

# Evolution of Responsiveness of Health System

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**Abstract** Responsiveness is concerned with meeting the legitimate non health expectations of patients. The paper tries to explain the concept, domains and evolution of responsiveness. WHO concept of responsiveness has been criticized for using a single composite score for comparing responsiveness between countries. In spite of recognizing these issues and after much debate, no empirical research has been undertaken. Hence there is a need to recognize what constituents of responsiveness need to be reorganized, which other elements need to be added to existing WHO proposed elements of responsiveness in culturally, socially, politically different society. The paper through extensive study on responsiveness concludes the need to tailor responsiveness domains according to citizen's priority in a particular background.

**Keywords:** Responsiveness, Health Systems, Elements of Responsiveness,

## 1. INTRODUCTION

There are three goals of health system given by World Health Organisation health, responsiveness and fairness of financing. The performance of a health system is measured on these parameters [29]. Responsiveness for any system is defined as 'The outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognizant and respond appropriately to the universally legitimate expectations' [34]. Here universally legitimate term is very important as some individuals may have unrealistic expectations which should not be considered when measuring responsiveness. Responsiveness is concerned only with a person's legitimate expectations regarding the non-health

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enhancing aspects of the health system as health related expectations are being taken care of in first goal of health system. For responsiveness both the distribution as well as average level of responsiveness in a country is considered important [34].

Various researchers in the past, suggested that the term ‘consumer’ should be used for patients as the user is not passive and dependent [32]. Some were in favour of use of term consumer over customer as consumers’ is used for a group of individuals who can protect their rights. According to them term patient denotes powerlessness and hence does not truly depicts the relationship with professional [13]. Terms which are often used along with responsiveness are quality of care and expectations [33]. Expectations are important as meeting expectations is what responsiveness is about. Also patient satisfaction which is often used to measure the quality of healthcare services is a complex mix of perceived need, expectations and experience. Quality of care is even wider. Unlike responsiveness it includes technical aspects of healthcare aspects of healthcare.

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## **2. EVOLUTION OF THE TERM RESPONSIVENESS AND QUALITY OF CARE**

In 1948 Health was defined by WHO as “A state of physical, mental and social well being and not merely the absence of disease”. Since then it has been emphasized that health system should meet factors related to patient well being besides meeting the medical needs of patients. Donafedian suggested three components of quality for health care: [15]

- a) Technical Quality related to appropriateness, effectiveness and technical competency and hence leads to an improvement in health outcomes.
- b) Process quality considers courtesy, respect, choice, communication, and autonomy. It is also named service quality and is concerned with management of interpersonal processes [35, 24, 20].
- c) Structural Quality whose dimensions are accommodation, affordability, accessibility. It is related to the quality of amenities

Responsiveness is related to interpersonal dimensions of quality of care (process quality) rather than to technical quality. Technical quality improves health, and is covered in health goal of WHO. Financial affordability is included partly in the fairness in financial contribution goal and partly through its impact on health outcomes in the WHO framework [16]. It does not form part of responsiveness. There does not exist a single quality of care framework having all the important domains of responsiveness [11].

### 3. RESPONSIVENESS AND PATIENT SATISFACTION

Patient satisfaction has been of interest to all ever since 1980s and different questionnaires have been used to measure it. It was concluded by various studies that patient satisfaction depends not only on health outcomes but also on other non health factors like respect for persons. Agency for Health Research & Quality (AHRQ) developed and funded Consumer assessment of Health Plans Survey and reporting kit (CAHPS). This captured the patient experiences [1]. In 2000, WHO broadened this concept to include health system and population interaction and not just patient and practitioner interactions. This concept was given the name –RESPONSIVENESS [28, 37].

