A FRAMEWORK FOR MEASURING RESPONSIVENESS

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1.0 INTRODUCTION

The World Health Organisation’s new framework for health system performance assessment has health, responsiveness and fairness of financing as the three goals of the health system (Murray and Frenk, 1999). This paper focuses on responsiveness to individuals’ legitimate expectations regarding the non-health enhancing aspects of the health system. It is not only the average level of responsiveness in a country but also the distribution of responsiveness that is of interest. Inequalities in distribution may take the form of social, economic, demographic and other types of inequalities. These issues are all important. The WHO health systems performance framework considers fairness a primary goal of health systems. Maximising social welfare depends on improving distribution, as well as increasing the average level of responsiveness.

Health system performance measurement is important: first as a means of identifying the shortcomings of health systems, as in explaining why countries with similar levels of income fail to achieve similar levels of health, responsiveness and fairness in financing; secondly, for providing indicators that allow evaluation of a health system over time. Both these activities in turn could contribute in the future to a pool of evidence that can provide the basis for confirming or rejecting if specific health systems policies (including financing and provision mechanisms) are particularly appropriate under given socio-economic conditions.

Patient satisfaction with non-medical aspects of care, is often associated with better compliance with treatment instructions, prompt seeking of care and a better understanding and retention of medical information (Murphy-Cullen and Larsen, 1984). The question then arises if better responsiveness is not automatically captured by better health performance. It can however be argued that achievements in the responsiveness domain contribute directly to patient welfare, as well as through improved health. The greater the responsiveness of the health system to the expectations of individuals’ regarding the non-health enhancing aspects of care the higher will be the level of welfare achieved, irrespective of its impact on health. For instance, while the ability to access emergency care promptly contributes to better survival and recovery rates, knowing that emergency care can be accessed rapidly provides peace of mind that has its own innate value. Likewise clean hospital surroundings and pleasant health care workers, who treat one with respect, improve a person’s quality of life. Therefore responsiveness has its own intrinsic value as a health system goal.

The concept responsiveness has been defined so as to encompass the non-health enhancing, non-financial aspects of the health system. This clear demarcation between medical and non-medical aspects is of importance in preventing double counting in the measurement of outcomes. On the other hand it is important to keep in mind that responsiveness relates to health promotion, prevention and rehabilitation as well as curative services, the most focused on part of the health system.

2.0 DEFINING RESPONSIVENESS

2.1 WHAT IS RESPONSIVENESS?

Responsiveness in the context of a system can be defined as the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals. Responsiveness can be viewed from two angles. Firstly, the user of the health care system is often portrayed as a consumer, with greater responsiveness being perceived as a means of attracting consumers. Secondly, responsiveness is related to the safeguarding of rights of patients to adequate and timely care. Owens and Batchelor (1996) cite patients' charters as an attempt to lay down the manner in which to "treat those who use health services as consumers within a market based and people centred system".

The use of the word patients is considered to underrate the status of the individual, as it implicitly crates a hierarchy. Owens and Batchelor (1996) suggest that the patient should be defined as a consumer, a rationale that originates from the emphasis on the market mechanism. Sitzia and Wood (1997) argue that the term consumer dignifies the professional/patient relationship in a way that the traditional term patient with its association of powerlessness against the medical establishment does not. Using the word client, customer or service user similarly moves away from the idea of the user of medical services being passive and dependent.

Carr-Hill (1992) argues that the term customer has the connotation of an individual where rights are concerned while consumer suggests that the individual is part of a group of users who can act together to safeguard rights. He suggests that the following seven principles should relate to consumers: access, choice, information, redress, safety, value for money and equity, but argues that their applicability in health may be limited, which results in the ability of consumers in the health system to act independently being restricted as well.

Among the words that are commonly used in the discussion of issues of responsiveness are satisfaction and quality of care. Patient satisfaction represents a complex mixture of perceived need, expectations and experience of care (Smith, 1992). Quality of care can cover a wide spectrum. Structural quality, can be defined as relating to dimensions such as continuity of care, costs, accommodation and accessibility while process quality involves the dimensions of courtesy, information, autonomy and competence (Campen et al, 1998). The terms 'service quality' are used by Kenagy, Berwick and Shore (1999) to refer to a set of issues including communication, sign posting, information provision and staff interaction with patients. Donabedian (1980) considers interpersonal aspects of quality and amenities of care along side the technical aspects of quality to be the three components of health care health care quality. The interpersonal component of quality is defined as the quality of interaction between the patient and provider or the responsiveness, friendliness, and attentiveness of the health care provider (Haas-Wilson, 1994). The literature suggests that the aspects of personal interactions in quality, strongly correlate with the issues of respect of persons in responsiveness.

2.2 DIFFERENCE BETWEEN RESPONSIVENESS AND PATIENT SATISFACTION

Responsiveness is different from patient satisfaction and quality of care though there are many overlapping aspects. Three main differences can be highlighted:

(1) **Scope**: patient satisfaction focuses on clinical interaction in specific health care settings whereas responsiveness evaluates the health system as a whole;

(2) **Range**: patient satisfaction generally covers both medical and non-medical aspects of care while responsiveness focuses only on the non-health enhancing aspects of the health system;

(3) **Rationale:** patient satisfaction represents a complex mixture of perceived need, individually determined expectations and experience of care. Responsiveness evaluates individual's perceptions of the health system against 'legitimate' universal expectations.

In particular, responsiveness moves towards getting individuals to rate their health systems against objectively set standards rather than evaluate their satisfaction. Much of the literature up to date has been on patient satisfaction. Many of the surveys too are biased towards measuring satisfaction rather than responsiveness, though surveys such as CAHPS have been moving in the direction of patient reports.

2.3 RESPONSIVENESS TO LEGITIMATE EXPECTATIONS

Expectations are often simply defined as individual's beliefs regarding desired outcomes. Yet the literature suggests that the definition of expectations, and more so the concept of expectations fulfilment is far from easy to define (Thompson and Sunol, 1995, Stanizzszewska, 1999).

Thompson and Sunol (1995) cite four types of expectations:

- Ideal: similar to aspirations, desires or preferred outcomes
- Predicted – realistic, practical or anticipated outcomes that result from personal experiences, reported experiences of others and sources of knowledge such as the media
- Normative – expectations that are based on what should or ought to happen
- Unformed – the situation that occurs when individuals are unable or unwilling for various reasons to articulate their expectations, which may either be because they do not have expectations, have difficulty

> expressing their expectations or do not wish to reveal their expectations due to fear, anxiety or conforming to social norms.

The difference between patient satisfaction and responsiveness as cited above is in focusing on normative rather than ideal or predicted expectations.

While many theoretical models relating to expectations fulfilment have been introduced (see appendix 1) this is an area that still remains under debate. These models relate to satisfaction in the traditional sense of relating it to individual ‘ideal’ expectations rather than normative expectations formation, but the arguments relating to satisfaction are of interest even in this context.

It is not responsiveness per se, but responsiveness to universally legitimate expectations that is of importance in assessing the health system. Expectations of individuals seem to be formulated mainly according to personal or societal experience. For instance, for a given health condition a six month waiting period for non-emergency surgery can be deemed satisfactory, if individuals consider this to be the norm for a particular health system. Individuals in another country may however feel that a health system that expects individuals to wait for six months for non-emergency treatment is by no means a responsive health system. With regard to evaluating the health system however overcoming the problem of divergence of expectations, necessitates the demarcation of ‘legitimate’ expectations.

For respondents’ expressed satisfaction is a relative judgement: a comparison between perceived performance and aspiration. This proposition has been elevated to the status of a theory - the multiple discrepancy theory – put forward by Michalos (1985). The basic point here is that to assess expressed satisfaction, it is insufficient to measure just the level of satisfaction (the extent to which aspirations are met given the self perceived performance level); both the level of aspiration and of perceived performance have to be measured. This is necessary because aspirations may be unrealistic given the level of available resources while evaluation of performance levels by individuals may differ widely from the actual or objective levels of achievement (Carr-Hill, 1992). The use of legitimate expectations rather than individual determined expectations could reduce the impact of discrepancy caused by individual idiosyncrasies.

Legitimate can be defined as conforming to recognised principles or accepted rules and standards. Ethical norms can be set in most instances without much debate as to the optimal desired behavioural process (as for instance the need to carry out medical consultations in a manner that safeguards patient privacy). While resource constraints may hamper the achievement of such outcomes, there is likely to be no debate as to the appropriateness of such norms. The setting of legitimate norms in the case of physical infrastructure and access to care is more difficult: for instance much debate exists with regard to the desirable waiting period for non-emergency surgery. Likewise there could be much argument as to whether satisfactory ventilation relates to windows, fans or air-conditioning.

