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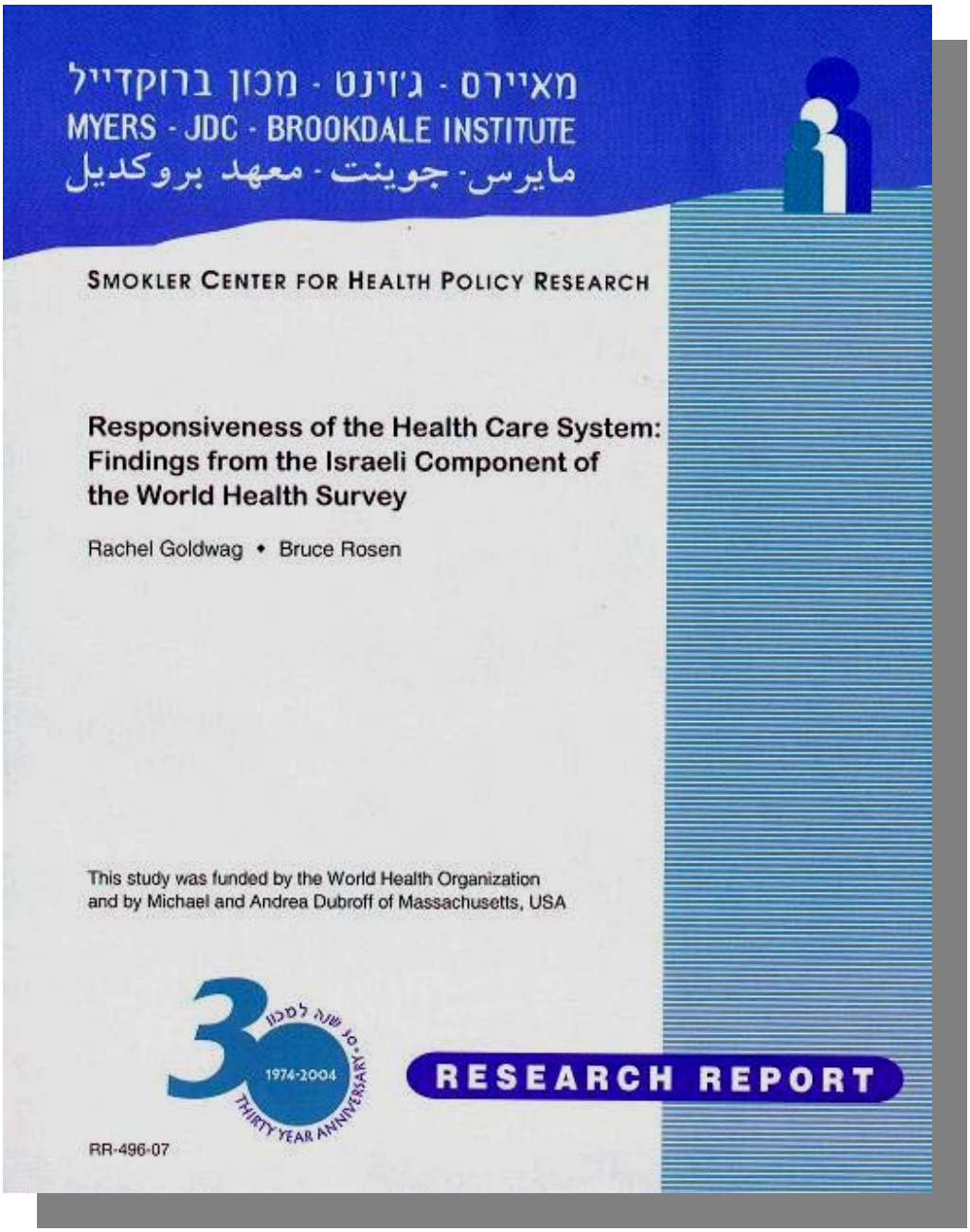

SMOKLER CENTER FOR HEALTH POLICY RESEARCH

Responsiveness of the Health Care System: Findings from the Israeli Component of the World Health Survey

Rachel Goldwag ◆ Bruce Rosen

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

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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.

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The study was funded by the World Health Organization and by Michael and Andrea Dubroff.

Table of Contents

List of Tables

List of Figures

1. Introduction

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 (as opposed to the technical or clinical aspects). The concept was popularized by Murray and Evans (2003), who state:

> When individuals interact with the health system, it influences their well-being. One pathway to achieve well-being is through improvements in health, but well-being is also influenced by other aspects of people's interactions with the health system. We define aspects related to the way individuals are treated and the environment in which they are treated as responsiveness.

