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Socioeconomic level and perception of quality of emergency care in a public hospital in Colombia

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ABSTRACT

Objective: To evaluate the quality of care perceived by emergency department users according to their socioeconomic status in a Colombian public hospital during the first half of 2025. **Materials and methods:** A quantitative descriptive cross-sectional study was conducted with a sample of 197 users treated in the emergency department. To collect the information, the questionnaire "Perception of the quality of care in the emergency department" was applied, an instrument derived from the SERVQUAL model and adapted to the characteristics of the study population in the chosen hospital in Colombia, restructuring its dimensions towards the evaluation of timeliness, information provided, trust, humane treatment, and administrative aspects. **Results:** The perception was mostly positive. Staff interest in solving problems (98.0%), friendliness (97.5%), preparedness (97.5%), humane and personalized treatment (97.5%), and understanding of patient needs (97.2%) achieved the highest scores. The overall rating of the service was "Excellent" or "Good" in 82.2% of cases. Likewise, the responses "as expected" and "agree" predominated, mainly in stratum 1 (49.2% and 44.7%, respectively), which shows a favorable perception of care among users with lower socioeconomic status, who represented 58.4% of the total sample. **Conclusion:** The perception of emergency care was highly positive, highlighting the technical and human quality of the staff. These findings underscore the importance of maintaining and strengthening patient-centered practices, promoting communication, empathy, and dignified treatment as pillars of the healthcare experience.

Keywords: humanization of care; quality of health care; patient satisfaction; emergency departments.

Scientific contribution:

This study demonstrates how users' socioeconomic status influences their perception of the quality of care in emergency services. Similarly, it highlights the usefulness of quantitative indicators in guiding continuous improvement initiatives and fostering sustainable impact within healthcare systems.

INTRODUCTION

Humanized healthcare is an essential component of healthcare quality, and it is defined as the provision of services that, in addition to meeting technical and scientific standards, recognize the dignity, values, and individual needs of users (1). This approach seeks to ensure dignified, empathetic, and respectful care, particularly in high-demand and emotionally charged settings such as emergency departments, where patients and their families often face critical and vulnerable situations (2).

Within the Colombian context, the Humanization Policy in Healthcare and Resolution 3100 of 2019 establish guidelines for integrating a humanized care perspective into hospitals, incorporating dimensions such as effective communication, accessibility, patient safety, and active family involvement (3). These guidelines are particularly relevant in primary-level hospitals, which serve as the entry point to the healthcare system and are responsible for resolving most low- and moderate-acuity emergencies.

Previous studies in Latin America show that the perceived quality of humanized care is influenced by factors such as resource availability, staff training, infrastructure, and service organization. Research studies conducted in Peru (4, 5), Chile (6–8), and Mexico (9) underscore the importance of interpersonal relationships and communication as central components of the user experience in emergency care settings. In Colombia, the study by Bautista-Gómez and van Neikerk (10) reveals gaps in access to and coordination of healthcare services in rural areas, attributed to systemic shortcomings in institutional innovation that may indirectly affect the quality of humanized care.

In Colombian municipalities, primary-level healthcare institutions serve as key providers of emergency services, serving a diverse population that includes both urban and rural residents. However, local evidence regarding the perception of humanized care quality in this context remains limited, thereby hindering the implementation of data-driven improvement initiatives. In this regard, assessing patient perception enables identification of strengths and areas for improvement, which may significantly contribute to strengthening hospital management and user satisfaction.

Within this framework, the objective of this study was to evaluate users' perception of the quality of care provided in the emergency department of a public primary-level hospital in Colombia, considering patients' socioeconomic conditions as a relevant factor that influences care experience. The aim is to generate evidence that can serve as a basis for implementing continuous improvement strategies, strengthening hospital management processes, and contributing to the development of more equitable care focused on user needs.

MATERIALS AND METHODS

A quantitative, descriptive, cross-sectional study was conducted to evaluate the perception of the quality of care in the emergency department of a public primary-level hospital in the municipality of the city of Casanare, Colombia. This design is appropriate for describing the characteristics of a population at a specific point in time and for analyzing trends or patterns in variables of interest (11). The data collection period corresponded to the first quarter of 2025, which provided a timely overview of the quality of care perceived by the individuals treated during that period.

