

Chapter 8. Being responsive to citizens' expectations: The role of health services in responsiveness and satisfaction¹

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8.1 Introduction

The world health report 2000 on the performance of health systems posited responsiveness to citizens' expectations as a central and particular goal. It pushed forward a debate that frames responsiveness as a valued and desired outcome of health system interventions regardless of the extent to which those interventions lead to health improvement (1). As noted in chapter 3, health services reforms place ever increasing emphasis on meeting citizens' expectations, improving responsiveness to patients and increasing both population and patient satisfaction.

In recent years, many countries have introduced reforms to enhance transparency, patients' rights and entitlements, choice of provider and access to services – all core elements of responsiveness. These strategic attempts to boost efficiency (by introducing market forces), improve access and increase the quality of the services are also intended to improve a system's responsiveness to the justified expectations of the population, albeit some of the reforms respond primarily to the articulate and advantaged.

The European Observatory's book on social health insurance (SHI) systems in western Europe (2) marshals evidence around this issue. Saltman et al. (2) show that, on average, these systems are associated with higher levels of responsiveness. However, they hypothesize that this correlation is not directly attributable to the funding mechanism but rather is due to other factors that are more pronounced in SHI countries. For example, the benefit baskets of covered services (i.e. the entitlements of the insured) have been defined more clearly. In addition, on average SHI countries spend a higher percentage of their gross domestic product on health care than tax-funded systems. Such extra costs or trade-offs are cost-effective or justifiable only if they recognize the value of responding to citizens' expectations.

First, this chapter explores the basic concepts behind *responsiveness*, *satisfaction* and related terms in section 8.2. The following three sections (8.3–8.5) consider the major approaches and actors to measure them, i.e. primarily WHO, but also the European Union and initiatives

¹ In: MCKEE M, FIGUERAS J (eds.) (2012) Health Systems: Health, Wealth and Societal Well-Being. Maidenhead: OUP, p. 175-208

to ensure patient orientation such as the Picker Institute's questionnaire for inpatient care (3,4) or the European Task Force on Patient Evaluations of General Practice (EUROPEP) instrument to assess primary care (5) . Section 8.6 describes comparative methodology and results. For example – the basic terms: “responsiveness to the legitimate expectations of the population for their interaction with the health system” and “satisfaction of the overall population with the health system” are different but overlapping. Recently, other dimensions have been added to the debate (e.g. “generosity of the system”), especially through consumer rights' initiatives such as the Health Consumer Powerhouse.

Section 8.7 aims to shed some light on the objectives and achievements of the main recent reforms aimed at increasing responsiveness in European health systems. The chapter concludes with some reflections about the significance of making responsiveness a health system goal and its instrumental value for reaching other goals. For example, higher responsiveness should result in higher utilization of services and better compliance for longer term treatment, and therefore in better health outcomes (assuming that services are effective and appropriate).

8.2 Responsiveness and satisfaction – conceptual and measurement issues

Both responsiveness and satisfaction are terms that aim to capture the degree to which health systems, or their components, are successful in responding to the expectations of the general population or a population subgroup of patients. A wide range of methods has been used to attempt to measure responsiveness and/or satisfaction over the last decades, most visibly work by Blendon et al. (6); population satisfaction questions in Eurobarometer surveys since 1996 (7, 8, 9, 10, 11); the Picker Institute's development of inpatient satisfaction surveys (3, 4); the EUROPEP instrument to assess general practice (5); and the WHO world health report 2000 (1).

Responsiveness and satisfaction are different but overlapping. WHO quotes “responsiveness to the legitimate expectations of the population for their interaction with the health system” (cf. section 8.3). This implies that there can be illegitimate or unjustified expectations too, but the instrument only captures those that are regarded as legitimate. The “satisfaction of the overall population with the health system” may be influenced by other expectations (which experts or policy-makers may consider illegitimate) and factors outside the direct control of the health-care system (such as government in general, cf. section 8.5). Thus, satisfaction is likely to be more dependent on expectations than responsiveness surveys – the lower the

expectations, the higher the satisfaction with the actual system and vice versa. WHO initially used a vignette approach in its responsiveness methodology in order to correct for different expectations but this approach was dropped due to the complex data requirements. It is extremely difficult to adjust for variations in expectations between countries and this has not been achieved with any approach to date.

Responsiveness captures various detailed dimensions of the system that users encounter. Satisfaction analyses the satisfaction of the whole population, i.e. regular (e.g. those with chronic illness) and irregular users as well as those who do not utilize the system (but still pay for it). Unlike similar measures in the quality-of-life and satisfaction domains, responsiveness has an additional criterion that requires self-reports to be based on one (or several) actual experience(s) with health services in the respondents' recent past (previous year). Usually these experiences are based on some type of interaction with the health system – with a specific person, a communication campaign or another type of event or action that did not entail direct personal interactions.

The WHO instrument focuses on what happened during actual contact rather than eliciting a respondent's satisfaction with, or expectations of, the health system in general. Thus it has much in common with patient satisfaction instruments such as those developed by the Picker Institute (cf. section 8.4). These usually contain a question regarding a general assessment of the care received but are based on patients' assessments of specific, predefined dimensions of care. They may rather more accurately termed patient responsiveness surveys.

All the responsiveness and satisfaction surveys mentioned so far are based on surveys among health system users and/ the general population rather than (for example) expert opinion or facility audits. This differentiates them from approaches based on an expert assessment of published data and health system characteristics. The most high-profile of these approaches is the annual Euro Health Consumer Index produced by the Health Consumer Powerhouse (12) (see section 8.6 for more details).

8.3 Responsiveness to legitimate expectations: methodology and results

The WHO measure aims to measure the responsiveness of the whole health system to the whole population (thus far it has been applied mostly to those with ambulatory and/or inpatient encounters) by examining what actually happens when the system comes into contact with an individual. This is conceptually different from either a population's general satisfaction with its health system or patients' satisfaction with the care they receive (13).

An extensive literature review covered disciplines including sociology, anthropology, ethics, health economics and management in order to elicit what people value most in their interactions with the health system. This was used to select a common set of dimensions (or domains) that characterize the concept of responsiveness. Eight domains were described as goals for health-care processes and systems; higher average health and lower health inequalities; and non-improvement.

The WHO surveys include two major categories (inpatient and ambulatory care) for responsiveness, each with a total of eight domains. The detailed contents of these are given in

Box 8.1.

