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Exploration of Fairness in Health Services: A Qualitative Analysis

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A content analysis of fair and unfair experiences described by students as customers of health care services was made. The way customers had been treated by the staff during the implementation of procedures, along with the information exchange between client and service providers turned out to have a strong impact on justice perception. An outstanding point is the reciprocity on the treatment. The clients' comments about waiting times and the physical and emotional consequences of patients' encounters with health services also played a major role in fairness perception and the patients' assessment of their experience. These matters should be considered in the management of health care services.

KEYWORDS content analysis, fairness perceptions, health management, health services, justice, patients

This work tries to shed light on the social processes that take place in complex health care settings by learning both what patients think is fair in their relationship with the health care services, and how these perceptions explain

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some of their reactions. This knowledge will lead to improving the objectives and results of authorities in the management of health care services.

The study is based on the organizational justice literature, trying to contribute both to improve the results related with customers and patients in the management of health services and to the understanding of justice concept. We will start by defining the basic points of organizational justice literature.

DIMENSIONS OF JUSTICE

The first goal is to examine how fairness perceptions might be understood in the health care service context. The justice literature suggests that there are at least three dimensions underlying fairness perceptions. On the basis of Adams' (1965) equity theory, it was posited that, to establish whether the results were fair, individuals made cognitive assessments of the ratio between their contributions and the outcomes they received in comparison with the contribution-outcomes ratio of others. This strategy focuses only on the results, and understands justice in *distributive* terms.

Despite the power of the distributive dimension on people's reactions (see, e.g., McFarlin & Sweeney, 1992), researchers eventually realized that there is something else, in addition to the outcomes, affecting the individuals' judgments about justice. More specifically, it was observed that people are interested not only in what they get, but also in how they get it (Thibaut & Walker, 1975). Thus, people are more willing to accept an outcome, even if it is unfavorable to them, if they perceive this outcome to have come about through a just procedure. This dimension focuses on the *procedural side* of justice perception.

So, having a "voice" or the rules of Leventhal (1980, i.e., consistency, precision, absence of bias, representativeness, correction, and ethically) increased the degree to which the procedure was seen as fair.

In addition to the distributive and procedural dimensions of justice, a third important dimension had to be taken into account: *interactional justice* (Bies & Moag, 1986). Interactional justice refers to the quality of the social exchange between two participants that occurs during the implementation of a specific process. It differs from procedural justice since the latter focus on the structural quality of the decision process (Cropanzano, 1993).

Currently, there is some controversy as to how many dimensions of justice should be distinguished, and which are exactly these dimensions (e.g., Blader & Tyler, 2003; Cohen-Charash & Spector, 2001; Colquitt, 2001; Colquitt, Conlon, Wesson, Porter, & Ng, 2001; Greenberg, 2001). The latest developments are centered on the distinction between interactional and *informational* justice. The latter comprises the quality and relevance of the information that is provided by the other party (Colquitt, 2001).

ORGANIZATIONAL JUSTICE AND HEALTH SERVICES

Considering the organizational justice framework in the health services management can shed valuable light on important results for these organizations. On the other side, disregarding the dimensional distinctions of justice can have severe negative consequences in service organizations, because it can lead to an incomplete or incorrect understanding of the influence of justice perceptions on customers' attitudes and behaviors. In mostly all works in this context, the study of the dimensionality of the concept of justice is either missing (Kimes & Wirtz, 2002) or only partially taken into account (Goodwin & Ross, 1992; Holbrook & Kulik, 2001; Mattila & Mount, 2003), and the many principles and subtleties that make up the justice dimensions have been largely ignored (Clemmer, 1993; Clemmer & Schneider, 1996).

Moreover, although justice researchers have focused on a wide variety of services, most of these are provided by market-oriented private organizations (for exceptions see Martínez-Tur, Peiró, & Ramos, 2001; Pérez-Arechaederra, Herrero, Garrido, Antón, & Masip, 2006; Verma & Sobti, 2002). However, authors such as Clemmer and Schneider (1996) pointed out the need to study more "social" or public services. One of these is the health sector, which offers a service that occupies a special place in society and is needed of more research attention (Berry & Bendapudi, 2007).