Murray and Evans divide responsiveness 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 provider choice. Appendix I elaborates further on each of these domains.

Responsiveness is a relatively new concept that was 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 (Murray and Evans, 2003). In this context, WHO focuses attention on five key measures for each country: fairness of financing, average health attainment, equity of health attainment, average responsiveness, and equity of responsiveness.

WHO experts have argued that, despite superficial similarities, the concept of responsiveness is distinct from patient satisfaction (Darby et al.). They note that responsiveness relates to people's objective experiences with the health system and not to whether they are satisfied with their care. As such, responsiveness is not affected by patients' expectations, while these expectations can have a significant impact on their satisfaction. Darby et al. also note that responsiveness is limited, by definition, to the non-medical dimensions of care (to distinguish it from health status, which is measured separately), while satisfaction can relate to either medical or non-medical dimensions and usually relates to both.

Responsiveness is important from the point of view of consumers and policymakers alike. From the consumer's standpoint, a responsive health system is good because it facilitates an effective flow of information between itself and its consumers. In addition, the philosophy behind responsiveness includes an awareness of the basic human rights of dignity and autonomy. From the policymaker's standpoint, improvements in responsiveness are sometimes possible with relatively small investments in technology, human resources, and funding (Darby et al.) and can generally be improved more quickly than health status.

This report describes the results of a 2003 study of the responsiveness of the Israeli health care system, including an analysis of key differences between population subgroups and selected comparisons with European countries. The study is based on the findings from the WHO World Health Survey (WHS), which was carried out in over 70 countries.

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 (Murray et al., 2001). The anchoring vignettes are brief fictional accounts of the care given to hypothetical patients (each 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 in responses to evaluative questions (such as patient satisfaction or responsiveness questions) among groups are an accurate reflection of real differences in care provision among them (King and Wand, forthcoming). This is because there may be differences in expectations for health care and this could affect responses. For example, individuals and population subgroups that are poorly treated by a health care system (or society in general) over an extended period of time may lower their expectations and may be satisfied with lower levels of performance. This does not mean, however, that the health system has responded to their universal legitimate expectations.

Another reason why differences in ratings may not accurately reflect differences in care is that language is often used differently by different groups of individuals. A good instrument should empirically ascertain the meaning of response categories on a particular question in each population (Murray et al., 2001).

One approach to measuring how care is actually being delivered is to ask one or more objective questions requiring quantitative or yes/no answers, such as:

- How long did you wait to see the doctor?
- Did the doctor identify himself when he walked into the room?
- How many other patients were hospitalized in the room with you?

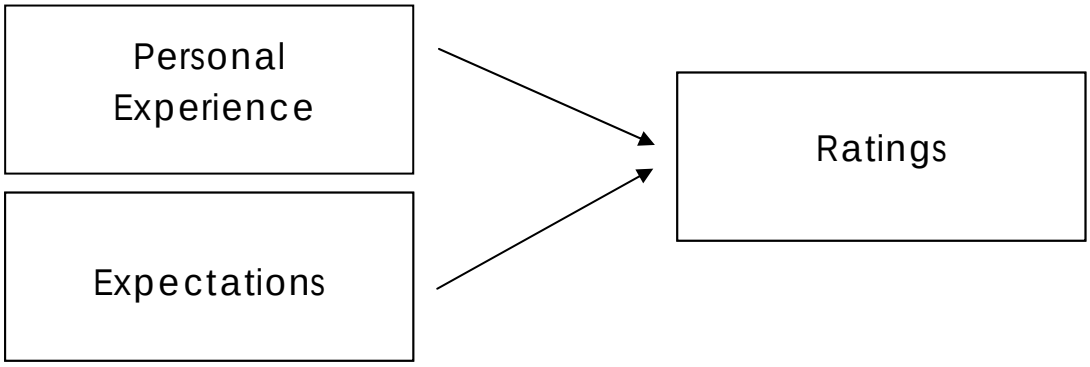
This approach works well when interest is confined to a relatively small number of objective and specific elements of service. It becomes problematic when there is interest in a broader assessment of the care provided. For example, even if attention is limited to a specific area such as dignity (or privacy, respect for autonomy, etc), it is hard to see how the level of service in that area can be fully captured in a limited number of objective, targeted, and simple questions. Some aspects of dignity cannot be captured in these types of simple questions. Moreover, even if we could ask a series of five to ten simple questions relating to the domain of dignity, we would not know whether we had fully covered the domain, how the various items should be weighted, and whether they should be weighted similarly for Jews and Arabs and for different socioeconomic

groups. The difficulty becomes even greater if one wants to cover the totality of responsiveness, in all its domains.