Box 8.1 Contents of the eight dimensions of WHO's responsiveness surveys

- 1. RESPECTFUL TREATMENT (DIGNITY)**
Being shown respect when greeted by and when talking to health-care providers.
Having physical examinations conducted in a way that respects your cultural norms.
- 2. CONFIDENTIALITY OF PERSONAL INFORMATION**
Having health-care providers listen to you when you talk.
Having information about your health and other personal information kept confidential.
Having conversations with health-care providers without other people overhearing.
- 3. CLARITY OF COMMUNICATION**
Having the health-care providers explain things so you can understand.
Giving the patients and family time to ask the health-care provider questions.
- 4. INVOLVEMENT IN DECISIONS (AUTONOMY)**
Freedom to discuss other treatment options or care regimes if you want.
Being involved as much as you want in deciding about your health care.
Freedom to express a preference for an intervention and to select a particular intervention.
- 5. CONVENIENT TRAVEL AND SHORT WAITING TIMES (PROMPT ATTENTION)**
Having short travel times and convenient access to health-care facilities.
Having short waiting times for consultations and admissions.
Having short waiting times for test results.
Having short waiting lists for non-emergency surgery.
Having nurses available when needed during hospital stay.
- 6. SURROUNDINGS (BASIC AMENITIES)**
Having enough space, seating and fresh air in the waiting rooms, examination rooms and hospital wards.
Having a clean facility (including clean toilets).
having healthy and edible food for patients in hospital.
Having comfortable sleeping arrangements for patients staying in hospital.
- 7. CONTACT WITH THE OUTSIDE WORLD AND MAINTENANCE OF REGULAR ACTIVITIES (SOCIAL SUPPORT)**
Having family and friends visit you as much as you want when you are a patient in hospital.
Being able to maintain regular activities and keep in contact with family, friends and events in the outside world when you are a patient in hospital.
- 8. CHOICE OF HEALTH-CARE PROVIDER**
Being able to choose your health-care provider (place or person).
Being able to change health-care provider if you want to.
Being able to stay with the same health-care provider if you want to.
Being able to consult for a second opinion or with a specialist if so desired.

Source: (14)

The data presented in the world health report 2000 were based on expert opinions but WHO consequently undertook two large population surveys in a number of countries. The multi-country survey study in 2000/01 (MCS study) (13) and the world health survey in 2002 (15) (WHS; for details see below) worked mainly via interviews, partly by postal surveys (in the MCS study). Interviewees in the MCS study were asked to rate their experiences over the past 12 months. While the questions regarding seven of the eight domains were relevant for both inpatient and ambulatory care, only inpatients were asked about social support. All domains included a summary rating question (scaled 1–5, from very good to very bad). In addition, several domains included report questions on how often a particular experience had occurred during encounters with the health system (scaled 1–4, from always to never).

Table 8.1 shows the available results for the thirteen EU15 countries in the MCS survey, i.e. five SHI countries (Luxembourg, Germany, Belgium, France, the Netherlands), seven tax-financed systems and a mixed system (Greece). WHO's weights were derived from the frequencies with which respondents ranked the different elements first. Prompt attention was perceived as the most important and choice of provider the least. When these are applied to the different components of responsiveness, the United Kingdom scores best for inpatient care (followed by Luxembourg and Ireland); Ireland scores highest for ambulatory care (followed by Germany and the United Kingdom). Unfortunately, no longitudinal data are available yet so there should be a very cautious interpretation about the impact of system characteristics and reforms on responsiveness.

Table 8.1 WHO's components of responsiveness for EU15 countries in the MCS survey, 2000-2001

	Autonomy		Choice		Communication		Confidentiality		Dignity		Prompt attention		Access to family and community support	Basic amenities	Country weighted mean		Relative order	
	In	Amb	In	Amb	In	Amb	In	Amb	In	Amb	In	Amb			In	Amb	In	Amb
Ireland	75	87	88	98	91	94	92	94	91	98	82	95	90	88	87	94	2	1
UK	81	81	93	98	85	85	90	96	94	95	82	81	95	77	88	87	1	3
Sweden	81	83	87	94	89	88	88	86	97	95	74	82	95	74	86	86	4	4
Luxembourg	83	83	88	98	90	81	83	82	92	91	83	82	94	74	87	85	2	9
Germany	74	84	85	98	74	85	83	87	85	90	85	94	89	83	82	89	8	2
Belgium	75	79	97	100	87	87	79	81	88	92	73	84	91	75	83	86	5	4
France	71	71	96	100	88	89	83	85	91	95	72	81	90	77	83	86	5	4
Netherlands	72	80	88	97	82	85	75	77	87	94	85	89	96	72	83	86	5	4
Finland	76	84	60	83	86	88	83	86	85	95	81	86	87	72	79	86	9	4
Spain	61	64	82	85	84	79	83	83	85	83	78	83	80	71	79	79	9	10
Italy	53	58	90	98	74	73	68	69	74	73	78	75	79	61	74	73	11	11
Portugal	66	67	78	85	71	76	70	71	66	71	71	76	74	65	71	73	12	11
Greece	44	48	71	72	49	53	79	81	61	63	61	71	78	59	62	64	13	13

Notes: countries are sorted by average level of overall responsiveness for inpatients and outpatients.

No data are available for other countries.

In = Inpatient care. Amb = Ambulatory care.

Source: Valentine *et al.* (16)

Except for confidentiality, the SHI countries score (on average) from 2%–8% more than tax-funded countries. The highest and most relevant advantages are seen in the area of choice. Clearly, this is not due to the SHI funding mechanism itself but rather to deliberate decisions to allow patient choice of provider in these countries (introduced later and often more restricted in other countries; cf. section 8.6).

The large differences within the country groups confirm that the funding mechanism is not the determining factor for higher levels of responsiveness. Countries that choose SHI contributions rather than taxation put more emphasis on certain dimensions of responsiveness. For example, France scores lower for prompt attention in inpatient care than

most tax-financed countries while the United Kingdom scores higher than almost all of the SHI countries for both autonomy and choice.

The more restricted character of choice in the United Kingdom compared with SHI countries raises the question of intercountry comparability. Can the same care receive comparatively high responsiveness scores when lower expectations are met but lower responsiveness scores if expectations are high and therefore not met? This question is addressed below.

8.3.1 Responsiveness and population expectations

The WHS 2002 (15) collected data on responsiveness among other aspects related to health systems performance. Data were collected from 69 countries globally, including 29 Member States of the WHO European Region .