Amala de Silva in discussion paper series in 1999 have explained main differences between responsiveness and patient satisfaction as: [14]

Name of the domain	Patient Satisfaction	Responsiveness
Scope	Clinical interactions in specific health care settings only	All interactions between population and health system
Range	Covers both medical and Non medical aspects of healthcare	Focuses on non medical aspects only
Rationale	Is a complex mix of perceived need, expectations and experiences	Individual perceptions against legitimate universal expectation are evaluated

### 4. DOMAINS/ELEMENTS OF RESPONSIVENESS

WHO proposed 7 domains of responsiveness after considering several health system surveys, literature review, discussion with researchers in health sector. The seven elements are:

- a. Dignity-Concerns with a person's right to be treated with respect. It safeguards certain patient's rights too.
- b. Autonomy- It gives the patient the right to choose treatment, diagnostic tests provided the patient is of sound mind
- c. Confidentiality- privacy in terms of communication, reports and records
- d. Prompt Attention- which means patient is attended to on arrival quickly and the waiting time is not too long. It not only improves the health outcome but also enhances patient welfare
- e. Quality of basic amenities- is mainly about cleanliness of the place, and food quality

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- f. Choice of care provider-patient should have the choice to be able to select the healthcare provider, to get specialist care and also to get second opinion
- g. Access to social networks- includes community interactions and support groups

Later eighth element Communication was added.

The first three elements namely dignity, autonomy, confidentiality have been put under one group and called respect for persons. The other four prompt attention, basic amenities, choice of care provider and access to social support form another group called client orientation.

## **5. IMPORTANCE OF RESPONSIVENESS**

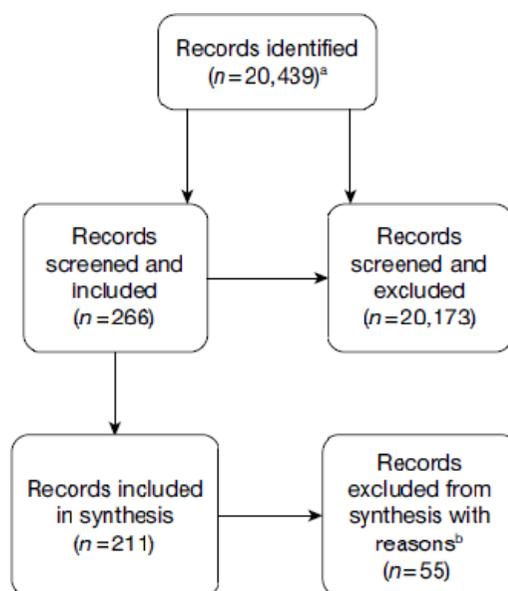
Responsiveness is important as:

- a. It has been seen that it improves the health outcome. Patients treated with care and concern, respond better to treatment. They seek care earlier and confide in health care providers. They are also more likely to comply with medical instructions and continue using medical services [21, 36].
- b. It is related to Human rights as human rights is the core of responsiveness. A survey conducted by WHO found that 25% respondents felt responsiveness was an important goal of health system [19].
- c. It ensures information flow between health system and patient
- d. Understanding responsiveness helps the provider to give better care to the patient there by leading to better patient satisfaction
- e. Finally, It also helps health authorities and the government to come up with policies which will respond to patient's needs and expectations in a better manner [14].

## **6. EXPECTANCY THEORY AND FACTORS AFFECTING EXPECTATIONS**

'Expectation' for a patient is defined as 'the anticipation that given events are likely to occur during, or as an outcome of, health care.' According to Psychological theory expectations are complex values, or beliefs coming from many cognitive processes[20]. These are custom-made by previous experiences [18]. Beliefs make up an attitude towards a particular phenomenon [2]. Expectations are dynamic and are a perception or type of belief about future events.

According to social cognition and response expectancy theories [4-9, 27, 25] forethought regulates human motivation and behaviour. Expectancies are formed on past experience and knowledge and influence future outcomes.



Source: [12].

**Figure 1:** Flow diagram summary of systematic search; a including duplicates. b. Papers were rejected from the review. If there was no mention of any aspect of patients' expectations. For examples, rejected papers focused on patients' experiences, desires, preferences, needs, hopes wants, health professionals' expectations, health care provision.

Expectancy theory proposes that satisfaction is determined by the degree of difference between expectations and experiences as given in 'gap model'. Expectations are not straight forward. The social Comparison theory explains how individuals compare themselves with others and evaluate their own opinions and abilities, and learn how to define the self. A patient's satisfaction depends a lot on his perception of what he has received when compared to others as given in Social Comparison Theory [17]. Relative deprivation theory explains this in details. Relative deprivation may also emphasize the individual experience of discontent when being deprived of something to which one believes oneself to be entitled, however emphasizing the perspective of the individual makes objective measurement problematic.

