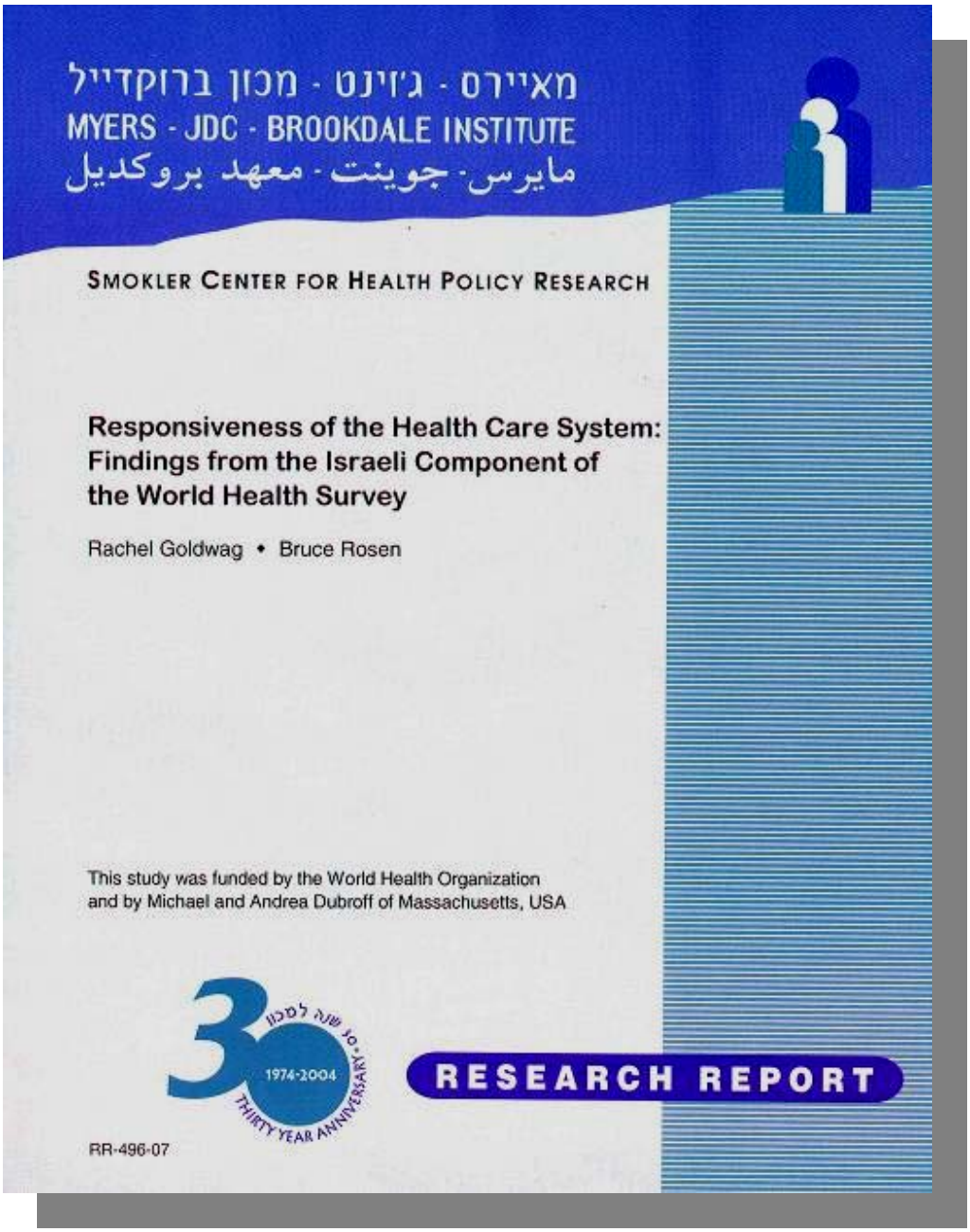
Myers - JDC - Brookdale Institute
מאיירס - ג'וינט - מכון ברוקדייל

Research Report

To facilitate easier navigation within this document, open the bookmark feature by clicking on the "Bookmarks" tab or by using the F6 key



Executive Summary

Background

As defined by the World Health Organization (WHO), responsiveness relates to patients' experiences with the health system, with a focus on the interpersonal aspects of the care they receive. Responsiveness can be divided into two main components: personal respect and client orientation. Personal respect includes treatment with dignity, privacy and confidentiality of medical information, patient-physician communication, and personal autonomy. Client orientation also includes four domains: prompt attention, access to social support, basic quality of amenities, and choice of provider.