The zone of tolerance concept, in particular, is of importance in examining responsiveness since the width of the zone is likely to differ with regard to the element of responsiveness under consideration. The zone of tolerance with regard to basic amenities for example, could also vary from country to country, depending on the general standard of living. For instance the concept of floor patients is perhaps more alien to those in developed countries to whom sleeping on the floor is not an acceptable condition whereas it is the norm in many poor tropical countries. These characteristics would lead to the tolerance zone regarding inpatient facilities being much wider in the latter context as compared to the former. In the case of responsiveness, given the acceptance of universal legitimate norms the question arises as to how wide the zone of tolerance could be allowed to be. It is also clear that in such a context the zone of tolerance for basic amenities is likely to be much wider than that for dignity.

In addition a complication exists, cited by Bond and Thomas (1992) who argue that increasing the quality of care may in fact become gradually associated with lower levels of satisfaction, since quality of care raises expectations. One way around the problem would be to list desirable characteristics such as adequate furniture and satisfactory ventilation rather than set specific standards. The objective of comparing health systems across countries however does make it crucial to determine objective norms with regard to access and quality of amenities.

The seven elements of responsiveness may not all be of equal importance. Socio-economic factors in particular may determine the importance attributed to different elements in different countries. For example, it is often argued that confidentiality is given far greater importance in Western developed societies than in developing countries. If expectations are affected by socio-cultural outlook, some may argue that it is important to build in a means of taking account of the importance given to the different aspects of non-medical care in different settings. This could be done through collecting importance ratings of elements at country level and using these to weight the performance of responsiveness as a whole. Such an action may seem particularly relevant in the context of cross-country comparisons since the importance a population gives to an element of non-medical care may affect not only its rating but the quality of the service provided. However if a normative judgement existed with regard to the relative importance of the elements, then country level weights would be contrary to the objective of achieving a universally determined optimal standard of health system responsiveness. The use of universal weights, averaging across countries and individuals is another option, but is far from perfect as a proxy for normatively determined weights.

2.4 DETERMINING THE RELEVANT NON-MEDICAL ELEMENTS OF THE HEALTH SYSTEM

The non-medical aspect of health care incorporated in responsiveness were picked through a review of the literature (see Annex 2 for table of relevant literature), examining surveys relating to patient satisfaction and discussions with researchers from different disciplines involved in health sector research.

2.4.1 Dignity

In recent health sector literature the concept of dignity seems to be most under consideration in the context of dying, in debates for and against euthanasia. The second most common context is in ethical debates on cloning and genetic manipulations. This is due to there being little debate today in developed countries regarding the importance of maintaining an individual's dignity in medical settings. These issues were under debate in the early 1990s with the advent of the AIDS epidemic. On the other hand developing countries are only beginning to focus on such research now.

This study defines dignity as the right of a care seeker to be treated as a person in their own right rather than merely as a patient who due to asymmetric information and physical incapacity has rescinded his/her right to be treated with dignity. This includes:

- the safeguarding of human rights such as the liberty to free movement even for individuals who have leprosy, tuberculosis or are HIV+
- treatment with respect by health care staff;
- the right to ask questions and provide information during consultations and treatment;
- privacy during examination and treatment

Health systems, it may be argued could achieve higher levels of health by isolating individuals with communicable diseases, or sterilising individuals with genetic disorders, but this would be a violation of basic human rights, and would be demeaning for the individuals involved. The safeguarding of human rights such as the liberty to free movement and association are therefore important aspects of dignity.

Howie et al (1999) argue that longer consultation times are highly correlated with higher 'enablement' scores. Enablement scores in their study are based on patient responses to the following questions: whether as a result of their visit to the doctor today they felt able to cope with life, understand their illness, able to cope with their illness, able to keep themselves healthy. The range of corresponding responses were much better/better/same or less and not applicable. They were also asked if this visit made them confident about their health and able to help themselves with response options of much more/more/same or less and not applicable. These questions capture some aspects of non-health enhancing welfare improvement. Longer consultations are likely to be correlated with greater opportunities for patients to discuss their problems with their doctors and to ask questions more freely, and therefore with greater 'enablement'.

Gross et al (1998) find that patients satisfaction levels are increased by doctors taking time to make conversation with the patient, such as make comments that are not related to health or crack a joke. They find that while in longer visits patients satisfaction increases with the amount of feedback information provided on laboratory results, conclusions generated from the history or results of physicians examination, that patients who have shorter visits are less satisfied when the visit is spent on being told such information. The authors suggest that this difference could be due to the speed at which such information is provided or due to patients missing the element of conversation and the relaxed atmosphere that encourages the airing of patient concerns.

Wensing, et al (1998) which reviews studies on patient priorities with regard to general practice care, find that many priority lists contain the desire for 'humanness' in health sector interactions. This issue is important not only in face to face interactions but in the case of health education and information dissemination as well. Preparation of brochures or posters on HIV/AIDS for example, need to take into account the emotional aspects of stigmatisation that could result from insensitive wording.

Privacy during medical examinations is of particular importance in encouraging individuals to utilise health services. The importance of the right to privacy in situations such as childbirth is stressed in Gilson, Alilio and Heggenhougen (1994).

2.4.2 Autonomy

Autonomy is self-directing freedom. In the context of this study it is defined as four rights:

- The right of an individual to information on his/her disease and alternative treatment options (this facilitates informed choice)
- The right to be consulted about treatment
- Informed consent in the context of testing and treatment
- The right of patients of sound mind to refuse treatment

An individual, it is assumed, would want to be treated as a rational individual able to make sound judgements if given the necessary information. The health care provider is an expert who can make decisions more easily due to asymmetric information but for autonomy to prevail within such a relationship the health care provider must disseminate information and leave the decision making to the patient rather than act as the sole authority. In instances where the patient, is not competent to make decisions their agents should be given the right to make decisions on their behalf.

Shackly and Ryan (1994) defines a good consumer as someone who is prepared to search for the best package of health care in terms of cost and quality, can adequately assimilate information on costs and quality of health care, and on the basis of such information, has the ability and the desire to make health care choices. Empirical evidence however suggests that consumers of health care are often not well informed and are often dependent on the health care provider for information. Owens and Batchelor (1996) questions the extent to which it is possible for consumers to fulfil their role, and more fundamentally whether they wish to fulfil it. Consumers of health care often desire advice, and hence willingly sacrifice their autonomy for the confidence generated by an expert decision.

Debate exists regarding the appropriate degree of autonomy. In contexts where patients may be reluctant to cope with autonomy, doctors may in fact burden them, if they follow a policy of doctor led autonomy, of providing all the information they consider relevant and getting the patient thoroughly involved in making decisions. The alternative, the patient led autonomy approach, shifts the focus to the patient, who would determine what degree of autonomy he/she desires, and would be responsible for guiding the doctor to provide the necessary information on alternative treatment options and for determining their own involvement.

Charles, Gafni and Whelan (1997) introduce four models in relation to autonomy. The first the paternalistic model has the health care provider making all decisions on behalf of the patient, since the provider is considered to be better informed this is considered to be optimal. The second model termed the informed decision making model, imposes the need for information dissemination on the provider and the responsibility of decision making on the patient. The professional agent model, has the patient willingly foregoing the right to decision making, though well informed, through voluntarily and explicitly transferring the decision making task to the provider. The final model termed the shared decision making model focuses on the sharing of both information and decision making between the patient and the provider, including the determination of preferences.

While these models are clearly demarcated in reality many doctor-patient relationships are likely to be a combination of these different approaches, varying by disease, patient profile and the inter-personal dynamics of the dyad. Particularly in the treatment of chronic illness the shared decision-making model may be extremely important in ensuring compliance.

In certain cultures the question of autonomy is further complicated by the need to consider family opinions rather than merely that of the individual. Where an individual voluntarily rescinds his right to sole determination of his own health care decisions, health care providers would be expected to consult with family members either in the presence or absence of the patient, the choice being made by the individual. Charles, Gafni and Whelan (1997) list the different roles, family or friends may play during the during the decision-making process: information gatherer, recorder or interpreter; coaching the patient to ask certain questions, advisor, negotiator on the patient's behalf regarding timing, place or treatment options and care taker who supports and reinforces the patients treatment decision.

In the case of minors or those who are mentally unstable, the autonomy automatically would devolve to the family. There is however a distinction drawn between the autonomy given to competent adults in their own care, and that of their children.

> "In cases involving competent adults, the principle of autonomy almost always takes legal precedence over the principle of beneficence which means for example that a Jehovah's witness has the right to refuse a blood transfusion, or a Christian Scientist a course of chemotherapy, even if he or she dies as a result. But with a minor, the state has the right – indeed the obligation to force the patient to comply with a life-saving treatment, even if it

> is forbidden by the family's religion." (Fadiman, The spirit catches you and you fall down, 1997, p. 80)

The question of autonomy is further complicated in the case of some cultures where adverse diagnoses are not shared with the patient. Anecdotal evidence is common in this regard for countries such as Japan, Sri Lanka and India. The family would make all the decisions in such a case, under the conviction that the patient is best left unaware of the actual diagnosis, in cases of cancer or other terminal illnesses. Health care personnel, aware of such traditions leave the decision of breaking the news of the diagnosis to the family, rather than the alternative practised in Western countries where the patient determines whether to share such bad news with his family. This contradiction in cultures poses a dilemma in determining a universal norm with regard to this aspect of autonomy.