The target population consisted of users who were treated in the emergency department during the data collection period. Inclusion criteria were being 18 or older, having completed care in the emergency department, and voluntarily agreeing to participate in the study. Patients with cognitive impairment that prevented them from completing the instrument were excluded. The selection was made using non-probability convenience sampling, based on user availability at the time of the survey. A total of 197 users participated, corresponding to the final sample analyzed, with a 95% confidence level and a 5% margin of error.

Data were collected using the questionnaire "Perception of Quality of Care in the Emergency Department," derived from the SERVQUAL model (12) and adapted to the characteristics of the study population in Colombia (13, 14). The instrument was restructured around the dimensions of timeliness, information provided, trust, humanized treatment, and administrative aspects. In addition, this questionnaire represents an adaptation of SERVQHOS, an instrument originally designed and validated in public hospitals in Spain and subsequently modified and validated by various authors internationally according to the characteristics of each target population (15–19).

For the present study, authorization was requested and obtained via email from a Colombian author who, in 2023, had adapted the instrument to national characteristics and subsequently subjected it to validation by other researchers. Within the framework of this investigation, the instrument was further adapted to the language and sociocultural particularities of the population of the city of Casanare to facilitate item comprehension and ensure more accurate interpretation by participants. Furthermore, an instrument validation process was conducted to confirm its relevance and adequacy for this specific population. Responses were recorded using a five-point Likert scale, allowing for quantification of overall perception and dimension-specific perception (20).

The reliability analysis of the questionnaire, calculated using Cronbach's alpha, yielded a value of 0.850, placing it

within the range considered "very good" (0.80–0.89), and reflecting high internal consistency. This means that the items of the instrument are strongly interrelated and consistently measure the construct of interest—in this case, perceived quality of care in the emergency department.

Similarly, Cronbach's alpha based on standardized items reached a value of 0.857, virtually identical to that obtained with non-standardized data. This similarity demonstrates that potential differences in item response scales do not significantly affect the instrument's reliability, thereby confirming its psychometric stability and robustness.

Data were coded and initially processed in Microsoft Excel® 2019 for data cleaning and preliminary organization. After that, the data were imported into IBM SPSS Statistics® version 26 for statistical analysis. Absolute and relative frequencies were calculated for qualitative variables, while measures of central tendency and dispersion were computed for quantitative variables.

To explore potential relationships between perceived quality of care and user characteristics, bivariate cross-tabulations and tests of association were performed using the chi-square test of independence. The satisfaction dimensions specifically selected were those related to medical information provided and the appropriateness of care provided by the healthcare staff, as these represent the most direct components of the clinical care experience and exhibited greater variability in responses. Socioeconomic status was used as a contrast variable, given that multiple studies recognize its influence on perception of care and the differences that may arise in service quality according to users' economic conditions (21–24). The application of the chi-square test of independence enabled the evaluation of observed differences and the identification of associations aligned with the study objectives, while avoiding redundant analyses of dimensions with homogeneous distributions or low discriminatory capacity. Results were organized and presented exclusively in tables, following the structure of the dimensions assessed by the instrument.

In Colombia, household economic conditions are classified through the official socioeconomic stratification system established by the National Administrative Department of Statistics (DANE). This system categorizes the population into six strata that indirectly reflect economic capacity and level of access to goods and services. For this study, strata were regrouped into five categories: extreme poverty (stratum 1), low (stratum 2), middle (stratum 3), upper-middle (stratum 4), and high (strata 5 and 6). This organization allowed for a more precise representation of participants' socioeconomic distribution and facilitated comparison of perceptions across groups with different economic conditions (25).

The study was classified as minimal-risk research in accordance with Article 11 of Resolution 8430 of 1993 issued by the Colombian Ministry of Health (26), as no interventions or intentional modifications were made to participants' biological, physiological, psychological, or social variables. Before the application of the instrument, the corresponding institutional authorization was requested, and subsequently, written informed consent was obtained from each participant. Confidentiality of information, anonymity of both the participants and the institution, and compliance with national and international standards for research involving human subjects were guaranteed. The study received written approval from the hospital's Institutional Ethics Committee, ensuring adherence to the principles of autonomy, beneficence, and justice.

