

# Chapter 9: Citizen and Patient Satisfaction, Responsiveness and Experience with the Health System – Role and Contribution to Performance Assessment<sup>1</sup>

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## 9.1 Introduction

The World Health Report 2000 (*WHR2000*) on the performance of health systems posited responsiveness to citizens' expectations as a central and particular goal. It pushed forward a debate that framed responsiveness as a valued and desired outcome of health system interventions regardless of the extent to which those interventions lead to health improvement (WHO, 2000). Health services reforms in many countries thus place ever-increasing emphasis on meeting citizens' expectations, improving responsiveness to patients, and increasing both population and patient satisfaction.

This text first explores the basic concepts behind patient and citizen experience, namely *satisfaction*, *responsiveness*, *experience* and related terms. The following sections consider the major approaches and actors to measure these, and discuss possible indicators and available data.

## 9.2 Conceptual and measurement issues

Satisfaction and responsiveness 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.

According to WHO, responsiveness is limited “to the legitimate expectations of the population for their interaction with the health system”. This has at least two major implications: (1) Unlike similar measures in the quality-of-life and satisfaction domains, responsiveness 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; (2) There can be illegitimate or unjustified expectations too, but the instrument used to measure

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<sup>1</sup> In: PAPANICOLAS I, SMITH P (eds.) (2013) Health System Performance Comparison. Maidenhead: Open University Press, p. 255-279

responsiveness should only capture those that are regarded as legitimate. The “satisfaction of the overall population with the health system”, as well as the satisfaction of patients with particular providers, 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). 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. As a response, questions in such surveys aim to capture the actual patient experience (e.g. waiting time) rather than a judgement on its appropriateness.

Related – but not identical – to the differences in terminology and concepts is the issue of the persons surveyed. In brief, three approaches can be differentiated: (1) the whole population; (2) persons with any health care encounter and thus experience; and (3) a subgroup of these, e.g. defined by a certain degree of illness or particular diagnosis. Thus, the last group encompasses regular users of the health care system (e.g. those with chronic illness, termed ‘sicker adults’ in the Commonwealth Fund surveys); the second includes regular as well as irregular users of the health care system; while the first group includes, in addition to these two groups, those persons who do not utilize the system (but still pay for it).

A wide range of methods has been used to attempt to measure responsiveness and/or satisfaction over the last decades, most visibly work by population satisfaction questions in *Eurobarometer* surveys since 1996 (European Commission, 1996, 1998, 1999, 2000, 2002); the Picker Institute’s development of patient experience surveys (Coulter & Cleary, 2001; Jenkinson, Coulter & Bruster, 2002); the EUROPEP instrument to assess general practice (Grol et al., 2000; Wensing et al., 2004; Petek et al., 2011); *WHR2000* (WHO, 2000); and work by the Commonwealth Fund (Schoen et al., 2007, 2009, 2010, 2011).

Measurement instruments, available data sources, the selection of indicators and the dimensions they cover are discussed in turn in the following section (including some results to highlight certain issues). More information about the international patient experience surveys, as well as national patient survey programmes, can be found in Garratt et al. (2008).

### *9.3 Measurement approaches, actors, indicators and data*

#### *9.3.1 Population satisfaction in Eurobarometer and other surveys*

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. The answers depend particularly on factors not yet well understood, i.e. (1) the context in which a survey takes place, e.g. coloured by recent media coverage of scandals, fraud or underprovision of services; (2) no differentiation between the system as a whole and certain subsectors about which the respondent may be more knowledgeable; or (3) 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. Busse et al. (2012) provide a complete overview of different population surveys over the last decades (updated results for the period since 1996 in Table 9.1).

All but one of these surveys share a common focus on the broader health system, but the actual questions – and therefore the range of answers that can be considered positive or negative – differ between surveys. One survey focuses on the local area of the respondents. In the International Health Policy surveys of the Commonwealth Fund, satisfaction with the health care system is only one item, while the others focus on domains of responsiveness and an assessment of actual care in terms of care coordination, quality, medical errors, and so on (see below).

The actual percentages of those answering that they are satisfied are – besides expectations and the assessment of the situation at any given point in time – dependent on: (a) the exact phrasing of the question; and (b) the number of answer categories. Regarding the former, Denmark provides a good example. In 1998, 91% were satisfied “with the way health care runs” (European Commission, 1998), while only 48% were satisfied “with health services” (European Commission, 1999); apparently Danes make a distinct difference between these terms. Regarding the latter, the relatively high 2008 Gallup results (Brown & Khoury, 2009) should be treated with caution, as only two answer categories were possible (positive and negative), while all other surveys presented at least three possibilities. Given such semantic and methodological complexities, the main attention should be devoted to the relative position of countries within the particular surveys.