As described above, respondents were asked to rate their last encounter with the (ambulatory or inpatient) health-care system on a five-point scale across eight domains. In addition, the survey contained vignettes depicting a variety of situations that may arise in people's interactions with the health-care system. Respondents were asked to rate these hypothetical experiences on a five-point scale ranging from very bad to very good. Five vignettes were used for choice and ten vignettes for every other domain. Available data on both responsiveness and expectations are given in **Table 8.2**. The data show wide variations in responsiveness scores – from 55.8 to 91.5 in outpatient care and from 51.6 to 90.3 for inpatient care. However, there were far fewer variations in expectations (56.3–64.3 in ambulatory care; 56.6–64.3 in inpatient care).

It is noteworthy that Austria showed both the lowest expectation scores and the highest responsiveness score. The country with the lowest responsiveness score (Ukraine) had comparatively high expectation scores. This led to the hypothesis that people with different expectations rate similar experiences differently. For example, those with low expectations may rate their last experience as good while those with higher expectations may rate an experience with similar characteristics and quality as only moderate. Respondents were asked to rate the vignettes in order to obtain a true measure of a person's experience.

Table 8.2 WHO's components of responsiveness for 29 available European countries in the WHS, 2002

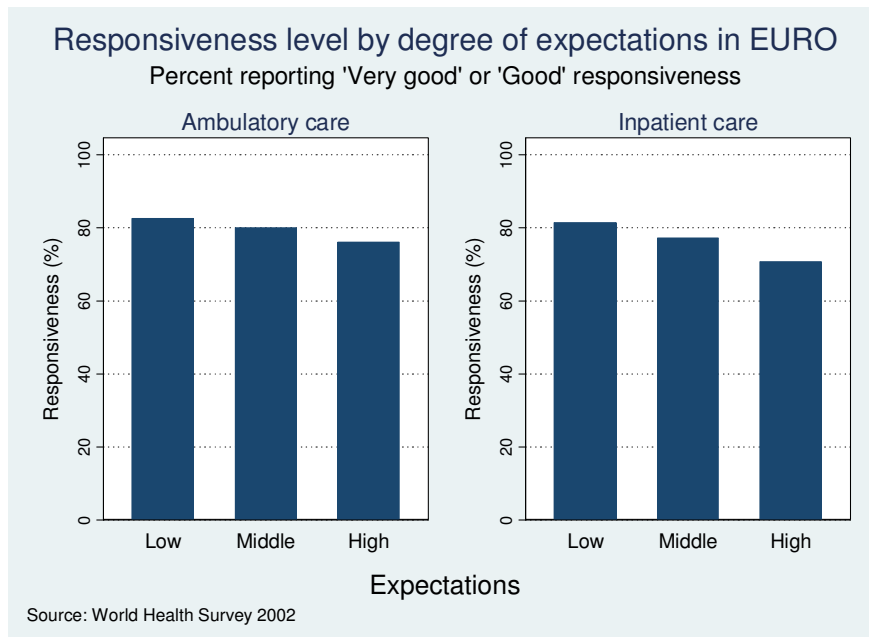
Country	Overall responsiveness (average ambulatory & inpatient) score	Ambulatory responsiveness score	Inpatient responsiveness score	Ambulatory expectations score	Inpatient expectations score
Austria	90.6	91.5	89.7	56.3	56.6
Luxembourg	90.4	90.4	90.3	62.3	61.4
Belgium	90.2	91.4	88.9	62.3	61.7
Denmark	85.9	89.2	82.5	62.5	62.3
Greece	85.2	85.3	85.0	59.7	59.2
France	85.6	89.1	82.1	62.2	61.6
Netherlands	84.3	89.1	79.4	60.1	59.5
Czech Republic	84.3	84.9	83.6	60.8	60.2
Ireland	84.2	82.2	86.1	61.0	60.6
Germany	83.9	86.9	80.8	60.1	60.1
United Kingdom	82.5	83.8	81.1	61.4	61.4
Israel	81.8	83.1	80.4	60.3	59.4
Finland	81.7	88.3	75.0	62.0	61.8
Georgia	80.0	81.5	78.4	60.9	60.1
Spain	79.2	81.0	78.3	64.3	63.7
Bosnia and Herzegovina	78.1	77.2	79.0	62.0	61.6
Slovenia	77.8	80.4	75.1	63.2	63.0
Sweden	77.6	77.1	78.1	63.6	63.3
Hungary	77.0	79.2	74.8	59.0	58.6
Norway	76.9	80.3	73.4	64.3	64.3
Slovakia	75.8	75.4	76.1	59.2	59.0
Portugal	73.2	68.2	78.1	60.5	61.0
Estonia	72.5	74.5	70.5	62.6	62.1
Italy	70.7	73.6	67.7	62.4	61.7
Latvia	70.4	72.5	68.2	64.2	63.7
Kazakhstan	69.5	68.7	70.2	61.5	60.9
Croatia	64.9	70.7	59.0	63.5	63.2
Russian Federation	57.7	55.8	59.5	62.4	61.9
Ukraine	55.6	59.5	51.6	62.9	62.1

Note: countries sorted by level of overall responsiveness.

Source: authors' calculations based on WHS data (15)

Fig. 8.1 shows the average responsiveness score when the 29 countries of the WHO European Region were divided into three equal groups (10, 10 and 9 countries) according to their differing levels of expectations – from low to high. For both ambulatory and inpatient care, overall population expectations increase as the responsiveness score (which is not adjusted for expectations) decreases. Also, the t-test for equality of means reveals that the average responsiveness scores for countries with high expectations are significantly different from those for countries with low expectations.

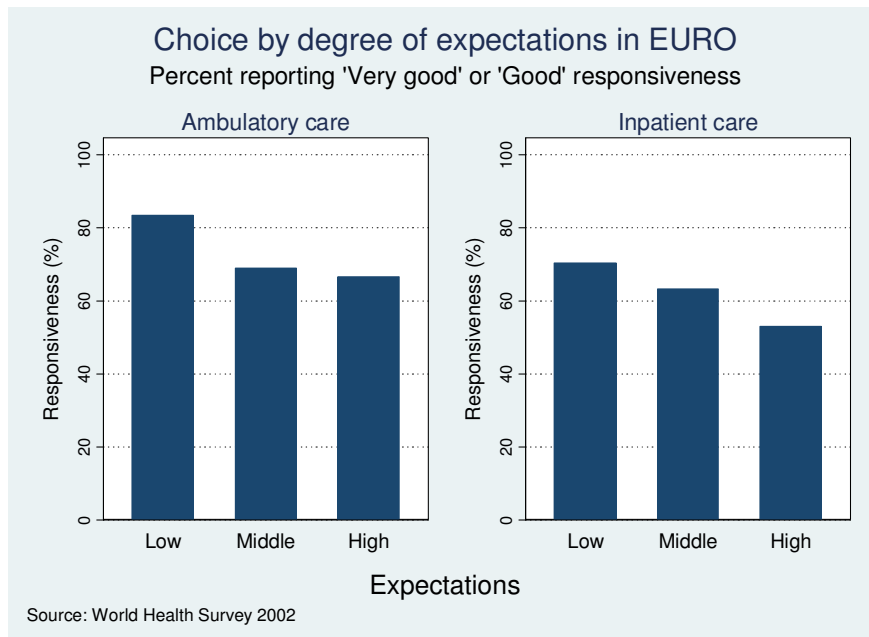
Fig. 8.1 Relationship between overall responsiveness and population expectations for 29 countries of the WHO European Region (EURO)