The services offered by health organizations have several unique traits which are crucial. When patients seek attention from health services they are usually in a state of need and in a particularly vulnerable position. Therefore, it is very likely that they will grant special importance to the way the service handles the situation. Illness, pain, and even the prospect of death stimulate very strong emotional states that yield uncertainty (Van den Bos & Lind, 2002) and tend to generate dependence on the health service or the health worker (Kulik & Holbrook, 2002). In Berry and Bendapudi's words, "health care is a rare service that people need but do not necessarily want" (2007, p. 111).

Likewise, health service clients must face especially severe levels of asymmetric information with respect to the service providers (Hausman & Mader, 2004; Seiders & Berry, 1998). The technical aspects of the service are extremely difficult to evaluate by lay people (Bowers & Kiefe, 2002; Che, Uli, Abdul, & Looi, 2004; Pérez-Arechaederra & Herrero, 2006), and it is especially complicated to know for sure whether the staff have performed as well as they can. If a worsening of the patient's health occurs, the patient and his or her relatives cannot ascertain whether the impairment was caused by the underlying disease or by a service failure (Bowers & Kiefe, 2002; Newhouse, 2002).

Common characteristics of the service sector are free competition among different organizations providing similar services, and the possibility for clients to choose from among them. But, at least in some countries, competition and choice are not as available in health services as they are in other sectors. The reason is that many people simply cannot afford to use a health service organization different from the one they are using.

All of these facts make health care services a special context for justice research. Feeling fairly or unfairly treated when dealing with this kind of service is likely to have very important consequences for both the patients and the organization.

In spite of the importance of considering justice, research on service organizations has focused very strongly on customer satisfaction and service quality (e.g., Parasuraman, Zeithaml, & Berry, 1988). A significant amount of this research has examined health services (e.g., Che et al., 2004; Mira, Aranaz, Lorenzo, Rodríguez-Marín, & Moyano, 2001; Swan, Sawyer, Van Matre, & McGee, 1985). However, only a few studies have taken the role played by justice perceptions into account (e.g., Swan et al., 1985). This limitation is likely related to the lack of a clear differentiation in the literature between quality and fairness. The empirical findings seem to be pointing to the same phenomena as antecedents of both quality and justice perception. Also, recent developments stress the importance of fairness perceptions in assessing the clients' experiences with the service (e.g., Carr, 2007). The relationship between service quality and fairness needs to be further explored in order to provide conceptual clarification.

Most of the few studies that have examined fairness in health care services have not explored the patient, or client, perspective, focusing instead on employees' justice perceptions (e.g., Elovainio, Kivimäki, & Vahtera, 2002; Laschinger, 2004; for exceptions see Naumann & Miles, 2001).

In addition to the patient perspective, the study of doctor-patient interactions may also shed some light on the antecedents of justice perception in health care organizations. Justice perceptions in the doctor-patient relationship have a strong impact on how well the patient adheres to the treatment (Kulik & Holbrook, 2002). Kulik and Holbrook (2002) built a model where certain antecedents of justice perception (voice, interpersonal treatment, choice of doctor, and the doctor's competence) explained the way the doctor-patient relationship affected (a) the patient's adherence to treatment, (b) the patient's physical recovery, (c) the patient's responses, and (d) the doctor's outcomes. Other authors also point out that providing the patients with adequate information facilitates the establishment of advantageous and effective relationships between doctors and patients: the doctor must consider the patient as a colleague (Verma & Sobti, 2002). In this vein appears Hausman and Mader's work (2004), in which they focus on the measure of social aspects of the patient-physician relationship.

THE PRESENT RESEARCH

In health services, distributive justice has been understood as the clients' perception of whether the outcomes after contact with the service were just, as well as the clients' consideration of the extent to which the organization gave them what they needed (Mattila & Mount, 2003). A client obtaining a gift or a discount following a service failure is also considered to fall within the distributive dimension (Goodwin & Ross, 1992). In short, the distributive facet refers to the degree to which the objective is obtained (Tax & Brown, 1998).