RESULTS

A total of 197 users of the emergency department in a low-complexity hospital were surveyed, all of whom met the established inclusion criteria. The sociodemographic distribution showed that the majority were women (54.5%). In terms of age, the group over 45 years old predominated (32.5%). In terms of marital status, the most frequent categories were "single" and "cohabiting" (38.8% each), indicating that 77.16% of the population is not formally married. With respect to socioeconomic status, the highest percentage corresponded to stratum 1 (58.4%). The most represented educational level was secondary education (39.6%), and most respondents resided in urban areas (70.1%).

Hospital physical and technological conditions

Findings showed that 70.1% of surveyed users reported that hospital signage met their expectations, and 74.6% expressed the same perception regarding the condition of facilities. These results reflect expectations being met, although without exceeding a notably functional care experience (Table 1).

Table 1. Hospital physical and technological conditions.

Variable	n	%
Signage within the hospital		
1. Much worse than expected	6	3.0
2. Worse than expected	7	3.6
3. As expected	138	70.1
4. Better than expected	25	12.7
5. Much better than expected	21	10.7

Table 1. *(Continuation).*

Variable	n	%
Condition of hospital facilities (appearance and comfort)		
1. Much worse than expected	4	2.0
2. Worse than expected	4	2.0
3. As expected	147	74.6
4. Better than expected	22	11.2
5. Much better than expected	20	10.2

Perceived quality during care

Results indicate a predominantly positive perception of the treatment received in the emergency department. In relation to timeliness regarding waiting time, 79.7% said they strongly agreed or agreed with the treatment received (Table 2).

A similar pattern was observed in users' perception of healthcare personnel performance: overall, most respondents indicated that staff treatment met, exceeded, and even far exceeded their expectations. In detail, the medical information provided to the patient received a positive rating of 92.4%; the medical information provided to family members, 96.9%; the interest of healthcare personnel in resolving problems, 98.0%; the willingness of staff to help, 96.9%; the confidence conveyed by the staff personnel, 96.4%; the kindness of the staff, 97.5%; the preparedness of the healthcare staff, 97.5%; the humane and personalized treatment, 97.5%; and the understanding of patient needs, 97.5% (Table 2).

Regarding users' perceptions of the administrative aspects of the emergency department, 87.8% rated the care provided by the billing staff as excellent or good, and 82.2% responded similarly when asked to rate this service overall (Table 2). These findings demonstrate high levels of satisfaction and trust in the care provided, reflecting a favorable balance between technical quality of care and humanized patient-centered treatment.

Table 2. Dimensions of perceived quality.

Evaluated Variable	Subcategory 1: Timeliness of care in the emergency department									
	Strongly disagree		Disagree		Undecided		Agree		Strongly agree	
	n	%	n	%	n	%	n	%	n	%
Timeliness regarding waiting time	4	2.0	14	7.1	22	11.2	124	62.9	33	16.8

Evaluated Variable	Subcategory 2: Users' perception of the quality of care provided by the healthcare staff									
	Much worse		Worse		As expected		Better		Much better	
	n	%	n	%	n	%	n	%	n	%
Medical information provided to the patient	7	3.6	8	4.1	144	73.1	20	10.2	18	9.1
Medical information provided to family members	3	1.5	3	1.5	142	72.1	30	15.2	19	9.6
Staff interest in resolving patient concerns	2	1.0	2	1.0	148	75.1	25	12.7	20	10.2
Staff willingness to assist	2	1.0	4	2.0	148	75.1	24	12.2	19	9.6
Confidence conveyed by healthcare personnel	2	1.0	5	2.5	136	69.0	32	16.2	22	11.2
Staff courtesy	1	0.5	4	2.0	137	69.5	33	16.8	22	11.2
Preparedness of the healthcare staff	1	0.5	4	2.0	135	68.5	34	17.3	23	11.7
Humanized and personalized treatment	3	1.5	2	1.0	130	66.0	37	18.8	25	12.7
Understanding of patient needs	2	1.0	3	1.5	133	67.5	35	17.8	24	12.2