Source: World Health Survey 2002 (15)

Only prompt attention, communication and choice show a statistically significant association within individual domains. **Fig. 8.2** shows an example of choice of health-care provider. National populations with low expectations for choice expressed a substantially higher responsiveness for choice in ambulatory care than populations with higher expectations. For inpatient care, responsiveness decreased with increasing expectations.

Fig. 8.2 Relationship between responsiveness for choice of health-care provider and population expectations for 29 countries of the WHO European Region (EURO)



Source: World Health Survey 2002 (15)

Table 8.3 depicts the five countries with the highest average expectations for each of the domains.

Table 8.3 Five countries with the highest expectations for each responsiveness domain under client orientation and respect for persons (highest expectations = rank 1)

Prompt attention	Choice	Basic amenities	Social support
1. Spain	1. Bosnia and Herzegovina	1. Spain	1. Portugal
2. Ukraine	2. Norway	2. Luxembourg	2. Norway
3. Latvia	3. Georgia	3. France	3. Slovenia
4. Croatia	4. Latvia	4. Belgium	4. Sweden
5. Russia	5. Croatia	5. Italy	5. Croatia

Dignity	Communication	Autonomy	Confidentiality
1. Norway	1. Norway	1. Norway	1. Norway
2. Sweden	2. Spain	2. Sweden	2. Sweden
3. Belgium	3. Slovenia	3. Ireland	3. United Kingdom
4. Denmark	4. Latvia	4. Spain	4. Italy
5. Luxembourg	5. Denmark	5. United Kingdom	5. Denmark

Source: authors' calculations based on WHS data (15)

On average, Norwegians reported the highest value of expectations for respect-for-persons domains. While Sweden and Denmark also featured commonly among the five countries with

highest expectations, there is a different pattern of expectations for client-orientation domains. Spain had the highest expectations for prompt attention and basic amenities but people from central and eastern Europe (CEE) and former Soviet Union countries also reported relatively high expectations for these domains.

Three main conclusions for WHO European Region countries can be drawn from the analysis above.

1. Some intercountry variations in responsiveness may be explained by differences in population expectations². This indicates that expectations-based adjustment to the scores may be necessary before meaningful intercountry comparisons can be made.
2. A smaller set of domains displayed a significant correlation between responsiveness and expectations. These included choice, prompt attention and communication.
3. Some country populations may have relatively higher expectations of certain domains of responsiveness than others.

8.3.2 Health care expenditure and responsiveness

The example of SHI countries noted above raises the question of whether the amount spent on health care explains differences in responsiveness. Keeping all other factors constant, well-resourced health system environments should be able to afford better quality care and receive better responsiveness ratings. A simple correlation for each responsiveness domain result (keeping development contexts constant by looking at correlations within World Bank country-income groups) was used to analyse whether higher health expenditures are associated with higher responsiveness (17). In general, the results show a positive association across many of the domains for most country-income groupings. Especially for high-income countries, there are clear correlations between total health-care expenditure and levels of responsiveness. If public expenditure alone is taken into account, there are correlations for even more domains. This suggests a more direct impact on levels of responsiveness – in other words, that private expenditure does not (or only marginally) contribute to higher levels of responsiveness. However, increasing levels of health expenditures are no guarantee that responsiveness will improve automatically. Conversely, lower responsiveness is associated with lower coverage and greater inequity in access.

² Although not tested in this analysis, variations in responsiveness across population groups such as poor/not poor, educated/uneducated within a country may also occur (at least) partly due to differences in expectations.

8.4 Patient responsiveness/ satisfaction surveys: methodology and results

As mentioned in section 8.2, patient satisfaction surveys constitute a third pillar of data. Usually, they belong more to responsiveness than to satisfaction as they are based on (i) predetermined domains, and (ii) patients' actual health-service encounters. They are shown here as they partly contradict the responsiveness data described in the previous section. Surveys are available for inpatient and for general practitioner care, the latter being the most important component of ambulatory care.

8.4.1 Inpatient care

Satisfaction surveys of inpatients have become regular practice in many countries of the WHO European Region but are seldom comparable, either within or (more likely) between countries. The Picker Institute questionnaire is an exception. This inpatient survey asks patients to report problems with particular aspects of their care upon discharge. It distinguishes seven dimensions of patient-centred care which overlap with the areas of responsiveness but draws different boundaries between them.

1. Information, communication and education – including clinical status; progress and prognosis; processes of care; facilitation of autonomy; self-care; and health promotion.
2. Coordination and integration of care – including clinical care; ancillary and support services; front-line care.
3. Physical comfort – including pain management; help with activities of daily living; surroundings and hospital environment.
4. Emotional support and alleviation of fear and anxiety – including clinical status; treatment and prognosis; impact of illness on self and family; financial impact of illness.
5. Respect for patients' values, preferences and expressed needs – including impact of illness and treatment on quality of life; involvement in decision-making; dignity; needs; and autonomy.
6. Involvement of family and friends – including social and emotional support; involvement in decision-making; support for caregiving; impact on family dynamics and functioning.

7. Transition and continuity – including information about medication and danger signals to look out for after leaving hospital; coordination and discharge planning; clinical, social, physical and financial support.

Results collected between 1998 and 2000 showed that patients in the United Kingdom reported more problems than those in Germany, for example (Table 8.4), even though their responsiveness was higher according to the data presented in Table 8.1.