The perception of procedural justice, based on the voice effect, is usually manipulated in experimental studies by giving or not the opportunity to present information or express feelings (e.g., Goodwin & Ross, 1992; Van den Bos, 2005). Some correlational studies in the health context have also considered this variable (Naumann & Miles, 2001). To measure procedural justice perception after the service, researchers have also examined whether the patients: (a) feel that the amount of time allocated to their problem was appropriate; and (b) think that the company was flexible in handling the problem (Mattila & Mount, 2003; Tax, Brown, & Chandrashekar, 1998). This interest in the time involved in the process reflects the idea that this variable has a crucial importance in service-providing (Durrande-Moreau, 1999), and is an antecedent of procedural justice perceptions (Bowen, Gilliland, & Folger, 1999; Tax et al., 1998).

Other antecedents of procedural justice are whether the organization giving the service assumed responsibility for failures (Bowen et al., 1999; Tax et al., 1998), whether the correct procedures were followed to attain the final objective, and whether the clients had some kind of control over the process.

Finally, interactional justice has typically been operationalized as the service provider offering an apology to the client (Goodwin & Ross, 1992), as the extent to which the staff was concerned with the client's problem, and the degree to which they displayed courtesy (Mattila & Mount, 2003; Tax et al., 1998), if the interaction was honest, the staff gave adequate explanations, and the degree to which the personnel made an effort to solve the client's problem (Bowen et al., 1999; Laschinger, 2004; Tax et al., 1998).

Despite all this research, the question arises as to whether the way in which justice is being conceptualized in services, particularly in health care services, is appropriate. In the studies described previously, certain antecedents of justice that emerged in other areas were used in the health context. The assumption is that they will be as predictive and pertinent in this context as they are in other areas. However, to our knowledge no study has been conducted to examine the specific antecedents of justice perception that

emerge naturally in the health services context. In order to fill this gap, this research explores what the users of health services considered just or unjust in this particular context. Content analysis (Bardin, 1996; Tesch, 1990), a very valuable methodology for finding out what aspects clients pay attention to when they judge fairness using their own words (see the recommendations by Finkel, 2001), is used. This research focuses on the contents of the categories that would naturally arise from the participants' descriptions. Therefore, no restriction has been imposed on the categories. This means that the theoretical framework derived from the literature, as well as any other previous conceptions, were left aside when analyzing the participants' accounts. This strategy is substantially different from those used in prior research (see Clemmer & Schneider, 1996; Mikula, 1986; Tax et al., 1998), and is more adequate to grasp the participants' genuine impressions.

Furthermore, most research on justice perception is actually research on injustice perception. For broadening the existing approaches to the study of justice perceptions this research took into account participants' descriptions of both fair and unfair situations involving the provision of health care by health organizations. Moreover, the study of justice perceptions can contribute to explain and improve many of the outcomes and processes that occur in organizations offering health services.

Finally, the clients of health care organizations have certain particular characteristics that can help define and specify both certain aspects of the dimensionality of justice and the existing theories of justice perception. To achieve this goal, it is necessary to know what clients understand by fair and unfair when they use a health service. This research is a first step towards that goal.

METHOD

Participants

Sixty-four undergraduate students of psychology participated in this study ($M = 21.33$ years, $SD = 2.54$). A number of participants (9.4%) did not report their gender; among those who did, 82.8% were females and 17.2% were males. As described below, each participant wrote a detailed description of what happened when he or she requested the services of a health care organization. The phrase was taken as the unit of analysis. 932 units of analyses were obtained from participants.

Procedure

The participants were given an instrument on which they had to describe in the greatest possible detail a fair or unfair situation in the health services

context that had occurred to them in the last three years. Time reference was limited in order to create a framework that would facilitate recall.

In order to elicit the broadest possible range of cases and quality, four different wordings of the question in the instrument were drawn up. More specifically, it was asked for a fair or an unfair situation, and it was either used “treatment” or “experience” terms¹. Thus, the participants ($N=64$) were asked to describe one of those situations: a situation in which they had received a fair treatment ($n=15$), a situation in which they had had a fair experience ($n=16$), a situation in which they had received an unfair treatment ($n=17$), or a situation in which they had had an unfair experience ($n=16$). The participants filled in the instrument during a social psychology lecture.