**Table 9.1: Satisfaction with country's health care system or availability of quality health care in city/area in EU15 countries plus Switzerland and Norway (in %), various surveys 1996–2011; countries sorted according to results of 2008 survey**

	Country's health care system												Health care in city or area
	1996 (A)	1998 (B)	1998 (C)	1999 (D)	2002 (E)	2004 (F)	2007 (G)	2008 (H)	2008 (I)	2008 (J)	2010 (K)	2011 (L)	2008 (M)
Luxembourg	71	67	50	72	58					90			90
Belgium	70	63	57	77	65					88			91
Finland	86	81	78	74	73					85			66
Austria	63	73	71	83	67					84			93
France	65	65	59	78	64	65		23	41	83	42	40	83
Sweden	67	58	46	59	48					79	44	40	77
Netherlands	73	70	70	73	46		42		42	77	51	46	89
Denmark	90	91	48	76	52					77			86
Spain	36	43	31	38	46	42		37		77			74
UK	48	57	49	56	31	32	26	17	38	73	62	51	85
Portugal	20	16	6	24	14					58			64
Germany	66	58	43	50	47	28	20	20	21	54	38	32	87
Italy	16	20	15	26	31	21		13		53			57
Greece	18	16	11	19	19					45			52
Ireland	50	58	23	48	20					40			64
Switzerland											46	69	
Norway											40	32	

Note: (A) & (B) "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*; (C) "And, on a scale from 1 to 10, how satisfied are you with health services in (our country)?: *answers 7, 8, 9 or 10*; (D) "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*; (E), (G), (I), (K) & (L) "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."); (F) "feel positively about health care system (in my country)"; (H) "How do you think (country) is doing in regard to health care?": *very well, well or neither well nor badly* (as opposed to "badly" and "very badly"); (J) "have confidence in (own) national health care or medical system" (as opposed to "no confidence"); (M) "satisfied with the availability of quality health care in (own) city or area" (as opposed to "dissatisfied").

Sources: (A) Eurobarometer 44.3 (conducted February–April 1996): European Commission, 1996; (B) Eurobarometer 49 (conducted April–May 1998): European Commission, 1998; (C) Eurobarometer 50.1 (conducted November–December 1998): European Commission, 1999; (D) Eurobarometer 52.1 (conducted November–December 1999): European Commission, 2000; (E) Eurobarometer 57.2 (conducted April–June 2002): European Commission, 2002; (F) The Harris Poll (conducted in June 2004): Taylor, 2004; (G) Commonwealth Fund International Health Policy Survey 2007 (conducted March–May): Schoen et al., 2007; (H) The Harris Poll (conducted in January 2008): Taylor, 2008; (I) Commonwealth Fund International Health Policy Survey 2008 (conducted March–May): Schoen et al., 2009; (J) & (M) Gallup World Poll 2008: Brown & Khoury, 2009; (K) Commonwealth Fund International Health Policy Survey 2010 (conducted March–June): unpublished data; (L) Commonwealth Fund International Health Policy Survey, 2011 (conducted March–June): unpublished data.

### 9.3.2 Responsiveness to legitimate expectations

In preparation for *WHR2000*, 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 (De Silva, 2000). This was used to select a common set of seven dimensions (or domains) that characterize the concept

of responsiveness. Four were grouped under 'client orientation' and three under 'respect for persons' (dignity, confidentiality and autonomy).

The data presented in *WHR2000* 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) (Üstün et al., 2001) and the *World Health Survey* (WHS) in 2002 (Üstün et al., 2003) both worked mainly via interviews and partly by postal surveys (in the MCS study). Both WHO surveys include two major categories (inpatient and ambulatory care) for responsiveness, each including a total of eight domains, as 'communication' was added as an eighth dimension (most closely related to the 'respect for persons' group).

The detailed labels of the dimensions, the weighing of each dimension in the *WHR2000*, and the number of questions used in the two surveys are given in Table 9.2, while the exact wording of the questions is presented in Table 9.3. Both WHO instruments focus on what happened during actual contacts rather than eliciting respondents' satisfaction with, or expectations of, the health system in general. Thus, they have much in common with patient experience surveys, such as those developed earlier by the Picker Institute (see below).