Table 8.4 Patients reporting problems with hospital, 1998–2000 (%); countries sorted from left to right by overall evaluation

	Switzerland	Germany	Sweden	UK
Overall level of care NOT GOOD	3.7	6.6	7.4	8.5
Problems with:				
* information and education	16.7	20.4	23.4	28.7
* coordination of care	13.1	17.2	NA	21.9
* physical comfort	2.6	6.7	4.0	8.3
* emotional support	14.7	21.9	26.0	27.1
* respect for patients' preferences	15.6	17.9	21.2	30.7
* involvement of family and friends	11.5	16.6	14.6	27.5
* continuity and transition	30.0	40.6	40.2	45.1
Would not recommend this hospital to friends/family	3.6	5.0	2.8	7.8

Notes: No data are available for other countries.

Source: adapted from Coulter & Cleary (3)

8.4.2 Care by general practitioners

Similarly, the results of an evaluation of (ambulatory) general practice care differ from those of the WHO MCS survey. EUROPEP surveyed more than 17 000 patients in 10 European countries on 23 items. Table 8.5 depicts selected results (5). In comparison with the outpatient care responsiveness data, these results are especially contradictory for the United Kingdom. Sweden shows clearly worse results compared to Germany, Belgium and the Netherlands (but roughly the same as those countries in the responsiveness figures).

In summary, different questionnaires with different items reach different results. In some instances this has a large impact on rankings. All methodologies are therefore rightly subject to further extensive critical debate.

Table 8.5 Evaluations of general practice care in ten European countries, circa 1998 (%); countries sorted from left to right by overall evaluation

	CH	SLO	D	B	ICE	NL	S	N	DK	UK
Overall evaluation	91	89	88	87	83	80	78	76	74	72
1. Keeping records and data confidential	96	97	94	97	97	95	88	91	96	91
2. Listening to you	96	95	92	93	93	89	85	85	79	83
3. Making you feel you had time during consultations	96	92	90	92	93	88	85	78	75	80
4. Providing quick services for urgent problems	96	89	95	93	86	85	84	83	81	71
... (15 other items)										
20. Offering you services for preventing disease	84	85	85	77	74	76	75	67	68	74
21. Getting through to the practice on the telephone	96	92	95	93	75	71	67	56	53	62
22. Being able to speak to the GP on the telephone	91	93	87	90	72	72	65	54	59	51
23. Waiting time in the waiting room	79	60	70	66	70	61	65	57	59	50

Notes: No data are available for other countries.

Source: Grol et al. (5)

8.5 Population satisfaction: methodology and results

In principle, the concept of population satisfaction with the whole health system is straightforward. In fact, it is difficult to measure satisfaction as the answers to all questionnaires depend on the specific wording of the question asked as well as the answer categories provided. In the circumstances discussed in this chapter these answers depend particularly on factors not yet well-understood, i.e. (i) the context in which a survey takes place, e.g. coloured by recent media coverage of scandals, fraud or underprovision of services; (ii) no differentiation between the system as a whole and certain subsectors about which the respondent may be more knowledgeable; or (iii) the inability to differentiate between the health-care system and government in general.

These caveats need to be kept in mind when drawing international comparisons. Comparisons of absolute levels of satisfaction should be treated with caution. Cultural and locally temporal differences in the expression of satisfaction and its dynamics make this a complex tool. Satisfaction data incorporate underlying expectations so that low satisfaction may mean high expectations which are unmet. Satisfaction would be higher in other countries with similar health care but lower expectations.

Table 8.6 incorporates data from different surveys over the last 30 years. They share a common focus on the broader health system, but the actual questions – and therefore the range of answers which can be considered positive or negative – differ between countries (see notes to Table 8.6). However, the order can be judged as a relatively good indicator.

Table 8.6 Satisfaction with the health-care system in EU15 countries (%), various surveys 1973/1976-2004; countries sorted according to 2002 survey

	1973/76 (A)	1988/91 (B)	1996 (C)	1998 (D)	1998 (E)	1999/2000 (F)	2002 (G)	2004 (H)
Finland	71		86	81	78	74	73	
Austria	79		63	73	71	83	67	
Belgium			70	63	57	77	65	
France		41	65	65	59	78	64	65
Luxembourg			71	67	50	72	58	
Denmark			90	91	48	76	52	
Sweden		32	67	58	46	59	48	
Germany	81	41	66	58	43	50	47	28
Netherlands	84	47	73	70	70	73	46	
Spain		21#	36	43	31	38	46	42
UK	85	27	48	57	49	56	31	32
Italy	38	12	16	20	15	26	31	21
Ireland			50	58	23	48	20	
Greece			18	16	11	19	19	
Portugal			20	16	6	24	14	

Notes: (A) level of satisfaction *very good or good*; (B) “*On the whole the system works pretty well, and only minor changes are necessary to make it work better*” (as opposed to “*There are some good things in our health-care system, but fundamental changes are needed to make it work better*” and “*Our health-care system has so much wrong with it that we need to completely rebuild it.*”); (C) & (D) Eurobarometer 44.3 (conducted February-April 1996) & Eurobarometer 49 (conducted April-May 1998), “*In general, would you say you are very satisfied, fairly satisfied, neither satisfied nor dissatisfied, fairly dissatisfied or very dissatisfied with the way health care runs in (our country)?*”: *very or fairly satisfied*; (E) Eurobarometer 50.1 (conducted November-December 1998), “*And, on a scale from 1 to 10, how satisfied are you with health services in (our country)?*”: *answers 7, 8, 9 or 10*; (F) Eurobarometer 52.1 (conducted November-December 1999), “*Please tell me whether you are very satisfied, fairly satisfied, not very satisfied or not at all satisfied with each of the following?*” “*(our country)’s health-care system in general*”: *very or fairly satisfied*; (G) Eurobarometer 57.2 (conducted April-June 2002), “*On the whole the system works pretty well*” or “*There are some good things in the way health care runs, and only minor changes would make it work better*”; (H) The Harris Poll (conducted in June 2004), “*feel positively about health-care system (in my country).*”

Sources: (A) Pescosolido *et al.* (18); (B) Blendon *et al.* (19); (C) European Commission 1996 (7); (D) European Commission 1998 (8); (E) European Commission 1999 (9); (F) European Commission 2000 (10); (G) European Commission 2002 (11); (H) Taylor (20)

The positive development in Austria is most striking. Austrians were only fairly satisfied in the 1970s (rank 4 of 7) and as late as 1996 (7/15) but were much more satisfied in 1998

(3/15), 1999/2000 (1/15) and 2002 (2/15). Similar but more stable positive trends can be seen e.g. in Finland (in spite of the drastic cuts in public health finances in the first half of the 1990s) or Spain³. In contrast, (relative) satisfaction figures have decreased in the United Kingdom (moving from first position in the 1970s to a midway position in 1999/2000 and eleventh among the EU15 countries in 2002); the Netherlands; and, to a lesser degree, Germany. Italy and Portugal score continuously low.