The vignettes constitute an alternative approach. They are based on the concept that in answering evaluative questions about their personal experience, respondents will be influenced by both their actual experience and their expectations. In order to isolate actual experience, there is a need to "control" or "adjust" for expectations, much as one might adjust for age in making comparisons of disease rates or health care utilization among all population groups. In order to do so, there is a need for an independent measure of expectations. These are provided by the standardized vignettes, in which all respondents are asked to rate the level of responsiveness in scenarios such as the following:

> Ruth was speaking to her doctor about an embarrassing problem. There was a friend and a neighbor of hers in the crowded waiting room and because of the noise the doctor had to shout when telling Ruth the treatment she needed.

The assumption is that, as the scenarios relate to a third party (rather than the respondent) and are the same for all respondents (as opposed to personal experience, which varies from person to person), they can provide pure measures of how different people interpret and select different response categories ("expectations" in our jargon). These can then be used to control/adjust for the role of expectations in the responses to the questions on personal experience, yielding corrected measures of personal experience.



An important advantage of this approach is that it requires only a limited number of broad questions about personal experience. For example, in the WHS, only one personal experience question is asked about dignity during hospitalization:

> For your last hospital stay, how would you rate your experience being greeted and talked to respectfully?

On the other hand, the approach has the disadvantage that in order to measure differences between groups in expectations/use of response category, several different scenarios (ranging from the very impressive to the very problematic) must be presented for each domain; in the case of the WHS, five different scenarios were used for each of the eight domains, resulting in a questionnaire that is too long and unwieldy to be administered in its entirety to all respondents. In the case of the WHS, this was resolved by presenting each respondent with vignette scenarios for only two of the eight domains.[1]

Several additional concerns exist with regard to the use of anchoring vignettes in general and in particular with regard to their use in assessing responsiveness in Israel as opposed to other countries. To begin with, the approach is still relatively new; the use of vignettes is relatively untested in large, empirical studies and is still in the process of development. Secondly, there is concern that the limited number of vignettes per domain (as in the five used in the WHS) is not sufficient to fully cover a complex domain, particularly given the need to give expression to the special concerns of various population subgroups. Thirdly, vignettes that were developed to meet the needs of a multinational survey may not be appropriate for Israel and for comparisons among population subgroups in Israel. Finally, it may be that even in rating standardized vignettes and, despite the effort to focus them on a third party rather than themselves, respondents nonetheless give ratings that reflect, in part, their own recent health care experiences.

Nevertheless, the anchoring vignettes appear to be a promising tool for establishing the meaning of various response categories, thus making it possible to take into account systematic differences in expectations and in the meaning/use of response categories. Accordingly, they will be used in this report – albeit cautiously, in light of the limitations noted above.

Note that vignette scores can be used in one of two ways. One way is to make numeric adjustments to the raw responsiveness scores. That is the way that Murray and colleagues propose they should be used, but to date they have not provided a clear demonstration of how this is to be done using large sample responsiveness data. The other, less ambitious, way in which vignettes might be used is to present inter-group differences in vignette scores alongside inter-group differences in responsiveness scores. This makes it possible to view the differences in responsiveness scores from a broader perspective. That is the approach that we will employ in this report. This approach is neither conceptually conclusive nor numerically exact, but it does suggest alternative interpretations of responsiveness data and, given the limitations of vignettes noted above, seems to us more appropriate at this stage in their development.

[1] With this technique it is still possible to estimate "expectation levels" for all domains for any subgroup of interest (e.g., Arabs, persons with low-incomes, etc.) and use them to adjust responses to personal experience questions at the group, or even the individual, level (based on the individual's socio-demographic characteristics). However, it precludes individual-specific measurement of expectations and more refined adjustments of the individual's responses to personal experience questions.

In this report we will use the WHS's anchoring vignettes to provide insights into comparisons of responsiveness among key population subgroups within Israel. Ideally, we would also want to use the vignettes to shed light on differences in responsiveness between Israel and Europe; unfortunately, we are unable to do so as the WHO has not yet published the vignette scores for the European countries.