Informed consent is also important in the context of screening for disease. As there is a combination of benefit and harm in all procedures the individual being screened must receive full and accurate information about the procedure and give their informed consent. When uncertainty exists regarding false positives and negatives for instance, this matter should be discussed with advice being explicitly supported by the best available evidence (Austoker, 1999).

2.4.3 Confidentiality

Information relating to the patient and his illness should not be divulged during the course of care, except in specific contexts, without the prior permission of the patient. This is linked to the idea that the patient's welfare is the supreme concern of the health care provider. This would involve:

- conducting consultations with the patients in a manner that protects their privacy
- safeguarding the confidentiality of information provided by the patient, and information relating to an individual's illness, except in cases where such information needs to be given to a health care provider, or where explicit consent has been gained.

The aim of preserving confidentiality poses questions particularly in the context of public health. The notification of AIDS cases became an issue in the early 1990s but in many countries has now been resolved with the emphasis being on protecting the identity of the infected person. In reality, in developing countries however the lack of universal precautions often causes the health care profession to be much less strict about confidentiality in such cases.

Dilemmas faced by health care professionals in the face of the need for preserving confidentiality include the issue of public safety and split loyalty in the case of treating more than one member of a family. The emphasis in the former case has been on educating the individual of the risks involved in his/her interactions with society, while in the latter it has been to encourage the individual to share the information voluntarily with others at risk.

In developed countries many recent debates have involved the storing of health care records on electronic databases and the right of access to such information. Particularly in the context of private insurance and employment the confidentiality of medical information becomes paramount. Genetic information databases are another related area of contention. At the other end of the spectrum, in developing countries discussion still prevails as to whether patient information should be kept fixed to the bed head, a practice currently followed in most hospital settings.

2.4.4 Prompt Attention

Prompt attention is defined in this study to consist of three characteristics:

- Patients should be entitled to rapid care in emergencies, and
- Patients should be entitled to care within reasonable time periods even in the case of non-emergency health care problems or surgery so waiting lists should not cover long periods.
- Patients seeking care at healthcare units should not face long waiting times for consultations and treatment.

Achievement of prompt attention is often subject to the constraints imposed by a limited resource base. Geographical accessibility is of particular importance as the ability to access health care fast, taking account of distance, availability of transport facilities and terrain, reduces uncertainty and tension for individuals, contributing directly to welfare, which is the aspect of importance here rather than the health impacts of rapid treatment. Showing respect for peoples' time and feelings is the issue at stake rather than providing urgent medical care. The latter would be captured under health and health inequality.

2.4.5 Quality of Basic Amenities

This aspect relates to the provision of physical infrastructure and a conducive care environment. The study defines basic amenities in the following manner:

- clean surroundings
- regular procedures for cleaning and maintenance of hospital buildings and premises

- adequate furniture
- sufficient ventilation
- clean water
- clean toilets
- clean linen
- healthy and edible food

These are sometimes termed ‘hotel facilities’. Drugs and testing facilities and medical equipment are also seen as essential in creating an environment conducive for care provision but these aspects are categorised as medical care and are therefore not considered in this study.

Prevention measures, involving non-personal prevention activities such as cleaning public areas, spraying insecticide, preventing mosquito breeding in wastelands are some of the activities that also need to be taken into account under the quality of basic amenities. This concept should not be limited to health care facilities but relate to the health system as a whole, which encompasses interactions with the health system in ones workplace, school or home as well.

2.4.6 Access to social support networks during care

The study considers that patient welfare is best served if the individual has access to support networks during care. In certain instances, the fact that health care facilities are not distributed evenly within a country result in patients being treated in locations far from their usual surroundings, and this is likely to deprive them of access to social support networks like family, friends and community. This study considers that procedures in the provision of inpatient health care should allow

- regular visits by relatives and friends
- provision of food and other consumables by relatives and friends, if not provided by the hospital
- religious practices that do not prove a hindrance to hospital activities or hurt the sensibilities of other individuals

Particularly of interest may be the issue of conjoint treatment: that is the integration of Western Allopathic medicine with traditional healing arts (Fadiman, 1997). The patient’s welfare may well be maximised by conjoint treatment, if the latter forms of ritual and treatment are neither harmful nor contrary to Western Allopathic care.

The involvement of NGOs and community-based organisations in the care of patients is also of importance, particularly where patients have no family networks to sustain them. In some cases such organisations may interact with the health care institution in improving the welfare level of patients, whereas in other instances they would focus on the patients and assisting them to improve their quality of life. Once again the distinction needs to be made between health enhancing interactions like the building of a new children's ward and the health non-enhancing activities such as providing newspapers or painting walls. The role of such organisations also becomes important in the context of home care and rehabilitative care. The health system needs to facilitate NGO activities particularly if it is not able to provide such services due to financial constraints.

2.4.7 Choice of Care Provider

Choice with regard to institution and individual providing care is of importance to health system users. The ability to choose between care providers becomes increasingly important as the other aspects of responsiveness are met. The cost of providing choice of care provider is most severe for countries that are human resource constrained. Debate exists whether choice of care provider is indeed a luxury, beyond the grasp of developing countries. Setting universal norms in such a context is difficult, and in order to be a realistic may have to be linked to an exogenous criterion such as the number of trained health care personnel in a country.

The ability to exercise preferences increases an individual's utility since choice itself is a desired outcome. In particular individuals may have preferences with regard to specific individuals or treatment by persons of a particular gender, age group or race. Cultural factors and emotional bonding often result in women preferring female health care providers particularly in the context of reproductive care. Hall et al (1994) focus on the relationship between the gender of the patient and provider and satisfaction levels. Some studies find that women providers are preferred for showing more empathy and spending more time with patients. Others find that patients have more confidence in male health care providers as a result of traditional hierarchical convictions.

Individuals are often keen on consulting the same health care provider on subsequent occasions, particularly if they are returning to the health care unit for the same complaint. Choice of care provider includes the choice of consulting the same doctor as much as consulting a different doctor if one has been unsatisfied in previous encounters. The ability to consult the same doctor on a regular basis has the added advantages of systematic diagnosis and treatment, as well as better compliance through the development of patient trust.

Choice of health care provider includes the patient's right to consult a Specialist if he or she wishes to do so. This refers not to instances where the patient's health condition demands specialist care, but where the patient and/or family wishes for their peace of mind to gain an expert opinion. Direct access to Specialists is likely to be contrary to the efficient implementation of a referral system, and in turn is likely to prove to be a burden on already over stretched Specialist services, particularly in developing countries. This aspect of responsiveness is not arguing for Specialist services to be necessarily provided free or on an ad hoc basis, but for the creation of channels that would allow patients to access Specialist care.

Choice of care provider is also important since it enhances the likelihood of other responsiveness elements being practised. Competition is known to improve the quality of basic amenities provided by private health care units, while health care providers, often dependent on word of mouth recommendations of patients, are likely to be more aware of the need for respect of persons, in contexts where a choice of care provider exists.

The barriers to such choice, other than the constraint imposed by shortages of trained health care personnel, are procedural: either lack of flexibility in referral practices, insurance procedures or legislative obstacles to the setting up of health care units. Stewardship is likely to be of particular importance in ensuring sufficient choice of care provider.

3. MEASURING RESPONSIVENESS: USE OF SURVEYS

3.1 REVIEWING EXISTING PATIENT SATISFACTION SURVEYS

As responsiveness is a new area of research no instruments existed for measuring responsiveness as defined by the WHO. A critique, of the different patient satisfaction surveys reviewed in the process of preparing the WHO Responsiveness household survey module, is presented in Appendix 3. As the mandate of the survey on responsiveness varies from the objectives of many of these surveys, and focuses in particular on the health system rather than specific health care locations or plans, these surveys were merely used to identify relevant questions. Literature surveys relating to quality in the health system and patient satisfaction provided the base from which to identify the elements and sub-elements that should be included under responsiveness of the health system (see Appendix 2). Developing country experiences do not get sufficiently captured in this exercise, despite extensive efforts to track down such literature through database searches. Issues of responsiveness have only become important in health system research in developing countries of recent. In addition research findings in developing countries are more often presented as reports or dissertations than as journal articles. Efforts need to be made in the future to collate such research reports, and to encourage researchers in developing countries to publish their findings in journals.

Table 1 shows the elements of the proposed WHO measure of responsiveness cross-tabulated with other well-known patient satisfaction surveys and studies.