Analysis and Development of the System

The descriptions were analyzed using traditional content analysis (Bardin, 1996; Tesch, 1990) and following some of the suppositions of grounded theory (Glaser & Strauss, 1967; Henwood & Pidgeon, 2003). Both techniques have been of great use in health research, especially when a reality-based frame of reference is sought for the topic under study (e.g., Elliott & Olver, 2002). Content analysis was the best available methodology to yield the most detail and best satisfy our purposes.

First, the researchers have to familiarize themselves with the descriptive material and to look for commonalities across the diverse statements. This iterative method led to the detection of regularities that, eventually, gave rise to a number of categories (see Henwood & Pidgeon, 2003). These categories were then grouped in an articulated global system on the basis of their topics and functions (see the results section).

After familiarizing themselves with the category system, two independent judges coded all the descriptive material. The phrase, defined as “a coined expression, generally made up of two or more words, making sense but without forming a clause, and whose full meaning can not be deduced from the elements composing it” (R.A.E., 2010) was established as the unit of analysis for this coding. After the coding, the two judges discussed and resolved their disagreements.

RESULTS

Creating the Category System

The system was made up of three independent subsystems. One same unit of analysis had to be situated within each of them. The subsystems were these described next.

SUBSYSTEM 1

Subsystem 1 (S1) focused on the substantive contents of the unit of analysis, i.e., those elements that referred to a number of specific aspects of the health service attention process and the circumstances surrounding it. This subsystem contained 59 mutually exclusive categories. Fifty-eight of these were grouped into four thematic areas: descriptive aspects, the attention process, the interaction between the client and those delivering the service, and the consequences of the encounter. The remaining category was the does not apply category, where those contents that could not be inserted in any of the four thematic areas were allocated.

SUBSYSTEM 2

Subsystem 2 (S2) took in the clients' evaluations of the contents of S1, i.e., the participants' considerations as to whether the contents included in S1 were correct and appropriate or not. S2 had only three categories: positive valence, negative valence, and does not apply.

SUBSYSTEM 3

Subsystem 3 (S3) focused on the assessments made about the way those things described in the categories of S1 were done. This system also had only three categories: positive valence, negative valence, and does not apply.

Thus, one same unit of analysis could refer to a specific content (S1) that could be positive or negative (S2), and could have been given in a way the user considered positive or negative (S3).

Coding

Two separate judges coded all the material using the category system described above. Agreement coefficients were very high ($\kappa = .99$ for S1, $\kappa = .99$ for S2, and $\kappa = 1.00$ for S3). Any disagreements were discussed after coding. As a result, some improvements were made to the system relating mainly to nuances in the definitions of the categories.

SUBSYSTEM 1

S1 had a large number of categories. "Descriptions" was the first thematic area of S1, made up 24.7% of the total. This is not surprising, as the instructions explicitly asked the participants to make detailed descriptions of what had happened. Attention Process, the second thematic area, represented 26.7% of the total. Some of the categories in this area—such as reason for contact, waiting time until attended, treatment, and diagnosis—reflected a

sort of generic script of what a contact with the health services is like. This can explain why these were frequent categories.

Two main topics were distinguished within Client-Service Provider Interaction (the third thematic area): (a) information, and (b) interpersonal treatment. Information made up 15.8% of the total of S1. Thus, a series of categories concerned the information given and asked for, paraverbal language, how the providers of the service handled the information given by the client, whether the rules were made explicit by the staff, and whether these rules were followed by both parties. Also, as part of the interaction thematic area, a series of the categories that emerged referred to interpersonal treatment (e.g., interpersonal behavior by the service providers, medical treatment, recognition of errors with/without an apology, the staff's personal interest in their own work, and so on). Interpersonal treatment made up 12% of the total of S1.

The fourth thematic sector, Consequences of the Encounter, represented 13.4% of the total of S1. The remaining 7.4% corresponded to the category Does not Apply.