In our analysis of differences among population subgroups within Israel, we decided to focus on Arabs vs. Jews and other non-Arabs and income (high vs. low). We chose to focus on these groups because most past studies had found relatively high satisfaction rates among Arabs and poor persons[2] (Gross et al., 2005.; Yuval and Berg, 1997), while various "objective" measures of access to care had suggested that these groups might be receiving less good care. The anchoring vignettes provided an opportunity to increase our understanding of these seemingly contradictory findings by examining differences in expectations and response category cut points.

2. Methodology

2.1 The Study Population, the Sampling Method, and the Study Sample

The survey population for the Israel component of the WHS comprised all Israeli residents over age 22. The sampling frame was the computerized national telephone list, which covers 92% of households in the Israeli population – those that own a landline telephone (Central Bureau of Statistics [CBS], 2003). Sampling of the respondents within each household was done randomly, without replacement, to ensure accurate representation of the Israeli population. Within each household fitting survey criteria, one randomly chosen adult member (age 22 and above) was interviewed.

The study team initially sampled 1,858 households. Of these, 77 were ineligible for the survey, leaving a net sample of 1,781. Of the net sample, 1,236 interviews were completed, which accounts for a 70% response rate. Reasons for non-response include refusal to participate (19%), a health or mental health problem (6%), language barrier (2%), and other problems (3%).

2.2 Weighting

In order to ensure that population estimates would be representative, the sample was weighted in two stages. In the first stage, each individual received a weight based on his/her probability of being sampled. The sampling proportion was determined by the number of telephone numbers in

[2] In contrast to most past studies, a 2005 Myers-JDC-Brookdale Institute population survey found higher satisfaction with health plans among Arabs than among Jews (Gross et al., 2007). The reasons for this change are not yet understood.

the database used, number of adults aged 18 or over in the household, and the number of telephone lines in the household. In the second stage, in order to overcome differential dropout biases, weights were calculated by population group,[3] gender, and age. The sample population was divided into 12 strata: by Arabs vs. Jews and non-Arabs; by men vs. women; and by age (18–44, 45–64, 65+). Each stratum received a weight that took into account its relative size in the population according to CBS estimates.

Table 1 compares the partly-weighted (i.e., after Stage 1 only) and fully-weighted samples to CBS estimates of the adult Israeli population (CBS, 2002). The fully-weighted sample and the CBS population data are similar in most demographic variables, except for an overestimation of individuals with a higher education in the sample population. However, the partly-weighted sample had more significant departures from the CBS population in such variables as population group and country of birth.

The weight for each individual was derived according to the formula:

$$w_i = \frac{P_s}{p_s} * M_j * \frac{1}{T_j} * \frac{N_h}{n_h}$$ [4]

[3] For the purposes of this report, "population group" refers to Arabs on the one hand and Jews and non-Arabs on the other.

[4] w_i=weight for individual *i*; P_s/p_s=proportion between the number of telephones in the database and the number of telephones in the sample (including dropouts); M_j=the number of adults aged 18 or over in the household; T_j=the number of telephone lines in the household; N_h/n_h=proportion between the number of individuals in the population (according to CBS figures) in stratum *h* and the number of individuals in the sample in stratum *h*.

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

Variable	WHS partly-weighted sample	WHS fully-weighted sample	CBS estimates (2002)
N	1,236	1,236	4,273,070
Gender			
Men	44.5	48.3	48.3
Women	55.5	51.7	51.7
Age			
18–44	56.8	58.1	58.1
45–64	28.3	27.1	27.1
65+	14.9	14.8	14.8
Education			
0–8 years	9.3	10.1	14.4
9–12 years	41.7	42.9	47.1
13+ years	48.9	47.0	38.5
Region			
Center	69.4	68.4	67.9
Periphery	30.6	31.6	32.1
Population group			
Jewish/non-Arab	90.3	85.0	85.0
Arab	9.7	15.0	15.0
Work status			
Working	62.7	62.6	
Not working	37.3	37.4	
Of those: Unemployed	13.1	12.7	
Immigrant from FSU since 1990 (1999 data)			
Yes	13.9	15.4	16.0
No	86.1	84.6	84.0
Country of birth			
Europe/America/FSU	27.5	32.7	34.7
Asia	5.0	5.4	6.3
Africa	6.4	6.7	8.3
Israel	59.6	55.2	50.7
Health Plan*			
Clalit	54.8	55.2	55.2
Maccabi	22.5	21.4	23.7
Meuhedet	12.1	12.1	11.1
Leumit	10.6	11.2	10.0
Mean number of persons per household		3.8	

*National Insurance Institute data (2002)

2.3 Data Collection

Research data was collected via telephone interviews that were conducted at the Myers-JDC-Brookdale Institute between January and June 2003. Interviews ranged from 25 to 45 minutes and were conducted by interviewers who were specially trained for this questionnaire. Most of the interviews were carried out in the primary language of the respondent – Hebrew, Russian, or Arabic. A few were conducted in English.