Evaluated Variable	Subcategory 3: Users' perception of administrative aspects of the emergency department									
	Very poor		Poor		Fair		Good		Excellent	
	n	%	n	%	n	%	n	%	n	%
Billing staff service	2	1.0	4	2.0	18	9.1	117	59.4	56	28.4
Overall service rating	1	0.5	3	1.5	31	15.7	98	49.7	64	32.5

Association between dimensions of perceived quality and users' socioeconomic status

Descriptive analysis indicates that across all socioeconomic levels, perception of healthcare services tends to be positive, with the response "as expected" predominating, followed by ratings above expectations. In stratum 1, most responses were concentrated in moderate satisfaction levels, whereas in strata 2 and 3, "better" or "much better than expected" perceptions were more frequently observed. However, stratum 2 showed a higher number of negative responses compared to the other groups. It is important to note that no participants belonged to strata 4 or 5; therefore, these levels were not included in the comparative analysis.

To contrast these differences, the chi-square test of independence was applied. Statistically significant associations were found between socioeconomic status and perception of the medical information provided ($p = 0.001$), as well as perception of the appropriateness of care provided by the healthcare staff ($p = 0.000$). These findings indicate that service quality ratings vary according to socioeconomic stratum. However, measures of association suggest that although the relationship is statistically significant, the magnitude of the effect is not strong. In summary, the results show that socioeconomic status is associated with perception of healthcare services; nevertheless, differences are not extreme, and an overall favorable trend is maintained across all groups (Table 3).

Table 3. Dimensions of perceived quality associated with users' socioeconomic status.

Variables	Socioeconomic status						p-value
	Stratum 1		Stratum 2		Stratum 3		
	n	%	n	%	n	%	
Medical information provided to the patient by the healthcare staff							
1. Much worse than expected	2	1.0	5	2.5	0	0.0	0,001
2. Worse than expected	3	1.5	5	2.5	0	0.0	
3. As expected	97	49.2	40	20.3	7	3.6	
4. Better than expected	10	5.1	8	4.1	2	1.0	
5. Much better than expected	3	1.5	14	7.1	1	0.5	
Appropriateness of care provided by the healthcare staff							
1. Strongly agree	24	12.2	31	15.7	5	2.5	0,000
2. Agree	88	44.7	37	18.7	4	2.0	
3. Not sure	1	0.5	0	0.0	1	0.5	
4. Disagree	2	1.0	1	0.5	0	0.0	
5. Strongly disagree	0	0.0	3	1.5	0	0.0	

Stratum 1: low socioeconomic status; stratum 2: lower-middle socioeconomic status; stratum 3: middle socioeconomic status.

DISCUSSION

The results indicate that users' perception of humanized care in the emergency department is predominantly positive, with emphasis on respect for patient dignity, staff kindness, and preservation of confidentiality. This finding is consistent with Martínez et al. (27), who reported that dignified treatment and respect are essential components of the patient experience and significantly contribute to satisfaction with healthcare services.

Within the dimension of respect for dignity, humanized and personalized care was positively rated by 97.5% of users, while understanding of patient needs reached 97.5% in the categories "as expected" or "better." These results align with the World Health Organization's framework (28), which identifies active patient participation as a core principle of person-centered care.

Regarding the medical information provided to patients, respondents reported receiving clear explanations about diagnoses and procedures, although a small percentage (7.7%) expressed disagreement. Previous studies suggest that clear clinical communication not only enhances understanding of health status but also reduces anxiety and improves treatment adherence (29). However, the presence of neu-

tral responses, representing 73.1%, shows that there is still room for improvement in patient education strategies in high-demand healthcare settings, such as emergency departments.

In terms of accessibility and timeliness, although 62.9% perceived waiting times as acceptable, 9.1% of users expressed dissatisfaction. This finding represents a relevant opportunity for quality improvement. While most respondents rated the care as adequate, those perceiving it as merely "acceptable" or "fair" may have experienced delays, insufficient information, or challenges navigating the service. Addressing these intermediate perceptions can raise the overall rating of the service, as it is precisely these users who define the threshold between complete satisfaction and constructive criticism. Studies such as that of Sánchez et al. (30) demonstrate that prolonged waiting times and lack of orientation are key determinants of dissatisfaction, even in services that maintain appropriate technical standards of care.