8.6 Comparative methodology and results

The WHO concept of responsiveness was developed following an extensive literature review covering disciplines such as sociology, anthropology, ethics, health economics and management in order to elicit what people value most in their interactions with the health system. This review formed the basis of the set of eight domains mentioned in section 8.3 (14). Many of these domains are present in existing patient questionnaires and studies (e.g. the Picker surveys or the EUROPEP evaluation), but none of these adequately captures all of the dimensions that emerged from the literature review. Hence, WHO developed an instrument (questionnaire) specific to responsiveness in order to cover all of the dimensions valued by individuals when they interact with health systems.

Table 8.7 demonstrates that the questions on the population's satisfaction with the health system in general (or the need to reform it) are in a separate category in the Eurobarometer surveys and do not overlap directly with any of the WHO responsiveness domains. Similarly, the Euro Health Consumer Index only partially overlaps with the WHO responsiveness domains. For example, it expands the concept of prompt attention to include "patients' rights and information" (with questions on the existence of patients' rights legislation, right to a second opinion, access to own medical record, readily available register of doctors, or a provider catalogue with quality listing); "generosity of public health-care system" (with indicators relating to the number of publicly paid cataract operations and kidney transplants or the inclusion of dental care in the benefit basket); and "pharmaceuticals" (including the degree of cost-sharing or the speed with which new cancer drugs are deployed in the system). The Euro Health Consumer Index also includes several outcomes' dimensions, the results of which also influence its overall ranking.

³ Data cover the entire period of the transition from a system based largely on social security contributions via a tax-funded national health service type of system to a tax-funded regionalized system.

Table 8.7 Selection of questionnaires/studies/surveys/rankings with questions on the responsiveness domain

	WHR 2000 ^a	Picker survey ^b	EUROPEP GP practice evaluation ^c	Eurobarometer ^d	Euro Health Consumer Index ^e
Outcomes					
Health-adjusted life years	X				
AMI mortality					X
Infant deaths					X
Cancer survival					X
Potential years of life lost					X
MRSA infections					X
Responsiveness/ Satisfaction					
Respect for dignity	X	X	X		
Respect for confidentiality	X	X	X		
Communication	X	X	X		
Respect for autonomy	X	X	X		X
Access to prompt attention/ waiting	X		X		X
Basic amenities	X		X		
Access to social support networks	X	X			
Choice of institution/ care provider	X				X
Patients' rights and information					X
Satisfaction with health system/ need for reform				X	
"Generosity" of system					X
Access to pharmaceuticals					X
Fairness in financing	X				

Source: Based on ^a WHO (1); ^b Jenkinson et al. (4); ^c Grol et al. (5); ^d European Commission (11); ^e Health Consumer Powerhouse (12)

Different dimensions may very well produce different results that reflect the selection of weights, domains and indicators (i.e. surveys capture different phenomena); differences in the methodology of data collection (e.g. sampling) and interpretation; or actual differences due to changes in the various health systems over time.

Table 8.8 provides data on the ranks of the EU15 countries in the WHO responsiveness surveys on inpatient and outpatient care respectively, the EUROPEP instrument to evaluate GP practices, the Eurobarometer 57.2 question on satisfaction and the 2007 version of the Euro Health Consumer Index.

Table 8.8 Rankings of the EU15 countries in selected recent surveys/ rankings, 1998–2007

	Responsiveness inpatient 2000/01 ^a	Responsiveness outpatient 2000/01 ^a	GP evaluation 1998 ^b	Satisfaction 2002 ^c	Euro Health Consumer Index 2007 ^d
Austria	na	na	na	2	1
Belgium	5	4	2	3	8
Denmark	na	na	5	6	7
Finland	9	4	na	1	6
France	5	4	na	4	3
Germany	8	2	1	8	4
Greece	13	13	na	14	15
Ireland	2	1	na	13	11
Italy	11	11	na	12	13
Luxembourg	2	9	na	5	9
Netherlands	5	4	3	9	2
Portugal	11	11	na	12	13
Spain	9	10	na	10	10
Sweden	4	4	4	7	5
UK	1	3	6	11	12

Notes: na: Not available.

Sources: Based on: ^a Valentine et al. (16); ^b Grol et al. (5); ^c European Commission (11); ^d Health Consumer Powerhouse (12).

Further to the initial statement that responsiveness seems to be higher in SHI countries. The data show that on average these countries (i.e. Austria, Belgium, France, Germany, Luxembourg and the Netherlands) fare better in all four surveys. This does not appear to be due to the funding mechanism per se (i.e. whether a population contributes to the health system through SHI contributions or taxes) because the difference becomes larger when consumer-orientation dimensions (i.e. generosity of the system), rather than actual patient experience with the encounter, are weighted. Assuming that the results are collected in a (relatively) valid manner, it can be interpreted that SHI countries put more emphasis on consumer orientation (such as choice of provider and purchaser, clearly defined entitlements, patients' rights including the right to claim entitlements). In turn this leads to better results if these dimensions are taken into account.

The results of these assessments are sometimes inconsistent or contradictory and are difficult to interpret. Overall, no individual survey enables any clear conclusions to be drawn about the differences in the degree of responsiveness between health systems and even less about the health system strategies that may explain them. Taken together, they provide a slightly clearer picture (especially for countries that score consistently high or low) but still do not

provide conclusive advice about the characteristics of the health systems that “explain” the differences.

However, it is important to note that such surveys do exist and will appear increasingly on the public’s agenda. Policy-makers have to deal with the pressures exerted by such league tables. They cannot simply dismiss the data as unreliable even when they are used to call for ineffective, inequitable or inefficient changes in the health-care system.

8.7 Health-care reforms that aim to increase responsiveness

In many (if not all) European countries, policy-makers have begun to react to the greater emphasis on – and the populations’ greater demand for – responsiveness in the health-care system. Important strategies include:

- defining patients’ rights and entitlements and making them transparent (e.g. definition of benefit baskets and patient rights charters);
- enlarging the benefit basket with services that primarily address dignity (especially palliative care) rather than health gain;
- addressing the issue of waiting lists;
- introducing or enlarging choice of provider and purchaser.