2.4 The Survey Instrument

The responsiveness module is a part of the larger WHO World Health Survey, which also includes demographic, economic, social, and health modules. The WHS instrument is available in two formats – a longer format for face-to-face surveys and a shorter format for telephone surveys. Along with 14 other countries that also chose to conduct the survey by phone, Israel made use of the shorter format. The Israeli survey included all the questions prescribed by WHO for telephone surveys, along with additional questions from the long form of the survey, which were added because of their special significance to the Israeli health care system. These questions dealt with issues other than responsiveness.

The original English survey questionnaire was translated to Hebrew and key terms were back translated and subsequently checked by a linguist. Russian and Arabic questionnaires were also obtained from the WHO; the Arabic was adapted to match dialects in Israel and both were adjusted to match changes made to the Hebrew questionnaire. Native Arabic speakers interviewed the Arabic-speaking population and interviews with immigrants from the former Soviet Union were conducted in Russian.

The responsiveness module contained eight components, which were the main dependent variables: Waiting time, treatment with dignity, clarity of communication, involvement in decisions, privacy,[5] choice of health care provider, cleanliness of surroundings,[6] and social support. The full set of responsiveness questions regarding inpatient care can be found in Appendix II. We also created a summary index for each population group, which was based on the average of the responses for each of the eight domains.

With regard to each of the responsiveness domains, respondents were asked one question about their personal experience with the health care system. All respondents who had been hospitalized in the five years prior to the survey (49% of the sample) were asked about their most recent hospitalization. All others were asked about their most recent ambulatory visit in the previous year. This is in keeping with the methodology prescribed by the WHO for all countries participating in the WHS. Note, however, that the result is that the set of respondents who

[5] While Murray and Evans identified the wider domain of "confidentiality" of medical information, respondents in the survey were asked only how they would rate the way the health services ensured they could talk privately to health care providers.

[6] Similarly, the wider area of "amenities" was limited to cleanliness of the facility.

answered the questions about ambulatory care is not representative of the general population, but rather of the population that had not been hospitalized during the previous five years. In particular, note that Arabs were significantly under-represented in this group; only 6% of those who answered the ambulatory care questions were Arab, compared with 20% of respondents who answered the questions about hospitalization, and 13% of respondents overall. This limits the precision of the estimates regarding ambulatory care for the Arab population.

In order to examine differences in expectations among groups, we analyzed ratings of the standardized vignettes for each responsiveness domain in addition to the questions about personal experience. Each respondent rated ten responsiveness vignettes, five on each of two domains. The vignettes presented a brief scenario followed by a question asking the respondent to rate each of them on a scale from 1 ("very bad") to 5 ("very good") – the same five-point scale that was used to elicit ratings of personal experience. Examples of vignettes can be found in Appendix III. Summary vignette scores were calculated by averaging the ratings for the five vignettes in each domain.

2.5 Pilot Test Results

A pilot test was conducted on a non-representative sample of 109 respondents. Following the pilot test, data collection continued and 1,236 interviews were completed, for a 70% response rate. Of these, 1,125 were full interviews and 111 were partial interviews. Interviewers attempted to contact potential respondents at various times of the day and on different days of the week in order to maximize the probability of reaching respondents. Ten percent of the total sample was interviewed a second time within a week of the initial interview, in order to calculate test/retest reliability. Results show that test/retest reliability was satisfactory. Data passed various quality assurance and logical testing by trained staff.

2.6 Data Analysis

The Israel-specific analyses presented below focus on the percentage of respondents who responded "very good" to the questions for each of the eight responsiveness domains. We decided to focus on the percentage that responded "very good" rather than combining "good" and "very good," as the higher cut point is more effective in discriminating among population groups. Note, however, that in comparing Israel with the European countries we were forced to use "good" as the cut point. This is because to date WHO has not made available data for Europe that distinguishes between "good" and "very good" responses.

The project team also computed two summary measures for overall responsiveness at the individual level:

1. The simple average of the scores (using a five-point scale) on all the relevant domains (8 for inpatient care, 7 for ambulatory visits) and
2. The percent of respondents whose average score was "very good" (i.e., at least 4.33).