Table 1: Questionnaires relating to responsiveness to non-medical aspects of care

	PSQ[1]	CAHPS [2]	CTS [3]	Hadad et al.[4]	ERS[5]	Picker Survey[6]	QUOTE[7]
Respect for dignity	X	X	X	X	X	X	
Respect for autonomy						X	X
Respect for confidentiality						X	
Access to prompt attention	X	X	X		X		X
Access to social support networks		X				X	X
Basic amenities				X	X		X
Choice of institution/care provider	X	X	X		X		X

Notes: [1] Patient Satisfaction Questionnaire – introduced by John Ware (1976).

[2] CAHPS questionnaire relates to health plans and is administered by AHCPR.

[3] Community Tracking Study, conducted by the Centre for Studying Health System Change at the Robert Wood Johnson Foundation, in conjunction with RAND.

[4] Hadad, Fournier and Potvin (1998) in the International Journal for Quality in Health Care, Vol. 10 No. 2

[5] Evaluation Ranking Scale – Pascoe and Attkisson (1983).

[6] Picker Commonwealth Survey of Patient Centred Care reported in Cleary et al (1991)

[6] QUOTE surveys used in the context of specific diseases (i.e. Rheumatic patients) presented in Van Hampen, Sixma et al (1998) in the British Journal of Rheumatology, Vol. 37.

The lack of an accepted theoretical underpinning for the concept of patient satisfaction has been noted by many over the years (Fitzpatrick, 1993, Williams, Coyle and Healy, 1998). Sitzia and Wood (1997) state that "logically, discussion of conceptual and theoretical issues should come before measurement but the opposite has been the case with patient satisfaction research". Patient satisfaction is in itself a complex concept relating to a number of factors including life style, past experiences, future expectations and the values of both the individual and society. This lack of a conceptual framework is considered to have been a major constraint in developing good satisfaction measures.

3.2 PROBLEMS OF MEASURING SATISFACTION: LESSONS FOR SURVEYING RESPONSIVENESS

As no previous work exists with regard to measuring responsiveness, this study draws heavily on the patient satisfaction questionnaire literature. While patient satisfaction and responsiveness are not the same concept, the degree of similarity makes such an exercise useful.

Patient satisfaction questionnaires have faced the following criticisms with regard to conceptualisation. The relevance of these criticisms in the context of evaluating responsiveness is highlighted in the discussion below.

- Satisfaction questionnaires tend to look at the system from the provider perspective. It is important to assess patient views first before preparing the questionnaire as the relative importance given to attributes of the system may vary between provider and patient. Focus groups would provide one means of overcoming this problem.

  In the case of measuring responsiveness the emphasis will be on the needs of the user of the health system. The criticism remains valid however since individual perceptions of what aspects are of importance are likely to vary, particularly from country to country. Focus group discussions will be held in the countries where the household surveys are being carried out, in order to gain a better understanding of patient perspectives at country level.
- Williams, Coyle and Healy (1998) argue that patient satisfaction questionnaires could give misleading results as individuals respond to satisfaction questions with a pre judged notion of what are the duties of specific health care providers and the resources and constraints of the health care system. For instance if the negative experiences faced are outside the duty of the service according to the respondent's perception, the service is excused and it is not represented as dissatisfaction. High satisfaction results may actually be merely representing low dissatisfaction given minimum levels of expected service. Similarly Avis, Bond and Arthur (1997) argue that patients may actually evaluate their initial contact with the outpatient service according to a stock of negative examples and assumptions and express relief and satisfaction when their care is not as bad as it might have been. Comparing satisfaction survey results across health systems then may be arbitrary, as there is no common base with regard to expectations.

  Responsiveness since it links the evaluation of the health system to legitimate expectations may guide respondents to score their health system more accurately, by explicitly defining for them a universal norm against which to measure their own experience.

Some of the criticisms of patient satisfaction surveys relate to issues that result in biased response patterns. In this regard different arguments and sometimes contradictory hypotheses, have been put forward:

- Those who are satisfied are more likely to respond (Allen, 1998).
- Those who have had unsuccessful experiences in obtaining health care are more likely to respond (Berk and Schur, 1998).
- Approval bias may result, as individuals are often reluctant to articulate their dissatisfaction.
- Social desirability bias argues that patients may report greater satisfaction than they actually feel because they believe positive comments are more acceptable to survey administrators.
- Cohen, Forbes and Garraway (1996) state that asking patients if they agree with a negative description of their hospital experience tends to produce greater apparent satisfaction than asking if they agree with a positive description.
- Time period under consideration may affect responses as negative experiences are easier to remember than satisfaction (Carr-Hill, 1992)
- Patients may have a positive bias when rating 'my care' (Carr-Hill, 1992) that could be counteracted by using more general questions.

- Cognitive consistency theory suggests that patients are likely to report they are satisfied as a way of justifying the time and effort they themselves have invested in their treatment.
- Fear of unfavourable treatment in the future may lead to positive responses.
- Individuals who wish services to continue may express satisfaction considering that this would encourage the provision of the service (Owens and Batchelor, 1996).
- Hawthorne effect, postulates that additional attention implicit in the data collection process and the apparent concern of the research sponsors about the patient's level of satisfaction are likely to lead to a positive perception of the services and consequently to a positive rating (Sitzia and Wood, 1997).
- Williams (1994) theory is that dissatisfaction is only expressed with an extremely negative event, either since gratitude as a phenomenon confuses satisfaction responses or due to simple indifference.
- Dissatisfaction may not be articulated if patients think that the problem is now past or will not be remedied or is trivial or too large to be solved.
- Etter et al (1996) suggest that there could be variance according to the organisation running the survey.
- On longer survey instruments, respondents may learn that responding affirmatively (negatively) to a question usually leads to more questions and this may affect the response pattern (Berk and Schur, 1998).

The following strategies are used in an attempt to counteract such biases:
- Controlling expectations by giving the respondent prior information about what should happen during a hospital visit/what an event should be like;
- Focusing on experiences rather than attitudes and opinions;
- Using open ended questions;
- Specific questions about the actual process of care can elicit critical responses, so such questions may be more appropriate than those that question on overall satisfaction.

Variations in the response patterns by socio-demographic characteristics have been noted. Murphy-Cullen and Larsen (1984) suggest that patient characteristics of race, occupation, education and type of organisational care setting are consistently non-predictive across studies of satisfaction levels, while income and age and being female are characteristics usually associated with higher patient satisfaction. Their study finds that consultations with younger health care providers result in higher satisfaction levels being reported. Hall et al (1994) suggest that ratings may vary by gender of patient and provider. More research needs to be carried out, to identify whether socio-economic and demographic characteristics lead to biases in the evaluation of health care systems, and whether such biases are culture or country specific.

4. SUMMARY AND CONCLUSIONS

Responsiveness and fair financing are intrinsic goals that complement health, as goals of the health system. Seven elements of responsiveness have been identified. Discussion during an international conference on the measurement of responsiveness, involving 35 experienced researchers, suggested that information and communication are sufficiently important to merit being a separate element. Many issues within the elements need to be considered further. In the case of dignity more attention needs to be focused on the overlap between human rights issues and dignity within a health system. Autonomy is a complex issue, particularly given differences in culture and determining a universal norm with regard to the individual versus family autonomy needs in-depth case studies. Choice of care provider is the other element that would benefit from greater analysis, particularly in developing a better understanding of the relationship between choice and the efficiency gained through formalised referral systems.

Household surveys would be the most important means of collecting information on responsiveness of the health system. Patient satisfaction surveys and studies can be useful in guiding the development of responsiveness instruments though the concepts are different with regard to range, scope and rationale. In order to gain a comprehensive understanding of the responsiveness of the health system to non-health enhancing aspects it will be important to supplement household patient satisfaction questionnaires with information gathered through facility surveys.

Concerns such as the abrogation of human rights in an attempt to control a communicable disease may not get reflected in a population survey as such an issue would only affect a small fraction of the population. Analysis of legislation, examining patient charters, media analysis and focus groups may be used to identify and measure the impact of such aspects.

Patient satisfaction surveys are being used in many developed countries in making management decisions at facility level. Health plans are also evaluated using such surveys. The performance of physicians, managers of health plans and staff are evaluated and bonuses determined on the basis of patient surveys (Colins, 1996). Strategic planners use patient surveys to gain an insight into the running of the market and to identify niches that are not served. Responsiveness surveys over time could prove to be equally useful at health system level in providing evidence that could guide resource allocation and management strategies.