After selecting and reviewing the literature available in English in this field on various databases like The Cochrane Library, MEDLINE, EMBASE, Web of Science. The key words used were 'patient expectation' or 'patient expectations' or 'healthcare'. It was found that for most studies:

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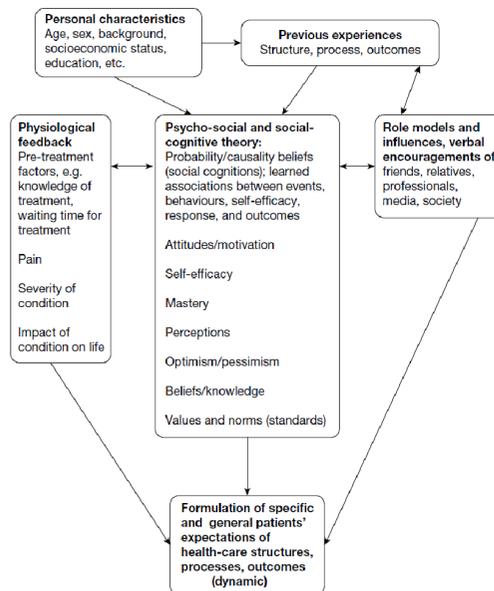
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- a. Research designs were weak
- b. Sample size was small
- c. Theoretical frame of reference was found absent in most of the papers
- d. Expectations questions were mostly untested

Hence it can be concluded that research on expectations is weak, hence contributions to knowledge is uncertain and with little attempt to examine expectations in detail [12].

Below is a proposed model of the several influences on patients' expectations of health care. The person's interactions with society influence the development of his expectations. expectations are dynamic and develop over time. Several factors that influence the development of expectations include :

1. Personal characteristics such as age, sex, socioeconomic status, education and background,
2. Physiological feedback
3. The patient's own belief system,
4. Their previous experiences
5. Communication with friends, relatives, professionals [12].



**Figure 2:** Model based on the literature of multiple influences on patients' expectations of health care.

Source: [12].

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A model of expectations should be dynamic and multidimensional (e.g. in relation to types of expectations) and should depict all determinants, including sociocognitive. It should also show potential causal pathways between expectations and related attitudes and behaviours (patient satisfaction), health behaviours (e.g. adherence to therapy) and patient-based health outcomes (health status and health-related quality of life)]. Till date we do not have a well validated, standardized instrument for measuring patient's expectations in any of these domains. Hence a lot of research is needed in this field [12].

## **7. CRITICISM OF WHO REPORT ON RESPONSIVENESS OF HEALTH SYSTEMS**

There has been a lot of discussion and criticism of WHO 2000 report which proposed 7 elements of responsiveness. Grounds for criticism are:

- a) Validity of using a single composite score to compare health systems of various countries [3, 22].
- b) Accuracy of using key informants or experts to assess responsiveness rather than the patients [30, 31].

Data collected from 17 European countries was analyzed by Blendon [10]. He confirmed that:

1. There was considerable difference between satisfaction of patient and national ranking given by WHO meaning higher ranking did not necessarily translate in to higher patient satisfaction and vice versa.
2. Another doubt raised by his report was on the appropriateness of making comparisons of health systems when there are differences in cultural, economical, political backgrounds [10].

Hsu Chicheng (2006) in a study conducted in Taiwan and published in biomed Central public Health journal found: [23]

WHO proposed Elements of responsiveness should be tailored to fit the cultural background when measuring the performance of health system

When measuring responsiveness from patient's perspective, importance people give to different aspects of health system should also be considered [23].

Issue of cross cultural validity of responsiveness elements as given by WHO has been raised by several WHO regional offices too.

## **CONCLUSION**

In spite of recognizing these issues and after much debate, no empirical research has been undertaken. After extensive review of existing literature we

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feel there is a need to reorganize or tailor the elements of responsiveness in each culturally, socially, politically different society according to the preferences of concerned population.

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