In order to learn how these aspects of S1 were evaluated, S2 and S3 were examined.

SUBSYSTEM 2

The frequency and the way in which the elements within each thematic area of S1 were evaluated in S2 were examined. In other words, the examination of S2 revealed what aspects of the health services the clients evaluated (the what question) and the way they evaluated those aspects (the how question).

Descriptions. Descriptions were almost always assessed in S2 as Does not Apply, i.e., the participants tended not to assign any valence to descriptions. Certainly, descriptions were mainly composed of narrative descriptive elements that identified the situation and were unlikely to include assessments.

Attention Process. Some of the categories in this area of S1 clearly appeared in the Does not Apply category of S2. These were reason for contact, examination, and medical treatment. The reason for participants not to make evaluations of these aspects might be that such aspects are beyond their expertise. However, the high frequency of these categories in S1 suggests that these topics are really important. The participants did make evaluations about some other categories within this group, such as waiting time, which was equally valued as positive and negative, but never as does not apply.

Some categories in the Attention Process group reflected a generic script about how things should occur in health services. In line with this

observation, many of the elements within attention process were assessed by the participants (e.g., waiting time, whether somebody dealt with the demand, or whether the patient was attended by their regular physician or health professional).

Client-Service Provider Interaction

1. *Information.* In S1, the most frequent categories within information were the service providers gave information, either not assessed or assessed as negative or insufficient, and the way the service providers handled the information given by the client,² seen as negative or incorrect.
2. *Interpersonal Treatment.* Individuals tended to remember how well they were treated, as well as the positive interpersonal behaviors of those giving the service. The latter particularly had an intrinsic positive nature, as they were behaviors that the clients considered went beyond the staff's requirements. These behaviors included, among other things, talking with the patients to calm them down, or providing "special" attention.

Consequences of the Encounter. The participants' assessments of the whole experience were mainly positive. Furthermore, the information about the physical evolution after the encounter and the feelings about the encounter were important to the clients, and were evaluated very often. Although both positive and negative assessments were frequent, there was a slight tendency towards negative assessments. Thus, the physical evolution and the feelings provoked by the encounter are always important, but more so when they are negative.

SUBSYSTEM 3

S3 assessed the way the service as described in S1 was given. The functionality of this system was not very clear because most of the cases were assigned to the Does not Apply category. However, occasionally information would be lost if this subsystem was not taken into account. For example, the category The Way the Service Provider Gave Information usually received a negative assessment. That is, regardless of whether the information provided by the service personnel was considered correct or not (S2), the way the information was given tended to be assessed negatively (S3).

DISCUSSION

Although the categories of S1 were grouped into four thematic areas, a number of subtleties made it extremely difficult to classify some of the categories

as one type or another. Nevertheless, this richness of detail is what gives shape to the aspects that the clients use to assess whether their experiences are fair or not. The characteristics of our category system can be especially relevant because, unlike other researchers (Clemmer & Schneider, 1996; Mikula, 1986; Tax et al., 1998), we did not impose categories coinciding with the justice dimensions that have been described in the literature.

Patients who use health care services expect things to take place in a certain way, that is, they have a generic script that they can readily describe, particularly if the episode was experienced as fair. This was reflected essentially in the categories pertaining to the Attention Process theme in S1. Furthermore, the participants add evaluative aspects to this script, judging the events as correct or not. These evaluations are normally based on second opinions or subsequent experiences that showed a bad (or good) performance on the part of the service providers (e.g., “the doctors didn’t know what they were doing . . . they sent me to a hospital in another town and there they told me everything that had been done wrong [during the previous treatment]”). Although the patient may find it especially difficult to assess the service given on the technical level (Bowers & Kiefe, 2002; Che et al., 2004), the patient does not hesitate to make evaluations of aspects such as the staff’s professional knowledge and competence, their interest in the work, and the overall performance of those giving the service, in line with Bendapudi, Berry, Frey, Turner, and Rayburn’s results (2006).

The clients, therefore, created their own view of what their encounter with the service was like. They recalled the information that was more accessible to them, and made spontaneous justifications and explanations regarding the motives for that behavior:

He asked a couple of questions without looking us in the eye, as if he were trying to take as little time as possible; he signed his paper and gave it to us, making us feel like we were wasting his time.