**Table 9.2: Definition, grouping and weights of responsiveness dimensions in *WHR2000* and number of questions used to measure it in two subsequent population surveys**

<i>Dimension</i>	<i>WHR 2000: grouping and weighing</i>	<i>Multi-Country Survey study 2000–01</i>	<i>World Health Survey 2002</i>
<b><i>Client-orientation</i></b>			
<b>Choice</b> of health care provider	5%	3 questions	1 question
<b>Prompt attention:</b> Convenient travel and short waiting times	20%	2 questions	2 questions
<b>Quality of basic amenities:</b> Surroundings	15%	3 questions	2 questions
<b>Access to family and community support:</b> Contact with outside world and maintenance of regular activities	10%	3 questions	2 questions
<b><i>Respect for persons</i></b>			
<b>Dignity:</b> Respectful treatment and communication	16.7%	4 questions	2 questions
<b>Confidentiality</b> of personal information	16.7%	2 questions	2 questions
<b>Autonomy:</b> Involvement in decisions	16.7%	3 questions	2 questions
Clarity of <b>communication</b>	Not included	4 questions	2 questions

Source: Author's own compilation based on: WHO, 2000; Valentine et al., 2003.

**Table 9.3: WHO dimensions of responsiveness and questions used to measure it in two population surveys**

<i>Dimension</i>	<i>MCS study 2000/2001: questions used</i>	<i>WHS 2002: questions used</i>
<i>Choice</i>	<p>How big a problem, if any, was it to get a health care provider you were happy with?</p> <p>How big a problem, if any, was it to get to use other health services other than the one you usually went to?</p> <p>How would you rate your experience of being able to use a health care provider or service of your choice?</p>	<p>How would you rate the freedom you had to choose the health care providers that attended to you?</p>
<i>Prompt attention</i>	<p>How often did you get care as soon as you wanted?</p> <p>How would you rate your experience of getting prompt attention at the health services?</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– the travelling time?</li> <li>– the amount of time you waited before being attended to?</li> </ul>
<i>Quality of basic amenities</i>	<p>How would you rate the basic quality of the waiting room, for example, space, seating and fresh air?</p> <p>How would you rate the cleanliness of the place?</p> <p>How would you rate the quality of the surroundings, for example, space, seating, fresh air and cleanliness of the health services?</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– the cleanliness of the rooms inside the facility, including toilets?</li> <li>– the amount of space you had?</li> </ul>
<i>Access to family and community support</i>	<p>How big a problem, if any, was it to get the hospital to allow your family and friends to take care of your personal needs, such as bringing in your favourite food, soap etc.?</p> <p>How big a problem, if any, was it to have the hospital allow you to practise religious or traditional observances if you wanted to?</p> <p>How would you rate your experience of how the hospital allowed you to interact with family, friends and to continue your social and/or religious customs?</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– the ease of having family and friends visit you?</li> <li>– your [child's] experience of staying in contact with the outside world when you [your child] were in hospital?</li> </ul>
<i>Dignity</i>	<p>How often did doctors, nurses or other health care providers treat you with respect?</p> <p>How often did the office staff, such as receptionists or clerks there, treat you with respect?</p> <p>How often were your physical examinations and treatments done in such a way that your privacy was respected?</p> <p>How would you rate your experience of being treated with dignity?</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– your experience of being greeted and talked to respectfully?</li> <li>– the way your privacy was respected during physical examinations and treatments?</li> </ul>
<i>Confidentiality</i>	<p>How often were talks with your doctor, nurse or other health care provider done privately so other people, who you did not want to hear, could not overhear what was said?</p> <p>How often did your doctor, nurse or other health care provider keep your personal information confidential? This means that anyone whom you did not want to be informed could not find out about your medical conditions.</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– the way the health services ensured you could talk privately to health care providers?</li> <li>– the way your personal information was kept confidential?</li> </ul>
<i>Autonomy</i>	<p>How often did doctors, nurses or other health care providers involve you in deciding about the care, treatment or tests?</p> <p>How often did doctors, nurses or other health care providers ask your permission before starting the treatment or tests?</p> <p>Rate your experience of getting involved in making decisions about your care or treatment.</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– your experience of being involved in making decisions about your health care or treatment?</li> <li>– your experience of getting information about other types of treatments or tests?</li> </ul>
<i>Communication</i>	<p>How often did doctors, nurses or other health care providers listen carefully to you?</p> <p>How often did doctors, nurses or other health care providers explain things in a way you could understand?</p> <p>How often did doctors, nurses or other health care providers give you time to ask questions about your health problem or treatment?</p> <p>Rate your experience of how well health care providers communicated with you in the last 12 months.</p>	<p>How would you rate:</p> <ul style="list-style-type: none"> <li>– the experience of how clearly health care providers explained things to you?</li> <li>– your experience of getting enough time to ask questions about your health problem or treatment?</li> </ul>

Source: Author's own compilation based on: WHO, 2000; Valentine et al., 2003.