APPENDIX 1

THEORETICAL MODELS OF SATISFACTION

1. EXPECTATION FULFILMENT MODEL

This model predicts that any experience that is congruent with that expected will result in satisfaction and any which differ will result in dissatisfaction. Linder-Pelz (1982) puts forward such a model defining satisfaction as being a construct that can generally be examined in two distinct ways:

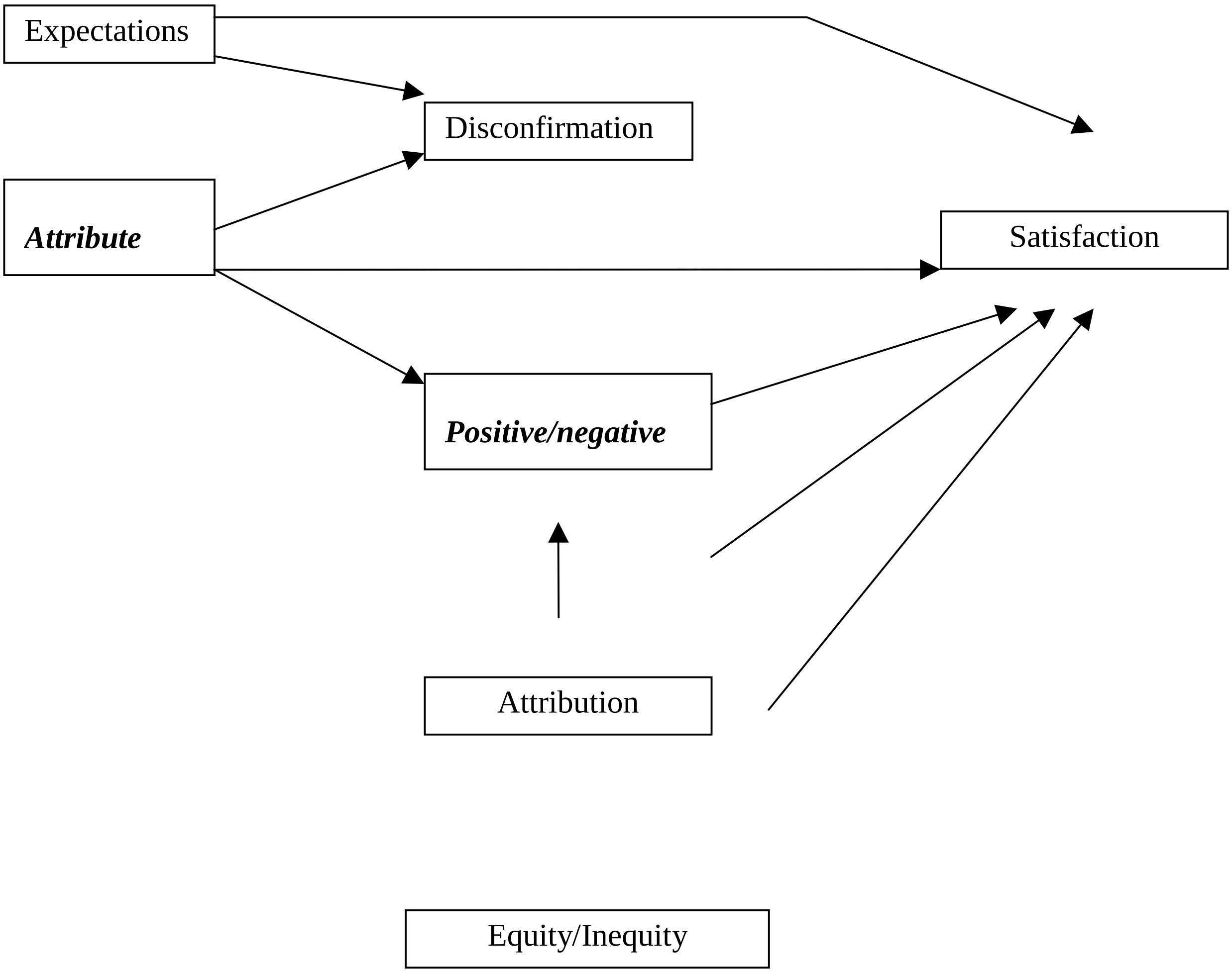
- as a dependant variable which is determined by patient and service characteristics
- as an independent variable which is predictive of subsequent behaviour

Linder-Pelz (1982) through content analysis of satisfaction studies proposes five patient social-psychological variables as probable determinants of satisfaction with health care:

- occurrences (individual's perception of an event)
- value (evaluation in terms of good or bad of an attribute or aspect of a health care encounter)
- expectations (belief about the probability of certain attributes being associated with an event or object, and the perceived probable outcome of that association)
- interpersonal comparisons (comparing with similar events experienced or known by the person)
- entitlement (individual's belief hat he/she has proper accepted grounds for seeking or claiming a particular outcome)

She concludes that expectations and perceived occurrences make independent contributions to satisfaction rather than satisfaction resulting from an interaction between expectations, values and occurrences.

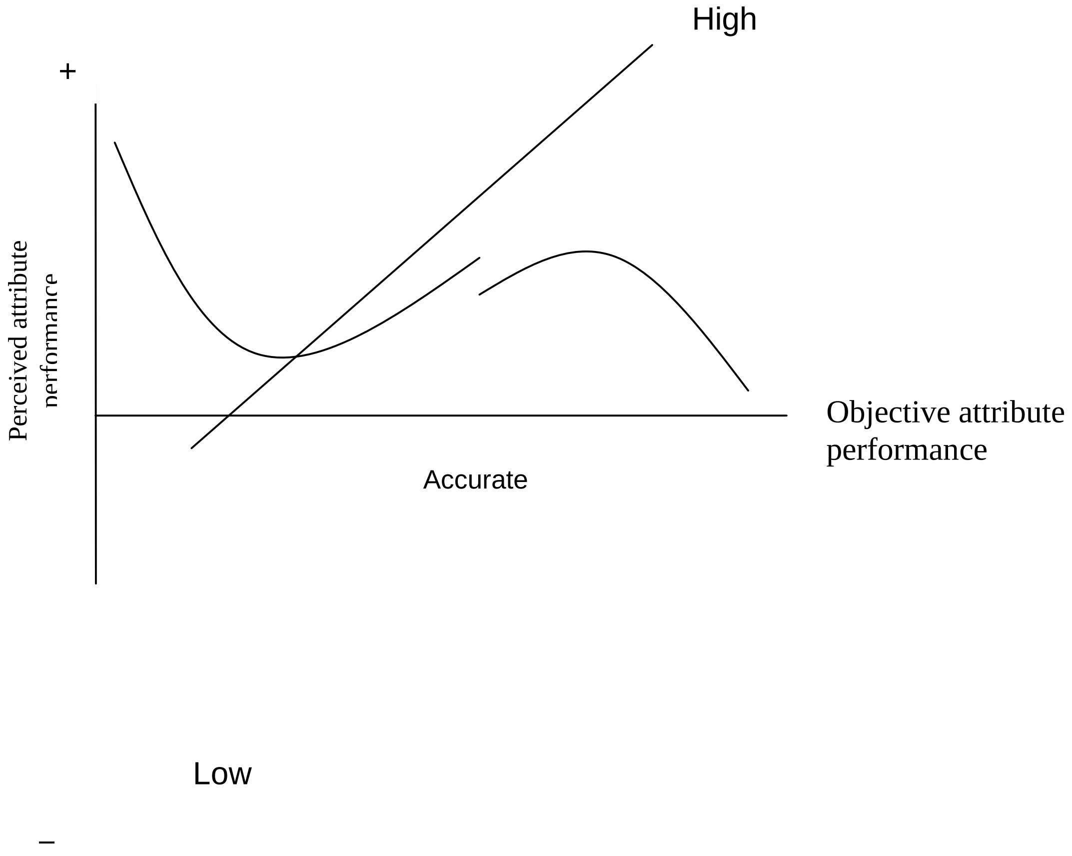
2. COGNITION-AFFECT MODEL OF SATISFACTION



Source: Oliver (1993)

Oliver (1993) has proposed a composite model that offers a way of considering the relationship between the various components of satisfaction. This cognition affect model of satisfaction has the disconfirmation paradigm placed between the preconditions of expectations and attribute performance and the outcome of satisfaction. The direct link between attribute performance and satisfaction is also recognised as important. The affect domains, both positive and negative, are seen as other inter intermediaries between both attribute performance and attribution and satisfaction outcome. Equity is posited as a further distinct contributor to satisfaction, unrelated to affect or other cognitive components.