Responsiveness is a relatively new concept developed by the WHO as one of the key measures of health system performance and objectives. It is part of a larger initiative to develop standards for comparing health systems worldwide in order to identify areas for improvement in services and health outcomes.

This report describes the results of a 2003 study of the responsiveness of the Israeli health care system, including an analysis of key differences among population subgroups and selected comparisons with European countries. The study is based on the findings from the WHO's World Health Survey (WHS), which was carried out in over 70 countries. In addition to exploring responsiveness, the WHS included an extensive battery of questions on health status as well as a set of socio-demographic questions.

One of the new and distinctive aspects of the WHS was the introduction and use of anchoring vignettes as a tool for standardization of responses. Anchoring vignettes are brief fictional accounts of the care given to hypothetical patients, each one focusing on a different domain of care and a different level of performance in that domain. By asking different respondents to rate the same set of vignettes, researchers seek to measure differences in expectations among the respondents.

For many years, researchers have been grappling with the issue of the extent to which differences among population groups in responses to evaluative questions (such as patient satisfaction or responsiveness questions) are an accurate reflection of real differences in care provision between the groups. This is because there may also be differences in expectations for health care and this could affect responses. For example, individuals and population subgroups that tend to receive relatively poor care from the health care system (or society in general) over an extended period may lower their expectations and may be satisfied with lower levels of performance. This does not mean, however, that the health system has responded well to their universal legitimate expectations. Furthermore, language is often used differently by different groups of individuals and a good instrument should empirically ascertain the meaning of response categories on a particular question in each population. The anchoring vignettes can be used to establish the

meaning of various response categories, thus making it possible to take into account systematic differences in the way groups respond to evaluative questions and differences in expectations.

Goals

The goals of the study were as follows:

1. To assess the level of responsiveness of Israeli health care for the population as a whole
2. To compare responsiveness levels across key population subgroups in Israel
3. To analyze how responsiveness levels vary across domains, both for the population as a whole and for key subgroups
4. To explore the extent to which differences in responsiveness in Israel across subgroups can be attributed to differences in expectations
5. To compare responsiveness in Israel with that in Europe

Methods

The Israel component of the WHS was carried out by phone interviews in 2003. The survey population consisted of all Israeli residents over age 22. The sampling frame was the computerized national telephone lists. The response rate was 70% (due primarily to a 19% refusal rate) and 1,236 interviews were completed. The observations were weighted to reflect differences in sampling probability and response rates. Most of the interviews were carried out in the primary language of the respondent – Hebrew, Russian, or Arabic. A few were conducted in English.

Questions on responsiveness related to the respondent's personal experience during their most recent hospitalization or most recent ambulatory care visit. One question was asked regarding each of the eight domains of responsiveness cited above. Respondents were asked to rate each on a five-point scale, ranging from "very good" to "very bad." For each population group, we created a summary index based on the average responses for the eight domains.

Expectations were measured using the standardized vignettes and the same five-point rating scales used to rate personal experience were used to rate the level of care provided in the vignette. For each domain, five different scenarios were rated, ranging from very problematic to very positive. Thus, if each respondent had been presented with all five scenarios for each of the eight domains, the questionnaire would have become too long and unwieldy. Instead, therefore, we split the sample into subsamples and each respondent was presented with vignettes for two randomly chosen domains.

Findings

Overall National Findings for Personal Experience

Using the summary score, we found that among the population as a whole, 48% rated inpatient care as "very good" and 31%, "good." The rating of ambulatory care was similar – 54% rated it "very good" and 28%, "good."

The domains of responsiveness in inpatient care that most of the respondents rated as "very good" were respect (59%), explanations (57%), and social support (possibility of visits) (56%), while the domain that the fewest respondents rated as "very good" was choice (30%). For ambulatory care services, respect and privacy were rated highest (67% and 65% "very good," respectively), while waiting time was rated the lowest (35% "very good").

Comparisons among Key Subgroups for Personal Experience and Expectations

We examined differences between Arabs and Jews and between high- and low-income groups. All differences cited in the text are statistically significant, unless otherwise noted.