Empathy and humanized treatment received the highest ratings, with over 90% positive responses, reaffirming the central role of the affective dimension in the patient–healthcare professional relationship. These findings are consistent with previous research highlighting that kindness and genuine interest in patient well-being are perceived as core indicators of healthcare quality, even surpassing timeliness in the service (31–35).

The privacy and confidentiality dimension received favorable evaluations, reflecting compliance with current ethical and regulatory standards, as established by the Colombian Ministry of Health and Social Protection within the framework of the fundamental right to privacy (36).

From a statistical perspective, these differences are not merely anecdotal. The chi-square test of independence revealed statistically significant associations between socioeconomic status and perception of both the medical information provided ($p = 0.001$) and the appropriateness of care delivered by healthcare staff ($p = 0.000$). This confirms that service evaluation varies according to the socioeconomic stratum.

This finding represents a meaningful contribution, as it demonstrates that satisfaction dimensions related to communication and quality of interpersonal treatment are perceived differently depending on socioeconomic status. Users from lower socioeconomic strata tended to rate the service as "adequate" or "as expected," whereas more polarized responses were observed among the middle strata. This difference can be explained by variations in expectations, prior access to health services, or perceptions of fairness in the care received. Recognizing these differences is essential for guiding targeted quality improvement strategies and ensuring equity in the user care experience.

These results align with prior research on disparities in perceived healthcare quality. For example, Cavero et al. (37) reported that patient satisfaction tends to be higher among individuals in higher socioeconomic levels, possibly due to greater expectations and prior positive experiences, although the effect remains moderate. Similarly, Alvarado and Paca (38) observed that despite socioeconomic differences, most patients report satisfactory levels of care, suggesting a relatively uniform standard in clinical care processes.

Overall, the results suggest that the evaluated emergency department demonstrates significant strengths in the humanization component of care, although it requires targeted improvements in timeliness and effective communication, particularly for users who perceive care as only acceptable. Implementing differentiated interventions based on socioeconomic status, along with training in assertive communication and patient flow reorganization strategies, may optimize the care experience and strengthen overall perceived quality.

This study has several limitations that should be considered when interpreting the results. First, the non-probability convenience sampling method may limit the full representativeness of the emergency department user population; however, this approach is appropriate for descriptive research in settings where participant inclusion depends on immediate availability. Additionally, no participants from socioeconomic strata 4 and 5 were recorded. This reflects the typical utilization pattern of public primary-level hospitals, where demand predominantly originates from low- and lower-middle-income households. Although this absence limits comprehensive comparison across all socioeconomic levels, it does not compromise the validity of the analysis conducted for the represented strata.

Furthermore, the data were based on users' subjective perceptions, which may be influenced by individual factors such as prior expectations, previous experiences, or emotional conditions while being treated. Nevertheless, the instrument showed high internal consistency, supporting the reliability of measurements. Finally, as this is a cross-sectional study conducted during the first quarter of 2025, the results provide a snapshot of the period analyzed and do not allow for the establishment of causal relationships or temporal variations in the perception of quality of care.

CONCLUSIONS

The findings suggest that socioeconomic status exerts a perceptible, though not determinant, influence on how users evaluate the care received. Although a positive perception predominates across all strata, the observed differences indicate that expectations, prior access to healthcare services, and cultural capital may shape the patient's subjective care experience. Lower socioeconomic strata tend to value fundamental aspects such as courtesy and respect more favorably, whereas in middle and higher strata, greater importance is placed on timeliness, clear communication, and effective resolution of healthcare needs. This behavior shows that perceived quality does not depend exclusively on the healthcare services provided, but also on the sociocultural context from which users interpret their clinical experience. This underscores the institutional challenge of ensuring equitable, accessible, and humanized care for all social groups.

It is recommended to periodically continue monitoring user perception, strengthening staff communication skills, and promoting a person-centered approach to reinforce empathy and dignified treatment. In addition, optimizing patient flow during peak-demand hours and leveraging technological resources to enhance timeliness and clarity of information are advised. Finally, future studies should be extended to other levels of care, incorporating socioeconomic and cultural variables to further explore the differences observed among strata.

Conflict of interest:
The authors declare no conflicts of interest.