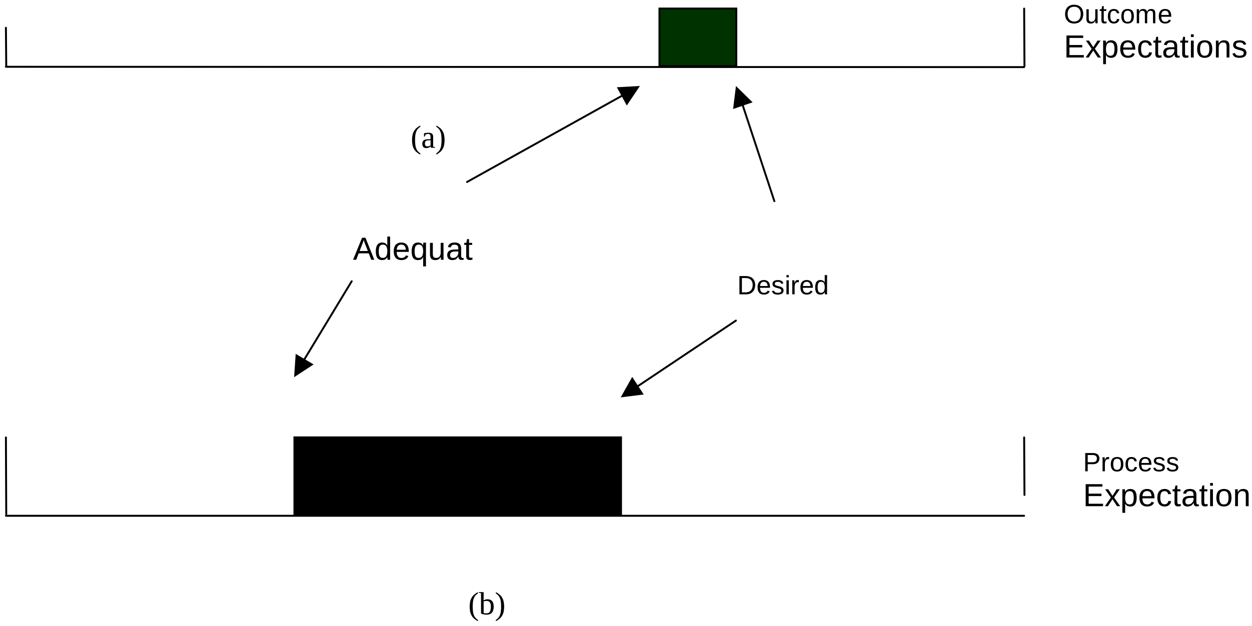
3. ASSIMILATION-CONTRAST MODEL OF PERCEPTIONS



Source: Adapted by Thompson and Sunol (1995) from Anderson (1973)

Here the horizontal axis represents the ‘actual’ or ‘objective product performance’ and the vertical axis represents the perceived product performance. Expectations are shown in the diagonal axis, which ranges from low to high. This model suggests that when perceptions of attribute performance differ only slightly from expectations there is a tendency for people to displace their perceptions towards their expectations, which is termed the assimilation effect. However if there is a wide disparity between perception of attribute performance and expectations, individuals tend to exaggerate the difference, resulting in a contrast effect. This model can be used to explain the phenomenon that there is little variance in satisfaction measures, expect under extreme circumstances.

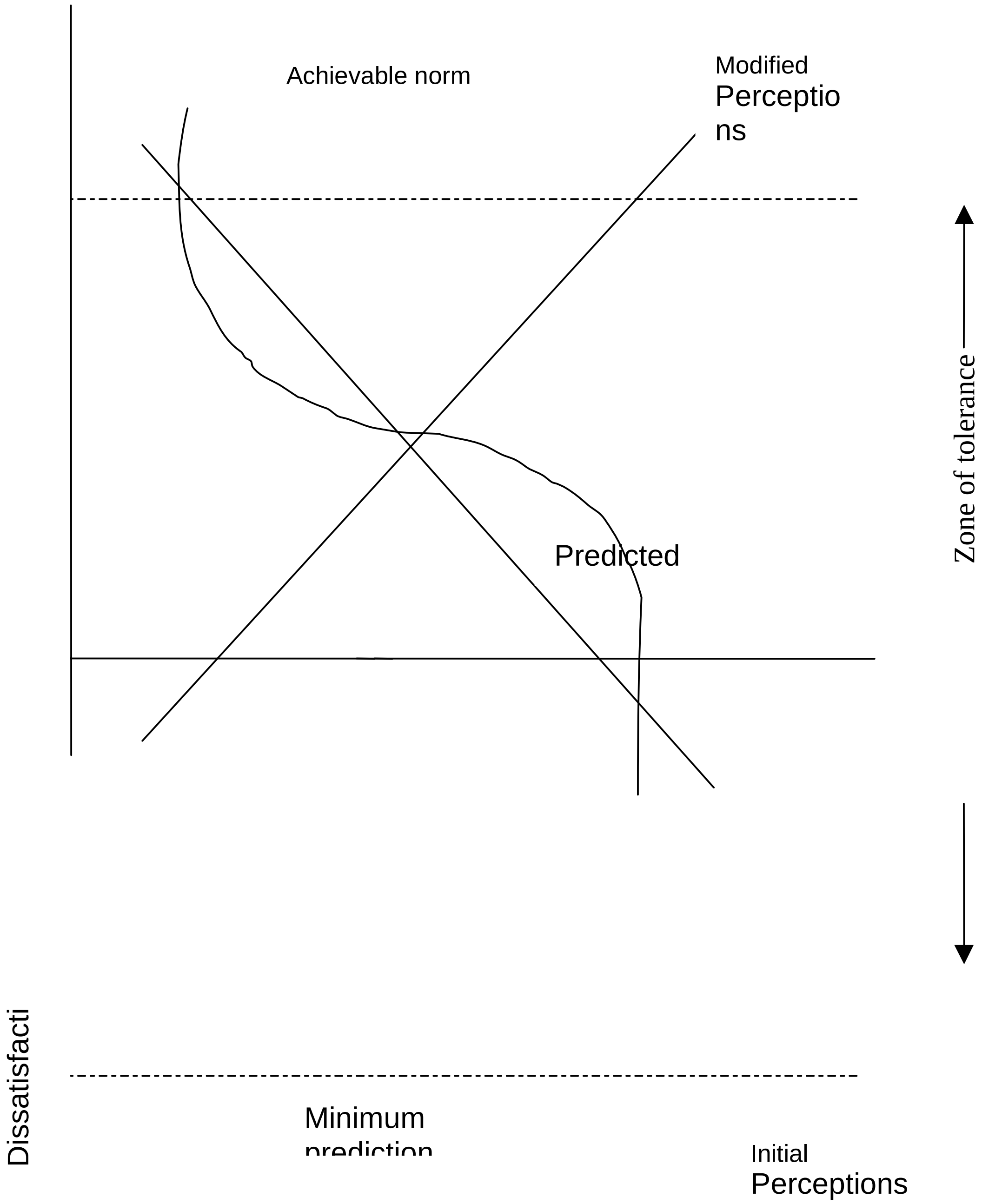
4. ZONE OF TOLERANCE MODEL



Source: Parasuraman, A., Berry, L.L. and Zeithaml, V.A. (1991) Understanding customer expectations of service, Sloan Management Review, 39, Spring.

This model introduces the concept of zones of tolerance to explain why satisfaction levels vary widely depending on the concept being evaluated. It argues, for example, that while quality of food is important it is likely to have a larger zone of tolerance and be at a lower desired level of service (b) than the reliability of a particular treatment regime (a). The importance of this model lies in distinguishing between expectations of outcome and process.

5. ASSIMILATION-CONTRAST MODEL OF SATISFACTION



Thompson and Sunol (1995) combine the assimilation-contrast model of perceptions with the zone of tolerance model. Unlike Anderson, they do not use the concept of objective performance, arguing that service users always judge services in perceptual terms. Satisfaction and dissatisfactions are defined under this model of the disconfirmation paradigm as situations where perceptions exceed predicted expectations

APPENDIX 2

Identifying the Components of Individuals' Satisfaction:

Review of the Literature

Aspect	**Studies**
Dignity	Ali and Mahmoud (1993) Avis, Bond and Arthur (1997) Bassett, Bijlmakers and Sanders (1997) Cleary et al (1991) Collins (1996) Etter et al (1996) Grol et al (1999) Gross et al (1998) Kenagy, Berwick and Shore (1999) Lim, Tan, Goh and Ling (1998) Morris (1997) Rurnbull and Hembree (1996) Rylance (1999) Wensing et al (1998)
Autonomy	Avis, Bond and Arthur (1997) Charles, Gafni and Whelan (1997) Cleary et al (1991) Coulter, Entwistle and Gilbert(1999) Meredith et al (1993)
Confidentiality	Grol et al (1999) Rylance (1999) Denley and Smith (1999)
Prompt attention	Collins (1996) Etter et al (1996) Grol et al (1999) Lim, Tan, Goh and Ling (1998) McIver (1991) Pascoe and Attkisson (1983) Ware et al (1983)
Access to social support networks during care	Cleary et al (1991)
Quality of basic amenities	Abramowitz et al (1987) Baker (1991) Collins (1996)

	McIver (1991) Ware et al (1983) Minnick et al (1997)
Choice of Care provider	Collins (1996) Campbell (1994) Hall et al (1994) Meredith et al (1993)

APPENDIX 3

REVIEW OF RESPONSIVENESS TO NON-MEDICAL ASPECTS SURVEYS

The following surveys were reviewed in order to evaluate their appropriateness as instruments capable of measuring responsiveness. Given that responsiveness differs from patient satisfaction, the concept these instruments target, the focus was on identifying relevant questions, question formats and issues rather than using the survey instruments per se.