Interviewees in the MCS study were asked to rate their experiences over the past 12 months. While Interviewees in the MCS study were asked to rate their experiences over the past 12 months. While the questions regarding six of the eight domains were relevant for both inpatient and ambulatory care, only inpatients were asked about social support and only outpatients about the quality of basic amenities. 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).

The WHS 2002 collected data on responsiveness, among other aspects related to health systems performance. Data were collected from 69 countries globally, including 29 in the WHO European Region. 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. These have recently been analysed to examine how they can be used to adjust for threshold effects across countries and enhance comparability in this area (Rice, Robone & Smith, 2012). Available data on both responsiveness and expectations are given in Busse et al. (2012).

### *Expectations and responsiveness*

Austria showed both the lowest (overall) 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. As shown in Busse et al. (2012), the responsiveness score (not adjusted for expectations) decreases as the population expectations increase for both ambulatory and inpatient care. 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. Some intercountry variations in responsiveness may thus be explained by differences in population expectations. This indicates that expectations-based adjustment to the scores may be necessary before meaningful intercountry comparisons can be made. This was especially the case for 'choice', 'prompt attention' and 'communication'.

Especially for ‘choice’, this was further underscored in a survey conducted by the Picker Institute around the same time (Coulter & Jenkinson, 2005). Respondents in eight countries – drawn from the general population, with patient experience-related questions limited to those with health care encounters – were interviewed about the choice of provider, their involvement in treatment decisions (autonomy), and communication with their physician (Table 9.4).

**Table 9.4: Questions used in Picker responsiveness survey, sorted according to WHO responsiveness domains and whether they address expectations or patient experience**

	<i>Expectations and values (whole population)</i>	<i>Patient experience</i>
<i>Choice</i>	In general, if you need to [consult a primary care doctor/consult a specialist doctor/go to hospital] do you think that you should have a free choice? Do you feel you have sufficient information about [primary care doctors/specialist doctors/hospitals] to choose the best one? Overall, how would you rate the opportunities for patients in this country to make choices about their health care?	
<i>Autonomy</i>	In general, when you need medical treatment and more than one treatment is available, who do you think should make the decision about which treatment is best for you?	How often did the doctor involve you as much as you wanted to be in deciding about your care, treatment or tests?
<i>Communication</i>		How often did the doctor: – listen to you carefully? – give you time to ask questions? – explain things in a way you could understand? Overall how would you rate how well health care providers communicated with you?

Source: Author’s own compilation based on: Coulter & Jenkinson, 2005.

Table 9.5 shows that Swedes expected very little choice of specialist (only 31%), while almost all Germans expected such a choice (97%). Spaniards ranged in between but were the most satisfied regarding their actual opportunities to make choices (even though they were not satisfied that they were provided with sufficient information to enable them to do so); both Swedes and Germans were only moderately satisfied in this regard. Polish respondents’ expectations were as high as those of the Germans, but were met to a much smaller extent. Expectations regarding autonomy also differed considerably, e.g. Spaniards expected significantly less patient autonomy than Germans.



**Table 9.5: Expectations for and rating of choice of different types of providers in eight European countries, 2002; countries sorted from left to right by responsiveness rating**

	<i>Spain</i>	<i>Switzerland</i>	<i>Germany</i>	<i>Italy</i>	<i>Sweden</i>	<i>Slovenia</i>	<i>UK</i>	<i>Poland</i>
<i>Expectation:</i> In general, if you need to [consult a primary care doctor/consult a specialist doctor/go to hospital] do you think you should have a free choice? (answering yes)								
Primary care doctor	89%	93%	98%	86%	86%	98%	87%	98%
Specialist	86%	84%	97%	83%	31%	87%	79%	95%
Hospital	78%	85%	94%	85%	54%	86%	80%	94%
<i>Information to support choice of provider:</i> Do you feel you have sufficient information about [primary care doctors/specialist doctors/hospitals] to choose the best one for you? (answering yes)								
Primary care doctor	30%	52%	52%	53%	31%	45%	40%	43%
Specialist	23%	41%	42%	53%	23%	25%	28%	32%
Hospital	32%	52%	42%	54%	36%	30%	35%	35%
<i>Rating:</i> Overall, how would you rate the opportunities for patients in this country to make choices about their health care? Average of answer categories 1–5 (very bad, bad, moderate, good, very good)								
	3.93	3.86	3.35	3.28	3.19	3.05	3.05	2.67

Source: Busse et al., 2012, based on: Coulter & Jenkinson, 2005.

### *Health care expenditure and 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 (Valentine et al., 2009). 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.