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Ethics approval:
The study was approved by the Hospital Ethics Committee, where the research was conducted, under Certificate 1, code FO012CL003 on March 26, 2025.

Authorship contribution:
PYNP: conceptualization, formal analysis, research; methodology, validation, visualization, data collection and tabulation, management of instrument validation, management of instrument licensing, coordination of institutional approval for study implementation, writing of the original draft, writing - review & editing.
CSOC: conceptualization, formal analysis; research, methodology, validation, visualization, management of instrument validation, management of instrument licensing, coordination of institutional approval for study implementation, writing of the original draft, writing - review & editing.
GOR: data curation, project advisory support, management of instrument validation, management of instrument licensing, research, validation, and writing of the original draft.
ALP: research; project advisory support; validation; writing of the original draft; writing - review & editing.

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REFERENCIAS

1. World Health Organization. Quality of care [Internet]. WHO; [n. d.]. Available from: https://www.who.int/health-topics/quality-of-care#tab=tab_1
2. Martí-García C, Fernández-Férez A, Fernández-Sola C, Pérez-Rodríguez R, Esteban-Burgos AA, Hernández-Padilla JM, et al. Patients' experiences and perceptions of dignity in end-of-life care in emergency departments: a qualitative study. J Adv Nurs [Internet]. 2023; 79(1): 269-280. Available from: https://doi.org/10.1111/jan.15432
3. Resolución 3100 de 2019, por la cual se definen los procedimientos y condiciones de inscripción de los prestadores de servicios de salud y de habilitación de servicios de salud [Internet]. Bogotá: Ministerio de Salud y Protección Social (CO); November 25, 2019. Available from: https://www.suin-juriscol.gov.co/clp/contenidos.dll/Resolucion/30039964#
4. Sánchez M. Caracterización del cuidado humanizado de enfermería en los servicios de urgencia y emergencia [tesis de segunda especialidad en Internet]. Lima: Uni-