CAHPS questionnaire

This questionnaire has now been combined with some elements of HEDIS (measure of NCQA) and is therefore known as CAHPS-2.0H. The survey is funded by the Agency for Health Research and Quality (AHRQ) and involves research groups from the Harvard Medical School, the Research Triangle Institute and RAND.

The questionnaire is administered to individuals who are enrolled on a health plan, with the name of the plan being ascertained at the onset, and with the questions relating to conditions under the health plan. Therefore if questions are extracted from this survey they will have to be adapted to relate to the health system. The questionnaires focus on adult health, child health, the chronically ill and medicaid beneficiaries.

The importance of this questionnaire lies in its use of patient reports rather than evaluations of patient satisfaction. The questions are formulated in such a manner that the frequency of events is asked about rather than the opinion of satisfaction with an event (i.e. How often does the doctor treat you with courtesy with responses of always to never, rather than how courteous is the doctor with responses of very discourteous to very courteous). This question format is useful in reducing the impact of subjective expectations.

The use of focus groups in developing the CAHPS instrument and the use of cognitive testing in determining whether the questions capture the intended issue are of particular importance. The former helps to gain a clear understanding of the perceptions and preferences of the different socio-economic groups covered by the survey. The latter too is of importance in eliminating any cultural biases that could occur as well as in verifying that the questions are lucid and unambiguous.

The question format of CAHPS would be appropriate in the responsiveness questionnaire since it is in line with individuals responding to universal norms or expectations rather than subjective views. Focus groups and cognitive testing need to be incorporated into the survey strategy.

Clinical Accountability, Service Planning and Evaluation (CASPE) Questionnaire

CASPE Research, an independent research unit, developed a patient satisfaction system (PATSAT). For the first time from 1991 onwards District Health Authorities and General Practitioner Fund Holders were in control of their budget to buy health care services from any hospital provider unit in UK. It was then considered important to have a means of measuring patient satisfaction.

This questionnaire obtains feedback from patients on many aspects of care using a speciality specific self-completion questionnaire administered routinely to in-patients. Responses are given according to a Likert scale. The questionnaire focused on 15 topics but it only looked at inpatient health care so it was not appropriate for the WHO measure of responsiveness, particularly as many of the questions relating to inpatient care were on medical issues.

Client Satisfaction Questionnaire (CSQ)

CSQ is based on the belief that client satisfaction is uni-dimensional although nine different aspects of care contribute to it. The objective of this questionnaire was to construct a simple client satisfaction scale that possessed sound construct validity, a coherent structure and stable psychometric properties. Originally it was developed to assess a very specific service location: mental health units.

A literature review on client satisfaction led to the identification of 9 dimensions of service delivery that could be targets of satisfaction ratings: physical surroundings, support staff, type of service, treatment staff, quality of service, amount of service, outcome of service, general satisfaction and procedures. 9 items were crated for each and submitted to panels of experts, whose editing reduced the number of items to 31. This module was field-tested. Then a shorter 8-item version (CSQ-8) was determined using factor analysis. Two 18-item versions (CSQ-18A and CSQ-18B) were also developed. Four point Likert scales were used. Final scores are calculated by adding item scores. No weighting was done so the 18 item survey value ranges from 18 to 72. Wilkins, Hallam and Doggett (1992) however argue that it is important to weight the dimensions.

CSQ 18B is used in the Williams, Coyle and Healy (1998) study. Williams, Coyle and Healy (1998) cite Tuan et al (1984) as stating that CSQ is one of the few instruments, which has well established psychometric properties. These authors carried out extensive tests of reliability and validity and found high internal consistency. The CSQ however has no clear conceptual basis so it is not possible to examine if content validity is achieved. As it was prepared to evaluate a mental health program some of the questions are not relevant for other settings.

Community Tracking study

Health care system evaluation carried out in 60 communities involves a longitudinal household survey. Centre for Studying Health System Change, at the Robert Wood Johnson Foundation runs the survey that also involves RAND. All elements of the health care system are assessed: users, purchasers, state governments, health plans, insurers, hospitals, physicians, physician organisations, community health centres, public health departments and consumer organisations.

Main questionnaire is 111 pages long. Respondents get paid for responding to the questionnaire. Topics include health insurance, access to health care, service use, satisfaction and quality, and socio-economic and demographic information including a number of questions on employment and earnings. There was also a self-response module.

Access involves questions relating to usual source of care, travel/waiting time to see a physician, difficulty in getting needed services and perceived changes in access. Satisfaction and quality relate to general satisfaction with care (primary and specialist choice), last doctors visit (satisfaction with medical examination, listening and explaining by doctor, trust in physician (to refer to specialist, not to perform unnecessary tests or procedures, not to be influenced by insurance regulations, to put the patient’s medical needs above all other considerations).

Questionnaire combines medical and non-medical questions and is too long to be adopted as it stands.

Donelan, Blendon et al questionnaire

This survey uses questions about the health system to assess impacts of reform and public satisfaction. It has been carried out in Australia, Canada, New Zealand, UK and USA in 1998 and used previously in 1990 in these countries as well as in Canada and the USA in 1994. A survey along the same lines also used in Mexico in 1994.

The surveys involved phone interviews and each interview lasted 11 minutes on average.

The questions cover the system as a whole, which is an important aspect in our evaluation. However these were very general questions that were likely to pick up general content or discontent with the political system rather than specific health related concerns, and so this question format was not considered to be appropriate in developing the responsiveness instrument.

Evaluation Ranking Scale (ERS) (Pascoe and Attkisson, 1983)

The stated objectives of designing this measure were that it should be capable of reliably registering satisfaction with specific aspects of health care delivery, resistant to response biases and briefly and easily administered. It was developed in response to inadequacies in existing measures.

Through a review of literature on evaluation theory and dimensions of health care, eight potentially key characteristics were identified. These were discussed with clinicians, administrators and patients before being included as the final ERS items. This process allowed for the separation of six different dimensions of care.

Attempts are made to attach differential weights to different aspects of care by assessing both perceived importance and satisfaction. Instead of employing standard weights derived from population averages, this approach has weights defined by each individual respondent.

Six cards are given to respondents that label and describe the aspects of health care delivery. First the patient is asked to sort the cards in order of their importance in judging a service. Then the patient is asked to rate the absolute and relative quality of the service on each dimension by placing the card on a chart (a single long vertical line calibrated 0-100 with 0 representing the worst possible and 100 the best). Cards may overlap and gaps between cards are completely at the patient's discretion.

Satisfaction scores are calculated by weighting individual items by the importance attached to them (e.g. 90 on the most important dimension scores 540). Mean scores are derived by dividing scores by the sum of the applied weights. This allows weighted scores to be calculated for each item and for the scale as a whole.

This study was criticised for not having direct evidence on test-retest reliability or internal consistency (Wilkin, Hallam and Doggett, 1992). Content validity was not tested. Combination of some elements was considered unusual (e.g. Obtaining appointments with clinic location; physical environment with waiting time).

The evaluation of importance is done here in a complex manner. Conceptually there is a distinction between importance and satisfaction regarding the dimensions but it is questionable whether respondents were careful in making this distinction in applying it to this complex scoring process. There was also the possibility of the results being affected by administrator’s influence. Standardising behavioural instructions for administrators in such cases is of importance.

The idea of evaluating importance as well as satisfaction seemed important, and a two-stage process to evaluate the two concepts with regard to each responsiveness element will be adopted in the responsiveness instruments under development.

FACCT Survey

FACCT is a non-profit foundation, established in 1995 with its headquarters in Portland, Oregon. This organisation has developed patient oriented measures of health care quality: measures that recognise the human experience in care. Emphasis is on providers being accountable to consumers, through focusing on patients' experiences and outcomes. The measures include health status, outcome of interventions and satisfaction. However this work focuses on specific ailments and diseases such as asthma, depression, breast cancer, low back pain etc. This made its format inappropriate in the context of the current need, to focus on the health system as a whole.

Haddad, Fournier and Potvin – 20 item scale (1998)

This survey is presented in an article titled ‘Measuring lay people’s perceptions of the quality of primary health care services in developing countries: Validation of a 20 item scale’ appearing in the International Journal for Quality in Health Care in 1998. A survey of previous questionnaires and literature had been used as the basis for preparing this questionnaire. Focus groups, experts and exit surveys were used to validate the questionnaire. The refined version of the instrument has 20 items rather than 47. This survey has a combination of medical and non-medical questions as well as questions relating to financial issues and issues specific to diagnosis and the treatment of women’s diseases.