Within the context of the attention process there were frequent comments, both positive and negative, about waiting time. This suggests that an important concern of patients is whether they are attended to punctually or not (e.g., “she signaled us with her hand to wait outside still . . . she even made us wait a long time, like 15 minutes;” “as far as I can remember, I think this was the first time they attended to me at the time of my appointment”). In fact, waiting time has been an object of study in service research as a whole, particularly in relation to improvement and satisfaction. The reason behind this interest is that waits are seen as something inconvenient that negatively affects perceptions of service quality (Groth & Gilliland, 2001). It is not surprising that waiting times, along with patient rights and information, emerged as important factors to be improved in European survey studies of health care (Health Consumer Powerhouse, 2007).

The interactions necessarily entailed in the provision of a service appeared in the participants' descriptions. This theme revolved mainly around two issues: aspects related to (a) the exchange of information, and those related to (b) interpersonal treatment. Traditionally, both areas have come under the interactional dimension of justice (Bies & Moag, 1986; Blader & Tyler, 2003). However, the latest developments point to the need to separate informational from interpersonal justice (e.g., Colquitt, 2001) as our results suggest.

In regard to the exchange of information, the clients repeatedly described rules and whether they were followed by both the service providers and the patients (e.g., "I patiently waited my turn in the waiting room until they called me on the loudspeaker;" "I went to get blood tests done without an appointment;" "they greeted each other and he let him go in first, although other people had come earlier"). This reflects traits of procedural justice—i.e., the clients take into account the procedures leading to certain outcome in order to assess whether they have been treated fairly or not. In the present case, clear reference was made to consistency in the procedures and their equal application to all the clients, in line with Leventhal's (1980) rules.

The way the service provider handled the information given by the client (i.e., whether the staff listened and paid attention to the clients) made up another interactional category. This idea emphasizes the reciprocity in the information exchange. This content was reflected in statements such as, "despite my complaints, he decided to release me." This idea is connected to the phenomenon of voice described by Folger (1986). Having a voice contributes to perceiving greater fairness, and the fairer a procedure is perceived to be, the greater degree of acceptance of the outcome obtained through that procedure (the so-called "fair process effect;" see Van den Bos, 2005). In health services, this effect means that the fairer a patient perceives the procedure that has led to a specific outcome (e.g., diagnosis), the more likely this patient is to view that outcome as positive, to accept it if negative, and to be more satisfied with the service. The perception of procedures is apparent in the category that recorded whether the patients were attended to by the person they expected. For example, if patients go to the service and are not attended to by "their" doctor, then their justice perceptions will probably be negative. By virtue of the fair process effect, one can furthermore expect these patients to be less accepting of the outcome (e.g., diagnosis or treatment).

Participants emphasized whether the staff provided information (S1), and they tended to value negatively both the information given (S2) and the way it was given (S3) (e.g., "I was angry at the way they spoke to me, but above all, what most infuriated me was that a doctor...gave me such an alarming diagnosis [which later turned out to be wrong!]"). This suggests that health services should pay greater attention to the amount

and quality of the information they give to their clients. On the other side, patients giving information concerning different matters (e.g., medical history, symptoms, or medical procedures with which they were already familiar), noted whether the staff made good use of these data. This indicates that health personnel should pay attention to the information the clients give them, should use that information and, above all should make sure that the patients notice this interest. Other categories were found that supported these recommendations. For example, clients needed to feel that they were being listened to. Eye contact emerged as an important indicator in this context.

In regard to the interpersonal treatment, the information gathered mirrors the perception of interactional justice formulated by Bies and Moag (1986), in which one can find key elements such as being treated with dignity and respect. The interpersonal treatment group encompassed descriptions about (a) how the staff treated the client, and (b) how the client treated the staff. They emphasized the reciprocity of interpersonal treatment and revealed a new area of the perception of interactional justice. The results likewise showed that when clients describe their experiences with health services they tend to recall positive aspects of interpersonal treatment. In particular, the participants often mentioned instances in which the staff went beyond their professional duties (e.g., “the social worker offered all kinds of help the whole time, even giving us her phone number in case we needed to talk to someone at any time”). This attitude, near to Masterson’s “prosocial behavior” concept (2001), was very positively valued by the participants and, in accordance with Tepper and Taylor (2003), was used as an indicator of fairness.