In almost all the domains, Arabs reported higher responsiveness with regard to their personal experiences than did Jews. With regard to inpatient care, the summary score was very high for 56% of the Arabs and 47% of the Jews. Arabs rated almost all domains higher, with particularly large and statistically significant differences for the domains of privacy, choice, and cleanliness. Only in the domain of waiting time did the Arabs give lower ratings and the difference was not statistically significant.

Small sample sizes for the Arab population limited the precision of comparisons for ambulatory care, but there, too, the percentage of Arabs reporting "very good" was consistently higher than that for Jews. For example, the summary score was 12 percentage points higher for the Arabs.

At the same time, Arabs also tended to give substantially higher scores than did Jews to most of the standardized vignettes. The implication is that the expectations of the Arab population are lower in most domains. The summary score was very high for 59% of the Arabs versus 45% of the Jews. Particularly large and statistically significant differences were found for the domains of respect, explanations, and privacy.

Thus, while the responsiveness scores for personal experience give the impression that Arabs are receiving better care than Jews are, the vignette scores raise doubts as to whether this is indeed the case. It may even be that they are receiving worse care, both overall and in certain key domains.

For example, in the case of explanations, Arabs rated their personal experience with inpatient care 13% higher than did Jews, but they rated the standardized vignettes 59% higher – indicating much lower expectations. The results suggest that the actual level of service may have been lower for Arabs, even though they expressed greater satisfaction. On the other hand, in the case of social support (i.e., how easily family and friends can visit), Arabs rated their personal experience slightly higher than did Jews and they rated the standardized vignettes somewhat lower, implying they have higher expectations. Thus, we can be surer that their experience in this domain is indeed better than that of Jews.

A similar analysis was carried out comparing the highest and lowest income quintiles. We found that, when relating to personal experience, these two groups gave similar scores on most responsiveness domains. However, there were some differences. In the inpatient setting, the higher income group rated waiting time and social support somewhat higher, while the lower income group rated choice of provider somewhat higher (although the difference was not statistically significant). In the ambulatory setting, the higher income group gave higher scores for respect and privacy.

The responses to the vignettes reveal that there are differences in expectations among the income groups that vary from one domain to another. The responses to the vignettes suggest that the lower income group has relatively lower expectations with regard to explanations and choice and relatively higher expectations with regard to social support. Thus, the relationship between actual experiences, expectations, and ratings of health services, is seen to vary across domains.

Although the responsiveness ratings are similar, in some areas there appears to be a lower level of care.

International Comparisons

The WHO has published responsiveness data for the average of the 14 European countries (henceforth "Europe") that fielded the survey by telephone (as did Israel). For both inpatient and ambulatory care, Israel's responsiveness scores were similar to those of Europe for most domains of care. However, Israel scored lower than Europe with regard to choice of provider for both inpatient and ambulatory care (60% vs. 70% and 77% vs. 97%, respectively), as well as on amenities (cleanliness) for inpatient care (79% vs. 87%). The relative rankings of the domains were similar in Israel and Europe, with the exception that ambulatory choice was ranked highest of all the domains in Europe, but was ranked sixth in Israel.

Unfortunately, vignette scores have not yet been published for Europe so we are unable as yet to assess the extent to which the Israel-Europe differences in responsiveness are due to differences in expectations as opposed to differences in level of service.

Concluding Thoughts

The appropriate way to interpret client assessments of health care services depends on the goals of the particular study involved (i.e., whether the objective is to assess how satisfied people are with the health system or to assess the performance of the health system). This is true with regard to both the national findings and the findings regarding key subgroups.

The study made it possible to compare responsiveness scores *across* domains within Israel as well as *between* Europe and Israel for each domain. As the study findings demonstrate, the answer to the question: "In which domains does the Israeli health care system provide relatively good responsiveness?" depends on whether the relevant comparison group is other domains or Europe. For example, while Israelis rated "respect" higher than other domains for inpatient and

ambulatory care, the ratings they gave to this domain were similar to those assigned by Europeans.

With regard to subgroups within Israel, the study makes it possible to compare the responsiveness scores with respect to actual experience and to examine differences in expectations based on the scores assigned to standardized vignettes. The study found that Arabs tended to give higher ratings for both their own experiences and standardized vignettes in most domains, suggesting that lower expectations may be leading to higher responsiveness and satisfaction ratings on the part of the Arab population – both in this study and in others. When we compared income groups, we found that the differences for both personal experience and vignettes tended to be smaller and less consistent.