Health Confidence Survey (HCS)

Employee Benefit Research Institute (EBRI) and Mathew Greenwald and Associates (MGA) sponsor the HCS. This survey tries to ascertain what Americans think about health care, what value they place on employer provided health insurance, attitude to health plans, managed care etc. The survey focuses on the youngest male, 21 years old or older.

The survey is carried out as a polling exercise. Questions relate to whether the system has got better or worse, and about changes that have occurred in different aspects of health care and society. Questions relate to cost, choice and quality of health care.

The responsiveness surveys attempt to get a snapshot evaluation rather than trend observations and therefore this survey format was not considered to be appropriate.

Medical Expenditure Panel Survey (MEPS)

This survey began in the US in 1977 and continues up to date, though the name has changed from National Medical Care Expenditure Survey to National Medical Expenditure Survey (NMES) and then to its current name. The instrument has been continually updated and improved. The surveys are conducted by the Agency for Health Research and Quality (AHRQ).

MEPS collects data on the specific health services that Americans use, how frequently they use them, the cost of these services, as well as on the cost, scope and breadth of private health insurance held by and available to the US population. The surveys, in particular focus on the expenditure patterns of special vulnerable groups like the elderly, veterans, children, minorities and the poor. They also examine private health insurance holding patterns among households with different demographic and employment status characteristics, in different geographic locale and according to differences in other factors.

In 1996, 10,000 households were covered involving 24,000 individuals in 195 communities across the nation drawn from a nationally representative sub-sample of households that participate in the NCHS National Health Interview Survey.

The satisfaction questions use a Likert (very satisfied/somewhat satisfied/not too satisfied/not at all satisfied) scale.

QUOTE questionnaires

Sixteen general questions and sixteen disease specific questions are included in the survey instrument (i.e. QUOTE-Rheumatic patients study in C. Van Campen, H.J. Sixma, J.J. Kressens, L. Peters and J.J. Rasker (1998) Assessing patients' priorities and perceptions of the quality of health care: The development of the QUOTE-Rheumatic patients instrument, British Journal of Rheumatology, 1998, Vol. 37, pp 362-368). The 16 general questions are posed in the context of four actors: GP, Rheumatologist, Home help and Home care agency. The questions are posed as statements. 21 indicators relate to GPs, 25 to Rheumatologist, 9 to home help and 15 are on the home care agency, with 3 other general questions to total 72. The elements were identified through a focus group with Rheumatic patients who were asked to comment on quality of care. The objective was to take a wider perspective than merely curative care.

Participating individuals are asked to rate the issues as unimportant, of little importance, important, extremely important (I_{ij}) by giving values from 0 to 10, and to rate the performance on each indicator in their perception as no, not really, on the whole yes, yes where the value is finally taken as the % of the population disagreeing with the statement (P_{ij}). The equation is as follows

Quality judgement (Qij) = I_{ij} x $P_{I\,j}$

with a higher value of Q reflecting greater dissatisfaction.

The importance of this framework lies in the fact that it generates 3 sets of information. These are information of what aspects of care patients consider important, performance indicators and information on the product which weights performance by importance given to the element of care. For instance short waiting times may be of extreme importance and performance on this element may be poor which would then result in a high value being given to Q which suggests a high level of dissatisfaction.

This idea of weighting by importance is interesting. The weakness however is that a few persons being dissatisfied with the performance of an element they consider very important could be rated the same as an aspect many individuals consider weak in performance but is considered to be of less importance. The fact that the importance and performance rating are subject to individualistic rating processes, and problems relating to summation of dissatisfaction level across individuals, cause the examples cited to be strictly dissimilar, despite the similarity of the Q scores.

The issue of relating importance to satisfaction needs to be examined in more detail, if we accept that the importance of elements of responsiveness should be determined on a normative basis.

PATSAT

This questionnaire is cited by Morris (1997) in an article titled Respect: Its meaning and measurement as an element of patient care which compares clinic observation records against a PATSAT questionnaire filled by the patient. PATSAT involves clinic specific questions related to a single episode of care. Such questionnaires are incorporated in ORYX, the next evolution of accreditation relating to the Joint Commission’s initiative to integrate performance measures into the accreditation process. The fact that the survey instrument focuses on a specific episode of care makes its format inappropriate for the current purpose.

Scale for the Measurement of Satisfaction with Medical Care (Hulka and Colleagues 1970, revised 1974)

The scale for the measurement of satisfaction with medical care was designed for use in a major study carried out by the American Academy of Family Physicians and the University of North Carolina to look into organisation, utilisation, and assessment of primary medical care. Authors adopted the indirect approach question format that assumes that responses will be based on experience rather than more general views about doctors and medical care, but hopes to avoid ‘loyalty bias’.

A review of lay and scientific literature yielded 300 statements in areas of professional competence, personal qualities, cost, and convenience aspects. This was reduced to 149 by the authors and then submitted to ‘judges’ (physicians, women’s club members, social workers and black college students) for rating. The original version employed dichotomous agree/disagree response categories.

The instrument was revised in 1974. The revised version has 42 items concerning doctors and medical care in general. Instructions however explicitly ask for responses to be based on personal experience as far as possible.

The response categories were expanded using Likert type five point scaling (strongly agree to strongly disagree). Scoring procedure is a hybrid of Thurstone and Likert methods. Item weights (taken from judges rating) multiplied by scores ranging from 2 (strongly agree) to –2(strongly disagree) for positive items (reversed for negative items). Scale product scoring is used. Scores for each dimension and total scale are calculated by summing item scores and dividing by the number of items completed.

Wilkin, Hallam and Doggett (1992) comment that the authors have concentrated on increasing the reliability of the scale but have given less attention to validity. The authors provide limited evidence on content validity and construct validity.

The superiority of indirect statements over direct statements remains under debate, with some researchers arguing that using the indirect means results in three sets of responses: those responding to the general issue, those responding on their own experience, and some responding using both alternatives. The use of the direct approach was adopted in designing the responsiveness survey instrument, as the indirect approach seemed to create greater uncertainty regarding response validity.

Ware’s PSQ

This questionnaire was designed specifically to evaluate primary health care. A pool of 2300 items judged to relate to satisfaction were drawn from other instruments, a population survey and the researchers own experience. Extensive reviews of all items led to the pool being reduced to 500. This review contributed to the formulation of a number of hypothesised dimensions. Factor analytic techniques were used to refine and delineate the contents of these dimensions. This reduced the pool to 80 items.

PSQI underwent extensive field trials and analyses. PSQII consists of 68 items covering 18 scales and 9 global sub-scales. A 43 item short form was developed. PSQII and the shorter version have been extensively field tested. An 18 item very short list also exists.

PSQIII was further modified to relate more to respondents' own medical care experiences rather than more general statements about doctors and care. PSQIII contains 51 items including both indirect statements about medical care and doctors in general, and direct references to the respondents’ own experiences of medical care. All versions of PSQ are designed for self-administration but interviewer supervised completion procedures have also been followed.

PSQ contains seven separate dimensions: general satisfaction, technical quality, interpersonal aspects, communication, financial aspects, time spent with doctor and access/availability/convenience.

A Likert scale was used. Balancing was done between positively worded and negatively worded statements. The instrument allowed for the measurement of total satisfaction as well as satisfaction with each dimension.

Wilkin, Hallam and Doggett (1992) state that among methods of measuring patient satisfaction only the PSQ has a clearly enunciated theoretical foundation. They also mention that it is possibly the best-developed and most extensively tested measure available. However they highlight the fact that it mixes direct and indirect statements, which make interpretation of the results more complex. The indirect approach of PSQII may be measuring more generalised attitudes about health services as well as aspects of life satisfaction rather than opinions about a specific service setting. PSQ can therefore provide a different response pattern

Wilkin, Hallam and Doggett (1992) comment that PSQII was poor on single item test-retest reliability but that the strength of the instrument lay in its global and sub-scale scores which achieved satisfactory levels of test-retest reliability and internal consistency.

A problem noted is that this survey instrument was formulated for the US and focuses only on the behaviour of doctors (ignores other staff).

These points were taken into consideration in deciding that it would be best to design an instrument to measure responsiveness rather than try to adapt Ware's PSQ.

WHO Regional Office for European Initiative

Study done in Moscow, Belgrade, Ioannina and Canterbury in 1988.

In addition to basic socio-demographic data, detailed questions were asked about consumer satisfaction with components of primary health care: use of services, accessibility and availability, professional skills and quality of care, involvement in health promotion, prescribing patterns, the doctor-patient relationship, communication skills, involvement with social problems and general satisfaction with GP care. The questions were mainly on GP interactions.

Rating scales of very satisfied to very dissatisfied (1 to 4) or in response to a specific statements from 1 yes definitely agree through to 5 strongly disagree or not at all were used.

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Ensuring quality health care: The challenges of measuring performance and consumer satisfaction (Summary of a workshop for senior state and local officials, South Carolina, June 4-6 1997)
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