Strategies to increase the first four WHO dimensions of responsiveness (dignity, autonomy, confidentiality and communication) also include changes in organizational and policy development. Staff education and training have been refocused to promote greater respect for human dignity; to ensure that personnel communicate effectively; and to foster the appropriate application of confidentiality policies. Information sharing has been made more effective and mechanisms put in place to allow patients a more autonomous role and to participate more in clinical decision-making, as legitimate co-producers of care. Such improvements are very likely to result in better compliance with treatment and care (particularly among patients with chronic conditions) and can be secured without necessarily requiring significant additional investment.

An indirect approach to influencing provider behaviour can be taken through broader regulatory initiatives such as the creation of patient rights' legislation or patient charters⁴; specific service guarantees, for example on waiting times; or an ombudsman function. Patients' rights are subject to numerous international and regional declarations and conventions. The increasing complexity of the health-care sector, the technological developments in medicine and the introduction of market elements in the health-care system have increased the need to guarantee patients' rights by law. Some commentators have questioned the emphasis on the legal approaches to patients' rights but an explicit consideration of the patient's perspective fits well with a general democratic evolution in many countries.

The concept of patients' rights is moving from a focus on individual rights — that is, restricting state intervention in the individual's right to life and privacy — to a focus on the collective right to health care. In addition to ensuring access to health services, the right to health care has also been interpreted as including consumer participation via procedural mechanisms to implement their preferences, for example the International Labour Organization (ILO) Convention No.130, also known as the European Social Code. WHO took up the subject of citizen participation and collective rights as early as 1994. Its *Declaration on the Promotion of Patients' Rights in Europe* states that “patients have a collective right to some form of representation at each level of the health-care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided” (22).

Another component to ensure transparency and clarity about patients' rights is an explicit definition of a benefit basket. This development is usually seen in the context of the health system's goal to improve health, as a benefit basket will be designed primarily to ensure that effective and cost-effective technologies are covered while those that are ineffective or less cost-effective are omitted. In order to ensure responsiveness it is also important to remember the right to die in dignity and that most people want to do this at home. This requires additional palliative-care services and personnel which should be part of the benefit basket. However, palliative care and hospices have to be treated separately as the usual health technology assessment (HTA) evaluation mechanisms (with their emphasis on health gain and cost effectiveness) may disadvantage such services.

⁴ For an overview of such initiatives within EU countries see (21).

It is perhaps even more challenging to create a climate that encourages health service personnel to treat patients well. Health workers typically value professionalism but where pay fails to meet legitimate expectations they may become demotivated and fail to deliver the highest quality care. Those that are paid particularly badly may raise money illicitly, responding only to informal payments and creating barriers to access. Maintaining responsiveness therefore implies providing adequate resources – a potentially challenging proposition. It may be expensive to increase pay but it creates an opportunity to refocus management and specify expectations. However, health system managers must recognize the evidence that policies that seek to micromanage clinical behaviour can lead to a loss of professional identity and undermine autonomy and motivation so that health workers do exactly what they are meant to, but no more.

Other dimensions of responsiveness (i.e. those that primarily improve the client orientation of services) are also likely to require a considerable commitment of resources. This is particularly true if capacity is to be increased in order to reduce waiting times or facilities are to be improved; and also if new client information systems or new complaints procedures are required. In combination or separately, policy-makers may also advance responsiveness by including explicit requirements to meet clients' expectations in contractual arrangements (where these apply) or by building them into service delivery strategies.

It has been argued that, in principle, *waiting times* can be reduced through supply-side policies if the volume of surgery is considered inadequate and by demand-side policies if it is not (23). Supply-side policies include raising public capacity by increasing the number of specialists and beds, or by using capacity available in the private sector. They also include increasing productivity by funding extra activity; fostering day-surgery; and linking the remuneration system of doctors and hospitals to the activity performed. On the supply side, the pronounced and prolonged reductions in long waits for coronary revascularization surgery in Denmark have been achieved by significant increases in activity, backed up by increases in capacity. Hospitals that breach the one-month waiting-time target must bear the expense of the patient's choice of a different public or private provider (even outside the country).

The striking reductions in long waiting times in England and Spain have been due to a combination of maximum waiting-time targets, additional activity and changed incentives. In addition, in Spain there appears to have been a marked fall in mean waiting times for patients requiring various procedures after financial incentives were linked to the achievement of waiting-time targets in 1998. Many OECD countries have implemented visible improvements

in the efficiency of surgical units, particularly by increasing the share of day surgery. However, increased activity to reduce waiting times is often swiftly followed by increased demand that returns waiting times to near their original levels. Any strategy to tackle waiting times is therefore a combination of increased capacity and approaches aimed at both providers (financial incentives to provide more services and/or disincentives for failing to meet targets) and patients (increased choice).

Client orientation can be viewed from two perspectives. Firstly, the collective and individual *influences* on care decisions – either when citizens influence the package of care and benefit coverage or the power of individual patients to get the care they desire or deem necessary. The second perspective looks at the *mechanisms* available to citizens to influence health-care decisions. Following Hirschman’s notions on organizational behaviour these can be grouped into voice and exit (24). Voice is essentially a political or administrative category, whereas exit is market-based. Voice mechanisms include information; consultation and assessment of public views; advocacy groups; formal representation; and patients’ rights. Exit revolves around consumer choice which is often portrayed as a core issue that touches on fundamental rights and is instrumental in increasing responsiveness.

The instrument of choice is used for providers and/or purchasers. Consumers in most countries have the right to choose their primary care providers (see **Table 8.9**). In SHI systems, consumers can also choose ambulatory specialists and hospitals (although gate-keepers are used in some countries e.g. the Netherlands). Choices are more restricted in national health service systems although this is changing rapidly in many countries. For example, patients in Sweden and Norway are allowed to choose any hospital outside their county of residence; in Denmark this is permissible only if waiting times are not met. Patients within the English national health service have also seen their hospital choices increase. Increased consumer choice of providers clearly increases responsiveness but there is debate over its negative impact on other social objectives, notably equity, cost containment and allocative efficiency. There is evidence that choice tends to benefit the higher (and usually better-informed) social classes and thus may lead to increasing health inequalities. The policy response should not necessarily be to reduce choice in line with the equity in poverty argument, but rather to focus efforts to ensure wider access to information and support choice among the underprivileged.