### *9.3.3 Patient experience surveys*

As mentioned previously, patient surveys of their experience of treatment by particular providers constitute a third pillar of data. Usually, these relate more to responsiveness than to satisfaction as they are based on: (1) predetermined domains; and (2) patients' actual

health service encounters. Surveys are mainly available within countries but also sometimes across countries, especially for inpatient care (see below), general practitioners (see below), and mental health care (comparative study across five countries with a total of 404 patients: Becker et al., 2000); as well as for specific groups of patients, for example, those with diabetes (comparative survey across 13 countries with a total of 5104 patients: Peyrot et al., 2006) or cancer (comparative survey across six countries with a total of 762 patients: Brédart et al., 2007).

### *Inpatient care*

While patient experience surveys among inpatients have become regular features in many countries of the European Region (e.g. in Denmark, Ireland, the Netherlands, Norway and the United Kingdom), they are seldom comparable across countries. The Picker Institute questionnaire is an exception (Coulter & Cleary, 2001; Jenkinson, Coulter & Bruster, 2002), but unfortunately this was only published once and was limited to a small number of countries. The survey asks inpatients to describe a range of aspects of their care upon discharge. It distinguished seven dimensions of patient-centred care, which largely overlap with the areas of responsiveness, but drawing different boundaries between them:

1. Physical comfort – including pain management; help with activities of daily living; surroundings and hospital environment.
2. Coordination and integration of care – including clinical care; ancillary and support services; front-line care.
3. Involvement of family and friends – including social and emotional support; involvement in decision-making; support for caregiving; impact on family dynamics and functioning.
4. 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.
5. Information, communication and education – including clinical status; progress and prognosis; processes of care; facilitation of autonomy; self-care; and health promotion.
6. 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.
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.

Available results across four European countries are summarized in Table 9.6.

**Table 9.6: Patients reporting problems with hospital, 1998–2000 (%); available countries sorted by overall evaluation from left to right, dimension sorted by average percentage from low to high**

	<i>Switzerland</i>	<i>Germany</i>	<i>Sweden</i>	<i>UK</i>
Overall level of care NOT GOOD	4	7	7	9
Problems with:				
– physical comfort	3	7	4	8
– coordination of care	13	17	NA	22
– involvement of family and friends	12	17	15	28
– respect for patients' preferences	16	18	21	31
– information and education	17	20	23	29
– emotional support	15	22	26	27
– continuity and transition	30	41	40	45
Would not recommend this hospital to friends/family	4	5	3	8

*Source:* Figueras et al., 2004, based on data from: Coulter & Cleary, 2001.

### *Care by general practitioners*

The measurement of patient experience with general practitioners has developed separately from other areas. The most developed instrument in this area is the EUROPEP one, produced by the European Task Force on Patient Evaluations of General Practice Care (Grol et al., 2000). This contains 23 questions, which cover issues relating to five of the eight responsiveness domains (prompt attention, dignity, confidentiality, autonomy and communication), as well as certain issues regarding processes during the physician–patient encounter, e.g. thoroughness, and patient-reported outcomes (“helping you to feel well so that you can perform your normal daily activities”). For a full list of the items see Table 9.8.

This survey was first applied in 17 countries in 1998 (Wensing et al., 2004; Table 9.7); detailed data on the 23 items were published for 10 countries only, involving more than 17 000 patients (Grol et al., 2000). The data on outpatient care responsiveness from the WHS in 2002 (Üstün et al., 2003; Busse et al. 2012; Table 9.7) are partly contradictory however; for example, Slovenia rated comparatively high in EUROPEP, but low in the WHS, while the opposite can be observed for Denmark. This may be due to the sampling strategy, i.e. the EUROPEP was only used by patients in a limited number of practices (around 36 per country), or due to the more specific questions asked. Kerssens et al. (2004) used yet another instrument to measure responsiveness in ambulatory care in 12 countries (Table 9.7; average results per country are not available).

**Table 9.7: Evaluations of general practice care in four different surveys; countries sorted from top to bottom by rating in 2009**

