doctors'), followed by (2) changes in administration procedures and admission in hospitals ('a different system of applications has been introduced again'; 'I don't know how to use the new smart card'; 'Who should I contact to get my examination?'), (3) patient empowerment ('how can I claim my rights?') and (4) chronic disease management ('why do I need a new prescription every month, instead one for a longer period?'), and (5) the financial costs of medical treatment and drugs ('it concerns me that I have to co-pay for my medications every month').

### Health professionals

Physicians and nurses also emphasized the organization of work and financial issues, with slight differences compared with patients. The most important issues were (1) inadequate resources to work with ('Again, we do not have enough syringes and gloves by the end of the month'; 'I have nowhere to change when I come to work'; 'The MR machine broke down again and we are all waiting until it gets repaired'), (2) an inadequate working environment ('I have nowhere to sit when I finish rounds'; 'Our workroom is terribly suffocating and there is no light'), (3) complex administration and waiting lists ('With this new method of registration of patients I just got more work'), and (4) insufficient funds for normal everyday work ('I would like to send patients for further analysis but we do not have enough resources').

Also, physicians and nurses identified the shortage of health care personnel as one of the major concerns: (1) shortage of registered nurses ('I am on call almost every weekend



of the month'; 'I can't go on sick leave because I have nobody to replace me' and (2) shortage of educated physicians in primary and secondary care (especially in rural areas).

The health care professionals identified other issues that are directly and indirectly related to staff shortages and decreasing resources: (1) health of health care workers ('it really bothers me when I have to come to work when my allergy starts'; 'there's no one at the operating room to replace me'), (2) communication between colleagues and departments ('sometimes documentation gets lost when we transfer patient from one department to another'; 'when we have a lot of work to do, we don't have enough time to inform our colleagues about everything the patient has undergone'), (3) night shifts ('sometimes it takes me days to recover from the night-shift'), (4) misinformed patients ('it frustrates me when patients don't take their medication because their doctor hasn't explained to them why and when they are supposed to be taking them', 'patients often wander around the hospital without knowing where they should be heading'), (5) workload ('sometimes I feel I will breakdown', 'I rarely have time to go to lunch'), and (6) new technology and equipment ('it is easier for younger generations to adapt to the new technologies').

Responsibility and obligations emerged as important themes, as physicians and nurses reported that legal issues and public criticism were important: (1) law processes ('patients are threatening to sue because they feel they have the right to even if you don't say "Hello" to them') and (2) public criticism ('it really bothers me when a colleague gets accused in the press').

Residents, like patients, emphasized administrative burden as a main concern regarding quality of care: administration work ('sometimes I feel I am an administrative clerk'; 'I fear that I spend too much time doing administrative work instead of talking to the patient').

The most concerning factors for residents, which were different compared with the other health care professionals, were (1) lack of adequate equipment ('sometimes we don't have enough sterile gowns for all residents so we can't assist in the operating room'), (2) obligations to do all ordered tasks ('I have to do everything I am told even though it is not really my responsibility'), (3) a huge number and frequency of patients per day ('it often happens that I don't have enough time to go to lunch or to the bathroom'), (4) lack of perspective for professional development ('I don't have enough time to do my research because I work long hours and I'm often exhausted'), and (5) working overtime ('I feel I can't leave until all the work is done').

## Discussion

The themes identified (and conclusions reached) by the health care professionals during the FGs were strongly connected with the themes identified from the interviews with patients. The most prominent obstacles to emerge for both groups were concerned with the organization of work, financial issues, and administrative burden. It is interesting that patients were equally concerned with the administrative/organizational issues, and it should cause us to reflect on the 'role' that patients play in the hospital setting. Obviously, they are not employees of the hospital, but viewing them as consumers of the service is too simplistic. Hospitals are populated by a range of professionals, both medical and non-medical, and the stressors/strains experienced by health care professionals are a combination of patient-driven demands and the organizational factors specific to the hospital environment. Hospitals are very interesting organizations, in that the culture of