Table 8.9 Choice of provider for primary and secondary care and of purchaser

Member State	Provider		Purchaser
	Primary Care	Secondary care	
Austria	Only contracted doctors	Free among public hospitals if no additional costs arise	No
Belgium	Free	Free among approved hospitals	Yes
Cyprus	Free choice of government doctors, not obliged to register with one GP	Free, on referral to hospital where doctor is employed	No
Czech Republic	Free	Free choice of contracted hospitals	Yes
Denmark	Group 1: Only GPs that joined collective agreement Group 2: Free	Free for public hospitals. If waiting time exceeds 1 month also private and abroad	No
Estonia	Free	Partly free choice with direct access (e.g. gynaecologists, psychiatrists); partly on referral with free choice	No
Finland	Determined by district of residence	Determined by district of residence	No
France	Free	Free among public and private (approved) hospitals	No
Germany	Free among contracted sickness fund doctors (97% of all)	Free choice among contracted public and private hospitals (99% of all beds)	Yes
Greece	In urban regions: insured choose doctor from a list. In rural areas: no free choice, insured goes to local insurance institute doctor	Only public hospital and registered clinic designated by the insurance institute, or in hospital of social insurance institute	No
Hungary	Free choice of contracted doctors	No free choice (only in case of emergency)	No
Ireland	Persons with full eligibility choose from list of local GPs	Limited	No, only for those insured under VHI
Italy	Free in region for approved GPs	Free for public hospitals and contracted private hospitals	No
Latvia	Free	On referral, patients can choose between contracted hospitals	No
Lithuania	Free	Free on referral	No
Luxembourg	Free	Free	No
Malta	Free	Free, however, due to size only limited number of hospitals available, e.g. only 2 general hospitals	No
Netherlands	Free	Free, but co-payment for uncontracted care may be needed in case of a benefits in kind policy	Yes
Poland	Free among contracted GPs	Free choice of contracted hospitals	No
Portugal	Free among contracted GPs	Free among public hospitals, and, if there is a waiting list, institutions approved by the Ministry of Health	No

Slovakia	Free among contracted GPs	Free, on referral	Yes
Slovenia	Free	Free choice of public hospital and contracted private hospitals	No
Spain	Free in area	No choice, according to region (except in case of emergency)	No
Sweden	Free	Free choice of regional public hospitals and approved private establishments	No
UK	Free	Patients can choose from a minimum of 4 local providers	No

Sources: Busse and van Ginneken (26); authors' own compilation

In countries where choice has been extended or there is essentially a free choice of provider there are concerns about the resulting fragmentation of care and duplication of investigations. For example, consumers may choose different primary care and ambulatory care providers for the same episode. While this responds to the expectations of users, it is clinically undesirable as it gives rise to poorer health outcomes and undermines efficiency by over-utilizing services. Also, patients value some “treatments”, therapeutic interventions and medicaments that are neither efficacious nor cost effective. These pose a direct conflict between responsiveness and efficiency. Policy makers need to manage these trade-offs, although there is growing evidence that they overestimate the importance that patients attach to unlimited choice.

Several countries have also introduced a free choice of insurer (notably – Switzerland, Germany, the Netherlands). The evidence on whether this free choice enhances consumers' capacity to choose and increases efficiency is rather disappointing. It suggests that the choice of insurer might not function well for all (particularly for bad risks) and that the information is not always adequate to support informed choices. Moreover, consumer reluctance to switch insurers has not heightened competition. There has been little increase in the quality of health services, either because the funds lack the instruments to do so, as in Germany, or because they do not use the available instruments, such as selective contracting in the Netherlands. By contrast, Busse concluded that (generally speaking) the introduction of individual free choice of insurer in Germany was successful, since it raised the funds' accountability and stimulated their development from payers to more active purchasers (25). However, there is no conclusive evidence that this has increased the responsiveness of the system.

In a review of trade-offs, equity is certainly another key consideration that has potentially very significant conflicts with responsiveness. Measures to increase responsiveness (e.g. those that focus on choice) may favour those sectors of the population that are better able to

compare and choose between options. This tendency to benefit the younger, healthier, more affluent and better educated (who can negotiate the services they want) has been termed the inverse law of participation – widening the equity gap.

Again policy-makers need to be explicit about how they balance competing issues and to be proactive in pursuing equity; widening access to information about services; and using positive discrimination strategies to increase access and choice for the socioeconomically disadvantaged. Policy-makers may also make use of other equity considerations. There is explicit evidence on disparities in responsiveness, particularly towards ethnic minority populations. One of the best documented examples is the widespread discrimination against Roma populations across Europe. Direct and indirect strategies on equity in responsiveness will tend to improve access and so reduce health inequalities. These may be exacerbated if strategies overlook the ability of different population groups to benefit from responsiveness initiatives like choice.

All trade-offs need to be considered within the wider context and the part that responsiveness can play in producing societal well-being. As always, context is hugely important. This is an area in which culture plays a very significant part in shaping perceptions, making it particularly difficult to extrapolate from one country or population group to another. Policy-makers will need to adjust the priority they attach to responsiveness and the measures they take to achieve it in order to reflect societal norms and expectations as well as the availability of resources. However, it is not inevitable that resource constraints (and a commitment to equity) lead to levelling down to the lowest common (responsiveness) denominator.

8.8 Conclusions

Eight years after the publication of the World Health Report 2000 it is undisputed that responsiveness, i.e. the reaction of the health system and health service providers to act in accordance with “the legitimate expectations of the population for their interaction with the health system” is a value in and of itself and a dimension of health systems that is genuinely valued by patients and citizens. It can involve significant extra expenditure, which begs the question, how much extra are societies prepared to pay for responsiveness, and how much will they pay for equity of responsiveness. However, many strategies that increase responsiveness are also cost effective in health gain terms. For instance responsiveness leads to better compliance with treatment which is especially significant for chronic disease treatments. The role of health system stewards, therefore, must be to promote (as always)

good governance, transparency and accountability; to refine the use of existing resources to enhance responsiveness; and to manage the trade-offs between goals when they arise.

Policy-makers need to be aware, that – while the importance of the concept “responsiveness” is more or less undisputed – considerable methodological issues remain regarding its measurement and interpretation. Policy makers thus might begin work to enhance responsiveness simply by addressing some of the concerns above and taking steps to improve the quality and comparability of assessments. Certainly, ensuring transparency in the composition of indices and the attribution of weights; flagging up underlying values; and promoting rigour in interpretation of results are all areas where health stewardship could (and should) take a lead and which will support efforts to improve the way health services treat citizens. Policy makers will need too to play their role in offering and interpreting information on responsiveness, empowering populations to contribute to decision making (including that on trade-offs); and in assessing the opportunity cost of investing in responsiveness rather than other health goals.

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