Our findings are consistent with those of Murray et al. (2001), who argue that differences in satisfaction probably reflect differences in both the level of service and the level of expectations. Leading health policy experts (Murray et al. [2001]; Blendon et al. [2001]) are divided on which of these – satisfaction or level of service – is the "truly important" parameter. Our own view is that satisfaction and level of service are both very important.

Our findings also suggest that the relationships between client assessments of care, expectations, and actual experience depend on which groups and which domains are being compared.

Finally, the study suggests that while the use of vignettes is imperfect and is still undergoing development, vignettes do appear to hold important promise for deepening our understanding of health system performance, inter-group differences, and cross-national differences.

This study was funded by the World Health Organization and by Michael and Andrea Dubroff, Massachusetts, USA.

Table of Contents

1. Introduction 1

2. Methodology 5
   2.1 The Study Population, the Sampling Method, and the Study Sample 5
   2.2 Weighting 5
   2.3 Data Collection 8
   2.4 The Survey Instrument 8
   2.5 Pilot Test Results 9
   2.6 Data Analysis 9

3. Findings – Overall, by Population Group (Arabs and Jews) and by Income Group 10
   3.1 Responsiveness Scores (Based on Personal Experience) 10
      3.1.1 Inpatient Care 10
      3.1.2 Ambulatory Visits 13
   3.2 Vignette Scores: Expectations in the Responsiveness Domains 18
      3.2.1 The Relationship between Standardized Vignettes and Personal Experiences 20
   3.3 Importance of Responsiveness Domains 22
   3.4 Selected International Comparisons 25

4. Discussion 27

Bibliography 29

Appendix I: The Components and Domains of Responsiveness 36

Appendix II: Responsiveness Questions 41

Appendix III: Vignette Examples 42

Appendix IV: Demographic Characteristics by Population Group 44

Appendix V: Multivariate Analyses 45

List of Tables

Table 1: Comparison between Demographic Variables of the Weighted WHS Sample and CBS Statistics of the Israeli Adult Population (2002) 7

Table 2: Distribution of Ratings of Responsiveness in Inpatient Care and Average Ratings, by Domain 11

Table 3: Responsiveness in Inpatient Care Summary Measures, by Selected Demographic Variables 13

Table 4: Distribution of Ratings of Responsiveness in Ambulatory Visits and Average Ratings, by Domain 14

Table 5: Responsiveness in Ambulatory Visits Summary Measures, by Selected Demographic Variables 17

Table 6: A Comparison of Responsiveness between Inpatient Care and Ambulatory Visits 18

Table 7: Ratings on Standardized Vignettes, by Population Group and Income Group 19

Table 8: High Responsiveness Scores in Personal Experience of Inpatient Care and Low Expectations Expressed via Standardized Vignette Ratings, by Population Group and Domain 21

Table 9: High Responsiveness Scores in Personal Experience and Low Expectations Expressed via Standardized Vignette Ratings, by Income Group 22

Table 10: Importance of Responsiveness Domains 23

Table 11: Inpatient Responsiveness in Israel and Europe 26

Table 12: Ambulatory Care Responsiveness in Israel and Europe 26

Table 13: Domains with Relatively High and Relatively Low Responsiveness 27

Table V-1: Linear Regression Results: Inpatient Responsiveness 46

Table V-2: Linear Regression Results: Ambulatory Responsiveness 46

List of Figures

Figure 1: Inpatient Responsiveness, "Very Good" Ratings, by Domain 11

Figure 2: Inpatient Responsiveness, "Very Good" Ratings, by Population Group 12

Figure 3: Inpatient Responsiveness, "Very Good" Ratings, by by Income Quintile 12

Figure 4: Ambulatory Visit Responsiveness, "Very Good" Ratings 14

Figure 5: Ambulatory Visit Responsiveness, "Very Good" Ratings, by Population Group 15

Figure 6: Ambulatory Visit Responsiveness, "Very Good" Ratings, by Income Quintile 16

Figure 7: Distribution of Responses, Standardized Vignettes 19

Figure 8: Importance of the Responsiveness Domains, by Population Group 24

Figure 9: Importance of the Responsiveness Domains, by Income Group 25