medicine is similar across the globe, and physicians (especially) are educated to take a very specific role in an organization. Mintzberg (1997) has written directly on the issue of the hospital cultures in *Toward a Healthier Hospital* and strongly insists that real organizational change can be effected only by a gradual bottom-up approach that does not threaten the roles that individuals have established within the organization. The present research suggests that viewing patients as partners within the health care environment is only path that will lead to real organizational change. The topic that was recognized from all of the participants was administrative hassle, which is one of the major obstacles preventing health providers focusing on caring for their patients. For patients, it was often associated with waiting lists and waiting for medical treatments/procedures as well as administrative procedures while in hospitals. Like health care professionals, they are also struggling with everyday administration. This contributes to a further lack of communication between health care professionals and patients, which is often a crucial point when patients decide to pursue legal procedures against health care professionals (Babic-Bosanac & Dzakula, 2006). Health care professionals and patient organizations devote considerable energy to advocating for better working conditions (health care professionals) and improved safety/better communication (patients), which is appropriate. However, 'better administration' is rarely at the forefront of such campaigns, but our data strongly suggest that more emphasis on administration could significantly ameliorate the problems associated with working conditions and patient safety. Much like Croatia, changes in the socio-political and demographic environment have provided the context for a range of United Kingdom Government policies designed to reorganize health services around the patient's journey and to focus on developing patient partnership and patient-centred care. Being patient centred involves much more than being dedicated and caring. It is a different way of thinking and behaving, where doctors and patients work together as true partners (Smith, 2003). There is also pressure towards a model of care that involves active involvement and participation (Coulter, 2002). Patients deserve to be partners in their own health care because health care can be delivered more effectively and efficiently if patients are full partners in the process (Holman & Lorig, 2000).

While hospitals in the United States are making gains in patient care quality, considerably more progress could be made through greater alignment of hospitals and physicians working together on quality improvement (Liebhaber, Draper, & Cohen, 2009).

The FGs and interviews suggest that Croatian health care professionals may be reluctant to remain in their jobs as reflected in their comments about substandard working conditions and remuneration: the changing nature of work in hospitals, job insecurity, high work pace, long and irregular working hours, low control over job content, low salary, occupational hazards, and old and new technologies. According to the Croatian Medical Chamber and the Croatian Nursing Council in 2011, the estimated shortage of health care professionals was 4,300 medical doctors, while the estimates for nurses vary from 3,000 to 6,000 and even to 13,000 (Dnevnik.hr, 2012). Our analyses provide insights into the factors that will exacerbate these shortages.

The picture that emerges in Croatia mirrors international trends. The World Health Organization estimates that there is a shortage of more than 4.3 million health workers in the world. The shortage includes more than physicians and nurses: pharmacists, dentists, laboratory technicians, emergency medical personnel, public health specialists, health sector management, and administrative staff (World Health Organization, 2006).

The increased number of chronic patients was recognized, both by patients and by health care professionals, as one of the factors linked to staff shortages that can influence



on poorer patient care. Besides a rise of chronic disease, the lack of staff causes are multiple and complex: population growth, increased purchasing power for health services, increased life expectancy, health workers' skills in demand in diverse settings (Byrnes, 2012). The number of people in need of health services in Croatia is rising not only due to demographic changes, associated with less doctors and nurses, but also with the increased centralization of health care in bigger cities. The regional specificity of hospitals in Croatia, as a well-known tourist destination, is also based on the fact that the number of hospital health workers is determined and employed according to the number of permanent residents. However, during the tourist seasons, some hospitals suffer from additional overload due to an increased number of patients. Lack of staff increases work overload, overtime, absenteeism, and presenteeism, in common with health care systems in many European countries (Rantanen & Tuominen, 2011). Many studies have shown that exhaustion and burnout are associated with more self-reported medical errors (West *et al.*, 2006). Moreover, doctors' feelings of discontent can damage the quality of patient care (Williams, Manwell, Konrad, & Linzer, 2007). Dissatisfaction and burnout not only affect the medical doctors' own well-being, but they may also have consequences for health policy and for patient care. Job dissatisfaction is a major cause of medical doctors' turnover (Bakker, Schaufeli, Sixma, Bosveld, & Van Dierendonck, 2000), and it may add to a negative image of the profession. This can lead to shortages of health care professionals, a main concern for health policy makers.