	1998	2002	Not reported (early 2000s)	2009
<i>Instrument</i>	<i>EUROPEP (% positive answers across 23 items)</i>	<i>World Health Survey (score)</i>	<i>Quote (quality of care through patients' eyes)</i>	<i>EUROPEP (% positive answers across 23 items)</i>
Surveyed population	25 052 patients in 17 countries; selected in GP practices irrespective of health status; avg. age ca. 50, 2/3 women	General population with GP encounter	5133 patients in 12 countries; different selection in each country*; age and sex not reported	7472 patients in 8 countries; selected in GP practices either due to high risk for cardiovascular disease or established coronary disease; avg. age ca. 67, 1/3 women
Switzerland	91.4#	–	–	93.0#
Belgium	87.2#	90.2	–	92.0#
France	63.9	85.6	–	88.4
Slovenia	88.4#	77.8	–	87.9#
Austria	89.7	90.6	–	87.5
Germany	88.2#	83.9	–	84.7#
Spain	84.6	79.2	–	–
Netherlands	79.9#	84.3	X	83.5#
Israel	79.4	81.8	X	–
Sweden	78.5	77.6	–	–
Portugal	78.3	73.2	X	–
Norway	76.5	76.9	X	–
Denmark	73.3	85.9	X	–
UK	72.8#	82.5	–	82.1#
Finland	70.1	81.7	X	–
Other European countries	Iceland, Turkey	Luxembourg, Greece, Ireland, Czech Rep., Georgia, Bosnia and Herzegovina, Hungary, Slovakia, Estonia, Italy, Latvia, Kazakhstan, Croatia, Russian Federation, Ukraine	Belarus, Greece, Ireland, Italy, Ukraine	–

Notes: \* X = included, – = not included; # detailed breakdown of results by question (see Table 9.8).

Source: Author's own compilation based on: Üstün et al., 2003; Wensing et al., 2004; Kerssens et al., 2004; Petek et al., 2011.

The EUROPEP survey was repeated in 2009, this time in eight countries. In contrast to 1998, the surveyed patients either had a high risk for cardiovascular disease or established coronary disease, i.e. were not selected irrespective of health status as in 1998. Table 9.8 presents the data for all 23 items for those six countries for which results were reported for both 1998 and 2009. As can be seen from the table, the average rating improved in four of the six countries over that period, especially the United Kingdom and, in general, differences across countries decreased.

**Table 9.8: Evaluation of general practice care in six European countries with data for 1998 and 2009 (% with positive rating); countries sorted from left to right by overall evaluation in 2009, items from top to bottom by average across countries in 2009**

	Switzerland		Belgium		Slovenia		Germany		Netherlands		UK		<i>Max difference</i>	
	1998	2009	1998	2009	1998	2009	1998	2009	1998	2009	1998	2009	1998	2009
Overall evaluation	91	93	87	92	89	88	88	85	80	84	72	82	19	11
1. Keeping records and data confidential	96	97	97	95	97	97	94	91	95	92	91	95	6	6
2. Providing quick services for urgent health problems	96	98	93	96	89	90	95	93	85	88	71	84	25	14
3. Listening to you	96	95	93	95	95	94	92	88	89	89	83	90	13	7
4. Helpfulness of the staff (other than the doctor)	93	95	83	90	89	92	92	93	84	86	70	84	23	11
5. Thoroughness	90	94	89	95	92	92	91	85	81	87	78	88	14	10
6. Explaining the purpose of tests and treatments	92	94	89	94	89	90	89	86	83	87	79	86	13	8
7. Making you feel you had time during consultations	96	95	92	95	92	88	90	86	88	88	80	89	16	9
8. Making it easy for you to tell him/her about your problems	94	94	88	93	87	85	89	87	83	85	81	89	13	9
9. Telling you what you wanted to know about symptoms/ illness	93	96	90	93	92	89	90	85	83	88	79	83	14	13
10. Physical examination	93	94	88	94	90	91	91	82	82	87	76	85	17	12
11. Getting an appointment to suit you	97	97	88	91	85	90	93	90	78	84	62	76	35	21
12. Helping you to feel well so that you can perform your normal daily activities	91	94	89	94	93	90	88	83	79	85	69	85	24	11
13. Interest in your personal situation	95	95	90	94	79	77	90	88	82	83	78	86	17	18
14. Helping you to understand the importance of his/her advice	89	92	86	93	91	90	86	84	80	83	76	82	15	10
15. Involving you in decisions about medical care	91	93	87	94	89	84	87	83	81	85	76	83	15	11
16. Offering you services for preventing disease	84	90	77	87	85	87	85	83	76	88	74	87	11	7
17. Quick relief of your symptoms	85	89	84	92	94	93	83	75	75	84	67	87	27	18
18. Getting through to the practice on the telephone	96	95	93	96	92	83	95	95	71	73	62	86	34	23
19. Knowing what he/she has done or told you during previous contacts	89	91	84	91	90	89	85	78	76	82	72	86	18	13
20. Preparing you for what to expect from specialists or hospital care	89	90	85	88	88	86	85	80	75	79	72	83	17	11
21. Help in dealing with emotional problems related to health status	90	91	85	90	87	83	85	80	76	78	71	83	19	13
22. Being able to speak to the GP on the telephone	91	88	90	94	93	88	87	84	72	71	51	83	40	23
23. Waiting time in the waiting room	79	83	66	73	60	75	70	67	61	72	50	72	29	16

*Source:* Author's own compilation based on data from: Groi et al., 2000 and Petek et al., 2011.