versidad Peruana Cayetano Heredia; 2021. Available from: https://hdl.handle.net/20.500.12866/11686
5. Arce MA, Aliaga-Gastelumendi RA. Calidad de atención y satisfacción del usuario en un servicio de emergencia de un hospital del seguro social. Acta Méd Peru [Internet]. 2024; 40(4): 308-313. Available from: https://doi.org/10.35663/amp.2023.404.2722
6. Monje P, Miranda P, Oyarzün J, Seguel F, Flores E. Percepción de cuidado humanizado de enfermería desde la perspectiva de usuarios hospitalizados. Cienc Enferm [Internet]. 2018; 24: 5. Available from: http://doi.org/10.4067/s0717-95532018000100205
7. Correa-Yantany K, Osorio-Spuler X, Bustos-Medina L, Toffoletto MC, Barrios-Casas S. Percepción de pacientes en relación a los cuidados humanizados otorgados por enfermería. Rev Cuid [Internet]. 2025; 16(2): e4477. Available from: https://doi.org/10.15649/cuidarte.4477
8. Francés E, Camaño R. Comunicación interna en centros de atención primaria de salud: una perspectiva de enfermería. Perspect Comun [Internet]. 2023; 16(2). Available from: https://doi.org/10.56754/0718-4867.2023.3351
9. López-Marure E, Vargas-León R. La comunicación interpersonal en la relación enfermera paciente. Rev Enferm Inst Mex Seguro Soc [Internet]. 2002; 10(2): 93-102. Available from: https://revistaenfermeria.imss.gob.mx/index.php/revista_enfermeria/article/view/749
10. Bautista-Gómez MM, van Niekerk L. A social innovation model for equitable access to quality health services for rural populations: a case from Sumapaz, a rural district of Bogota, Colombia. Int J Equity Health [Internet]. 2022; 21: 23. Available from: https://doi.org/10.1186/s12939-022-01619-2
11. Hernández-Sampieri R, Fernández-Collado C, Baptista-Lucio P. Metodología de la investigación [Internet]. 6th ed. México D. F.: McGraw-Hill Education; 2014. Available from: https://dialnet.unirioja.es/servlet/libro?codigo=775008&utm_source
12. Mira JJ, Buil JA, Rodríguez-Marín J, Aranaz J. Calidad percibida del cuidado hospitalario. Gac Sanit [Internet]. 1997; 11(4): 176-189. Available from: https://www.gacetasanitaria.org/es-calidad-percibida-del-cuidado-hospitalario-articulo-S0213911197712962
13. Barragán JA, Manrique-Abril FG. Validez y confiabilidad del Servqhos para enfermería en Boyacá, Colombia. Av Enferm [Internet]. 2010; 28(2): 48-61. Available from: https://revistas.unal.edu.co/index.php/avenferm/article/view/21376
14. Montenegro VY. Percepción de la calidad en la atención de salud de los usuarios del servicio de urgencias y sus factores relacionados en un hospital de primer nivel de atención, segundo semestre año 2023 [tesis de maestría en Internet]. Cali: Universidad del Valle; 2024. Available from: https://hdl.handle.net/10893/30535
15. Castro-Serralde E. Confiabilidad y validez de la escala SERVQHOS modificada para pacientes con tratamiento renal sustitutivo. Rev Enferm Inst Mex Seguro Soc [Internet]. 2020; 28(3): 200-210. Available from: https://revistaenfermeria.imss.gob.mx/index.php/revista_enfermeria/article/view/1078
16. Prada-García C, Benítez-Andrades JA. Evaluation of the satisfaction of patients seen in the dermatology department of a Spanish tertiary hospital. Healthcare [Internet]. 2022; 10(8): 1560. Available from: https://doi.org/10.3390/healthcare10081560
17. Pisón-Cárcamo E, Díaz de Cerio-Canduela P. Valoración de la satisfacción de los pacientes ingresados en Otorrinolaringología mediante la escala SERVQHOS. Rev ORL. 2018; 10(2): 91-101. Available from: https://doi.org/10.14201/orl.19038
18. Valenzuela XP, Calderón MC, Calle DE. Percepción de pacientes con discapacidad auditiva respecto a la calidad de atención recibida en centros de salud de Lima y Callao, Perú. Rev Enferm Herediana [Internet]. 2025; 18: e6608. Available from: https://doi.org/10.20453/renh.v18i.2025.6608
19. Marín-Tello CG, Rivera-Chávez LH, Fernández-Sánchez PL, Macías-Palacios NM, Cañarte-Alcívar JA. Calidad del servicio de enfermería en la Fundación Cottolengo: análisis con instrumento Servqhos-E. Pol Conoc [Internet]. 2019; 4(5): 204-247. Available from: https://polodelconocimiento.com/ojs/index.php/es/article/view/972
20. Cabrera-Arana GA, Londoño-Pimienta JL, Bello-Parías LD. Validación de un instrumento para medir calidad percibida por usuarios de hospitales de Colombia. Rev Salud Pública [Internet]. 2008; 10(3): 443-451. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0124-00642008000300009
21. Willems S, De Maesschalck S, Deveugele M, Derese A, De Maeseneer J. Socio-economic status of the patient and doctor-patient communication: does it make a difference? Patient Educ Couns [Internet]. 2005; 56(2): 139-146. Available from: https://doi.org/10.1016/j.pec.2004.02.011
22. Job C, Adenipekun B, Cleves A, Gill P, Samuriwo R. Health professionals implicit bias of patients with low socioeconomic status (SES) and its effects on clinical decision-making: a scoping review. BMJ Open [Internet]. 2024; 14(7): e081723. Available from: https://doi.org/10.1136/bmjopen-2023-081723
23. Dawson LP, Andrew E, Nehme Z, Bloom J, Biswas S, Cox S, et al. Association of socioeconomic status with outcomes and care quality in patients presenting with undifferentiated chest pain in the setting of universal health care coverage. J Am Heart Assoc [Internet]. 2022; 11(7): e024923. Available from: https://doi.org/10.1161/jaha.121.024923
24. Cordero MZ, González GJ. Factores socioeconómicos y de servicios de salud asociados con la mortalidad materna: una revisión. Rev Cienc Biomed