The entrance into the European Union (EU) should result in accelerated fiscal and structural reform in Croatia. It is forecasted that with its entry into the European Union as a Member State, Croatia will immediately lose another 500 medical doctors, and simultaneously 1,500 nurses will leave Croatia (Dnevnik.hr, 2012). Recent research on quality of health care has shown that despite the many restrictions introduced in the system, patient satisfaction with health care has remained relatively high (Croatian Institute for Public Health, 2006a,b). The Croatian health system is based on patient rights, patient-centred care, defined as the involvement of patients in making decisions about their care (Koska, 1990).

Patient enablement is based on the principles of patient-centred care, which are core values of practice (Coile, 1992; Montgomery & Hudson-Barr, 2004; Schulte, 2010; Weisman & Hagland, 1994). It is important for patients to be able to understand the nature of their problems and manage them (Wensing, Jung, Mainz, Olesen, & Grol, 1998). But the concept of patient enablement, a consultation outcome measure that reflects the extent to which patients understand their health problems and feel able to cope with them, as a result of the consultation (Howie, Heaney, & Maxwell, 1997), requires the additional engagement of health care providers, and in the circumstances when they are already overloaded, it can make one vicious circle. Health care professionals have to think about how to enable their patients to be aware of the shortages in resources and share the burdens associated with the limitations inherent in the system. This is challenging and will involve a need for health care professionals to redefine their roles and purpose within the hospital system. One of the patient rights, in the Croatian Act on the Protection of Patient Rights, is entitlement to information. The patient has the right to be informed about their health, recommended examinations and procedures as well as planned dates of examinations and procedures, advantages and disadvantages regarding examinations and procedures, right to decide on examinations and procedures, possible replacement of examinations and procedures, course of procedures, recommendations of life style, rights regarding health insurance, and actions to achieve them (Official Gazette, 2004).

The MoH in Croatia has the role of steward of the health care system, with a wide brief. The Croatian MoH has been given the task of implementing the Government adopted National Health Strategy covering the 2006–2011 periods. A considered national plan in Croatia for responding to the domestic human resource shortage does not currently exist and is urgently needed. The World Health Assembly Resolution endorsing the Global Plan of Action on Workers' Health calls upon Member States to develop national occupational health programmes to protect health workers (World Health Organization, 2007a). WHO, together with experts on occupational health, have developed a Global Framework for National Occupational Health Programmes for Health Workers to assist member countries to implement their agreements under the Global Plan of Action (World Health Organization, 2007a,b).

The present study provides a means of organizing and summarizing the findings from patients' and hospital workers' views on quality of care in two types of hospitals (one clinical hospital from urban area and county hospital that mainly covers rural area). However, a significant limitation is the fact that our analysis provides more in-depth analysis of health care professionals compared with patients. This reflects the fact that we had the opportunity to interview the health care professionals after their FGs. The FGs provided more dynamic data, and it was difficult to integrate the two different sources of data. Qualitative research is not intended to be generalizable, and thus, our study provides rich material on the context in Croatia. However, the strengths of the study are rooted in its inductive and grounded nature, which is consistent with the recommendations for bottom-up change in health care.

In conclusion, health care providers and patients equally recognize the factors and the principles of access and availability to health care, guaranteed by the Law, which can impact quality of care. Our results also indicate that the principles are not being fulfilled completely. This problem is beyond the health care professionals' possibility to solve, which is the main source of their stress and burnout that influence the quality of care. These factors are hard to overcome only by health care professionals or by patients alone, and partnership between health providers and patient associations is strongly recommended. Croatian Association for the Promotion of Patients' Rights can facilitate health care professionals in Croatia have to take patients' organizations as partners for advocating quality of care issues with the Croatian MoH to assure the accessibility, fairness, and equality of the health care through education, training, and supervision of hospital management.

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