Regarding individual items, 'providing quick services for urgent health problems', 'offering you services for preventing disease', 'getting through to the practice on the phone', 'waiting time in the waiting room' and 'getting an appointment to suit you' improved most across countries. Whether this is an effect of improved responsiveness over time or whether it is largely due to the different patient populations is unclear.

#### *9.3.4 International Health Policy Survey*

The Commonwealth Fund, a New York-based foundation has been conducting international surveys for a number of years, originally limited to five English-speaking countries (among them only one European country, namely the United Kingdom). Since the inclusion of six more European countries over the years (France, Germany, the Netherlands, Norway, Sweden and Switzerland), it has included eleven countries since 2010, among them seven from Europe. There are three distinct surveys, two of them population surveys (and the other focused on physicians), which are used in turn every three years. The general adult population was last surveyed in 2007 and 2010 (next survey planned for 2013), while 'sicker adults' were surveyed in 2008 and 2011, with 'sicker' operationalized as follows: 'fair or poor health'; 'had surgery or been hospitalized in past two years'; or 'received care for serious or chronic illness, injury, or disability in past year'.

Both types of population surveys by the Commonwealth Fund contain a question on satisfaction with the health care system (see above). The others focus on domains of responsiveness (especially access and communication) and an assessment of actual care in terms of care coordination, quality, medical errors and so on. Table 9.9 presents a selection of questions and results from the 2010 and 2011 surveys.

**Table 9.9: Example questions and results from the Commonwealth Fund’s International Health Policy Surveys, 2010 (adults with health care encounter) and 2011 (‘sicker adults’)**

	France	Germany	Netherlands	Norway	Sweden	Switzerland	UK
<i>Did not fill a prescription for medicine or skipped doses – Answer ‘no’</i>							
<b>2010</b>	88	93	90	93	88	90	95
<b>2011</b>	89	86	92	92	93	91	95
<i>Had a specific medical problem but did not visit a doctor – Answer ‘no’</i>							
<b>2010</b>	90	82	91	94	91	89	95
<b>2011</b>	90	88	93	92	94	88	93
<i>Skipped or did not get a medical test, treatment, or follow-up that was recommended by a doctor – Answer ‘no’</i>							
<b>2010</b>	90	89	89	93	92	89	94
<b>2011</b>	91	86	92	92	96	89	96
<i>If seriously ill, confident to receive the most effective treatment, including drugs and diagnostic tests – Answers ‘very confident’ or ‘confident’</i>							
<b>2010</b>	85	82	88	81	67	89	92
<i>If seriously ill, confident to be able to afford needed care – Answers ‘very confident’ or ‘confident’</i>							
<b>2010</b>	73	70	81	69	70	78	90
<i>Overall, how do you rate the quality of medical care that you have received in the past 12 months? – Answers ‘excellent’ or ‘very good’</i>							
<b>2011</b>	43	31	34	50	50	68	81

Source: Author’s own compilation, based on: Schoen et al., 2010 and 2011.

#### 9.4 Comparative methodology

All the satisfaction, responsiveness and experience surveys mentioned so far are based on surveys among health system users and/or 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.

Table 9.10 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*, Commonwealth Fund and Gallup surveys and do not overlap directly with any of the WHO responsiveness domains. The more recent *Euro Health Consumer Index* (which was published annually between 2006 and 2009) only partially overlaps with the WHO responsiveness domains; its overlap with the ‘respect for persons’ domains is especially weak as only aspects of autonomy are covered (for details of its subcategories, weighing and data sources, see Busse et al. 2012). The table also demonstrates that the EUROPEP instrument on patient experience in general practice, as well as the Commonwealth Fund’s survey, expand beyond responsiveness into asking patients about: medical processes during

the physician–patient encounter; quality and medical errors; and patient-reported outcomes – i.e. a patient questionnaire can be used for different dimensions of performance assessment.

**Table 9.10: Important questionnaires/studies/surveys/rankings with questions on patients’ and citizens’ experience; sorted by date first used**