Other important components related to interpersonal treatment appeared in our study. These are the staff’s admission of their own errors, the staff’s apologies (e.g., “then, an hour later, the nurse came out and apologized for having scolded me”), the clients’ perception of the staff’s interest in their own work, and the clients’ perception of the staff’s interest in matters regarding the patient (e.g., “she didn’t even look, or get up to see it [the injury] more closely, or anything”).

It is frequent that people needing a health care service has negative previous feelings (e.g., nervousness, insecurity, or uncertainty): “It has to be said that nobody goes very calm to these places . . .” It seems that when people are especially vulnerable or needy, the interpersonal treatment they receive and the behavior shown by those nearby seem to be particularly relevant (S1), and are frequently recalled with a positive valence (S2). In states of great uncertainty—such as when someone perceives her or his health to be threatened—individuals have more interest in, and feel a greater need for perceiving justice (Van den Bos & Lind, 2002). Thus, in a situation of this kind, individuals are more likely to see extra-role behaviors and the interpersonal treatment features referred before, as evidence of fairness.

This vulnerability makes it crucial for health care organizations to foster their patients' fairness perceptions in order to improve their service and results.

Despite the importance of these interpersonal aspects, health service clients do not overlook the distributive elements of justice—i.e., the outcomes (e.g., “he didn't offer me any solutions, and he didn't refer me to a specialist, he just scared me”). In this regard, it is noteworthy that the participants made explicit references to the proportionality between what they invested and obtained in their situation (e.g., “the only thing I thought was unfair was the price of the visit [40 Euros] in relation to the time it took [10 min]”). Related with the outcomes of their experiences, both the physical and emotional consequences of the encounter played an important role in the perception of distributive fairness or unfairness (e.g., “because the nurses didn't dress my wound, I ended up with a bigger and uglier scar than I should have;” “without even looking at me, he gave me a really alarming diagnosis and made me scared and tense for no reason”). Both kinds of consequences should be taken into account in future conceptualizations and measures of justice within the (health) service area.

Limitations and Future Research

The present study has many strengths, and the present findings are far-reaching. However, this study also has a serious limitation. Having used only students' descriptions means that all participants were young, and their experiences with health services and illnesses may be quite different from those of older age groups. Moreover, retrospective self-reports can be contaminated by variables related to recall (Tax et al., 1998). Research underway is addressing these issues.

A number of comments related to justice in the descriptions of health service clients connect with the theoretical statements on the topic. Aspects such as waiting times (which are linked to the perception of procedural justice), physical and emotional outcomes (which are related to the perception of distributive justice), extra-role behaviors by the service providers (which influence the perception of interactional justice), and the exchange of information (related to informational justice perception) are some of the specific topics that have turned out to be particularly relevant in the making of judgments about fairness in health care services. Future research in the area should take into account those issues and check its functionality. At the same time, these components of the perception of justice, resulting from this research, show concrete points that practitioners can consider to improve justice perceptions of patients and, therefore, their organizational results. The consideration of these components will improve the conceptualization of justice and will facilitate better predictions of organizational results in health care services, especially those directly related with patients.

NOTES

1. In colloquial Spanish language it is customary to speak in terms such as “They treated me fairly or unfairly in a given service” although they are not necessarily referring to relational aspects of justice. We included this different wording (treatment and experience) to expand as much as possible their responses.

2. This category (the way the service providers handled the information given by the client) may imply an assessment by the clients, which is more characteristic of S3 than it is of S1. However, it was included in S1 because it appeared very frequently as a distinct category in the clients’ descriptions and its contents could be assessed in S2 and S3 in the same way as the contents in other categories. For example, “she did not listen to what I was saying and looked away” would be included in this S1 category, and would be assessed negatively both in S2 and S3.

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