[Internet]. 2011; 2(1): 77-85. Available from: https://doi.org/10.32997/rcb-2011-3389
25. Departamento Administrativo Nacional de Estadística (CO). Metodología de estratificación socioeconómica urbana para servicios públicos domiciliarios [Internet]. Bogotá: DANE; 2015. Available from: https://www.dane.gov.co/files/geoestadistica/estratificacion/ManualdeRealizacion.pdf
26. Resolución 8430 de 1993, por la cual se establecen las normas científicas, técnicas y administrativas para la investigación en salud [Internet]. Bogotá: Ministerio de Salud (CO); October 4, 1993. Available from: https://www.minsalud.gov.co/sites/rid/lists/bibliotecadigital/ride/de/dij/resolucion-8430-de-1993.pdf
27. Martínez S, Gómez F, Lara ME. Percepción y cumplimiento del trato digno como indicador de calidad en la atención de enfermería en derechohabientes de una institución de salud. Horiz Sanitario [Internet]. 2015; 14(3): 96-100. Available from: https://doi.org/10.19136/hs.a14n3.810
28. Organización Mundial de la Salud. A69/39. Marco sobre servicios de salud integrados y centrados en la persona. OMS; April 15, 2016. Available from: https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_39-sp.pdfhttps://apps.who.int/iris/bitstream/handle/10665/253079/A69_39-sp.pdf
29. Rojas J, Moscoso LF. Adherencia al tratamiento en personas con alteraciones cardiovasculares: enfoques teóricos de enfermería. Cult Cuid [Internet]. 2020; 24(56): 256-270. Available from: http://doi.org/10.14198/cuid.2020.56.18
30. Sánchez Y, Gómez CA, Sánchez V. Planificación de la capacidad hospitalaria en condiciones de incertidumbre. Economicas CUC [Internet]. 2023; 45(1): e35364. Available from: https://doi.org/10.17981/econcuc.Org.5364
31. Navarrete-Correa T, Fonseca-Salamanca F, Barría RM. Humanized care from the perception of oncology patients from southern Chile. Invest Educ Enferm [Internet]. 2021; 39(2): e04. Available from: https://revistas.udea.edu.co/index.php/iee/article/view/346561
32. Rueda L, Gubert IC, Duro EA, Cudeiro P, Sotomayor MA, Benites EM, et al. Humanizar la medicina: un desafío conceptual y actitudinal. Rev Iberoam Bioét [Internet]. 2018; (8). Available from: https://revistas.comillas.edu/index.php/bioetica-revista-iberoamericana/article/view/8912
33. Borges L, Sánchez R, Peñalver AG, González A, Sixto A. Percepción de mujeres sobre el cuidado humanizado de enfermería durante la atención en el parto. Rev Cubana Enfermer [Internet]. 2021; 37(2): e4009. Available from: http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-03192021000200018&lng=es
34. Guillaumie L, Boiral O, Desgroseilliers V, Vonarx N, Roy B. Empowering nurses to provide humanized care in Canadian hospital care units: a qualitative study. Holist Nurs Pract [Internet]. 2022; 36(5): 311-326. Available from: https://doi.org/10.1097/HNP.0000000000000418
35. Ceballos CE, Gutiérrez S. Humanización de la atención en salud [tesis de grado en Internet]. Medellín: Universidad CES; 2012. Available from: http://hdl.handle.net/10946/1232
36. Ministerio de Salud y Protección Social (CO). Política de Privacidad y Protección de Datos Personales del Ministerio de Salud y Protección Social. Versión 02 [Internet]. Bogotá: MSPS; 2021. Available from: https://minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/OT/asis04-politica-privacidad-confidencialidad-msps.pdf
37. Cavero V, Hernández-Vásquez A, Miranda JJ, Alata P, Alegre M, Diez-Canseco F. Satisfacción y percepciones sobre aspectos de la ciudad que afectan la salud, por nivel socioeconómico, 2010-2019, en Lima Metropolitana. Rev Peru Med Exp Salud Pública [Internet]. 2022; 39(1): 44-53. Available from: https://doi.org/10.17843/rpmesp.2022.391.9888
38. Alvarado U, Paca FR. Análisis de la calidad de servicio desde la percepción del usuario en una institución prestadora de salud, Lima - 2021. Ciencia Latina [Internet]. 2022; 6(4): 4100-4139. Available from: https://doi.org/10.37811/cl_rcm.v6i4.2924