	Euro-barometer <sup>a</sup>	Picker inpatient survey <sup>b</sup>	EUROPEP GP practice evaluation <sup>c</sup>	WHR 2000 <sup>d</sup>	MCS study, WHS <sup>e</sup>	Euro Health Consumer Index <sup>f</sup>	Commonwealth Fund <sup>g</sup>	Gallup Poll <sup>h</sup>
Data sources used*	A	B	B	C, D	E	C, D	E, F	A
<b>Satisfaction</b>								
– with country’s health system	X						X	X
– with local availability of health care								X
<b>Client orientation</b>								
Choice of care provider				X	X	X	X	
Access/travel/waiting			X	X	X	X	X	
Basic amenities				X	X			
Access to social support networks		X		X	X			
<b>Respect for persons</b>								
Respect for dignity		X	X	X	X			
Respect for confidentiality		X	X	X	X			
Respect for autonomy		X	X	X	X	X	X	
Communication		X	X		X		X	
<b>Other issues related to responsiveness</b>								
Patients’ rights and information						X	X	
Range of benefit basket						X	X	
Access to pharmaceuticals						X (system level)	X (patient level)	
Care coordination							X	
<b>Processes and patient-reported outcomes</b>								
Processes			X					
Errors and quality							X	
Patient-reported outcomes			X					

Notes: \*A: randomly selected population; B: patients recruited within specific providers; C: routine data; D: experts; E: randomly selected adult population with health care encounter; F: randomly selected ‘sicker’ adults with health care encounter.

Source: Modified and expanded from Busse et al., 2012, based on: <sup>a</sup>European Commission, 1996, 1998, 1999, 2000, 2002; <sup>b</sup>Jenkinson, Coulter & Bruster, 2002; <sup>c</sup>Grol et al., 2000; <sup>d</sup>WHO, 2000; <sup>e</sup>Üstün et al., 2001, 2003; <sup>f</sup>Health Consumer Powerhouse, 2006, 2007, 2008, 2009; <sup>g</sup>Schoen et al., 2007, 2009, 2010, 2011; <sup>h</sup>Brown & Khoury, 2009.

Table 9.10 also includes information on the data sources, i.e. whether the results are based on a survey (general population; patients (recruited at random or within specific providers); or ‘sicker’ patients), routine data or expert judgement.

### 9.5 Methodological considerations

The questions of how satisfied patients are with their health care system; whether they have choice and access to providers; and whether they had a good (or bad) experience with the care from the provider, are important dimensions when assessing a health system’s performance. However, the terminology in this area is not yet consistent, and different terms



for similar concepts have contributed to confusion and hindering to establish the area as a firm indicator of health systems' performance.

Often, the interpretation of differences in data is complicated by: different definitions of domains and indicators; differences in the methodology of surveyed populations (general population, patients with any health care encounter, or sicker patients) and data collection (e.g. sampling); and the calculation of average scores. In addition, sample sizes are often too small to produce any valid values for the population in question. Only careful consideration of both the dimensions included and the population surveyed will enable potential gaps to be identified, for example, while it is necessary to base a rating of most dimensions of responsiveness on actual patient encounters, such a methodology will not identify those persons who could not access the system due to its poor responsiveness.

The results of these assessments are therefore often inconsistent or contradictory and difficult to interpret. As Garratt et al. (2008) note, "the difficulties in making such international comparisons are well documented and consideration must be given to methods of questionnaire translation, consistency in survey design and sampling processes, and differences in patient characteristics (Coulter & Cleary, 2001). For valid comparisons to be made across countries, questionnaires must demonstrate cross-cultural equivalence, that is similar levels of data quality, reliability and validity. In the absence of such equivalence, it is difficult to ascertain whether any differences found between countries is related to real differences in health care quality or differences in questionnaire performance.

The forward-backwards translation methodology is designed to promote cross-cultural equivalence (Leplege & Verdier, 1995). However, there is variation in the reporting of the results of such translation procedures, the focus often being on the results of cross-national comparisons rather than underpinning methodology. The sampling and recruitment of patients and survey administration including use of reminders and incentives, must also be consistent across countries so as to ensure representative samples. Comparisons must also control for potential confounders (Coulter & Cleary, 2001). The results of a systematic review found that a number of patient characteristics were consistently associated with patient satisfaction, including age, education and health status (Crow et al., 2002). Hence it is important that these variables are controlled for when reporting the results of cross-national comparisons."

As a result, it is often possible to "demonstrate" that a particular health system is "better" or "worse" than another one. If confronted with data of international comparative surveys, the

recipient is well advised to carefully check the basic underlying definitions, assumptions, database and results, before accepting any conclusions based on the latter.

#### *9.6 Conclusions and priorities for development*

Overall, no individual survey currently enables any clear conclusions to be drawn about the differences in the degree of satisfaction, responsiveness and patient experience across health systems and even less about the health system strategies that may explain them. All currently existing surveys contain different items, leading to different results. In some instances, such differences have large impacts on potential rankings. All methodologies are therefore rightly subject to further extensive critical debate. As there is currently no consistent source providing population and/or patient-derived measures of responsiveness and/or satisfaction, it will be necessary to establish such a source. Considering experience and regularity of surveys, the Commonwealth Fund's surveys are best suited to form the basis for such a development.

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