In addition, at the level of each population group studied, we created a summary index which averaged, across the eight domains, the percent of group members who chose each step on the 5-point scale.

Statistical analysis was conducted using the SPSS program (Statistical Package for the Social Sciences). Bivariate analysis was done using Chi Square tests to check relationships between non-interval variables. One-way analysis of variance (ANOVA) was used to check relationships between interval variables. Multivariate analysis was done using linear regressions as well as logistic regressions (when the dependent variable was dichotomous). In logistic regressions, the odds ratios denote the strength of the independent influence of each independent variable included in the model.

3. Findings – Overall, by Population Group (Arabs and Jews) and by Income Group

This chapter is organized as follows: Section 3.1 summarizes the respondents' responsiveness scores, which relate to their assessments of their personal experiences with the health system. This is done first for inpatient care (3.1.1) and then for ambulatory visits (3.1.2). In each case, we first present the overall findings for the full study population and then present comparisons between Arabs and Jews and between high-income and low-income groups. Next, in Section 3.2, we present the findings on how respondents rated the standardized vignettes, which seek to capture differences in expectations. Here, too, we distinguish between key population subgroups. We also relate the inter-group differences in vignette scores to the parallel differences in the personal experience scores. In the main body of the text, we will focus on the patterns for hospital care. There are two reasons for the greater focus on hospitalizations: first, the sample for the hospitalization questions is more representative than the sample for the ambulatory care questions. Second, due to the small number of Arabs who responded to the ambulatory care questions, those estimates are less precise. In Section 3.3, we present data on how respondents rated the importance of various responsiveness domains. Section 3.4 provides some initial findings comparing Israel with Europe. All differences cited in the text are statistically significant, unless otherwise noted.

3.1 Responsiveness Scores (Based on Personal Experience)

We present the findings primarily in terms of the percentage of respondents who rated each domain "very good." We do so first for inpatient care and then for ambulatory care.

3.1.1 Inpatient Care

As indicated in Figure 1, by far the lowest rated domain of responsiveness in inpatient care was choice of providers and the highest rated domains were respect, explanations, and social support. These results are further delineated for the full distribution in Table 2, and we see the same pattern for the average scores. Note that the question about choice of providers was phrased in a way that made it clear that the issue was choice of the professionals involved in the care, rather than choice of hospital.

Figure 1: Inpatient Responsiveness, "Very Good" Ratings, by Domain (Percent)

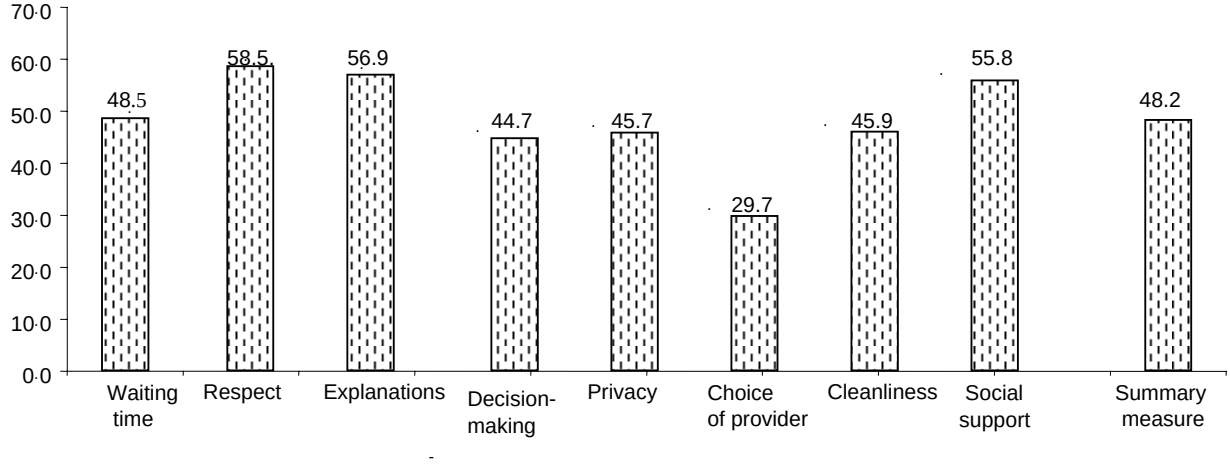


Table 2: Distribution of Ratings of Responsiveness in Inpatient Care and Average Ratings, by Domain (Percent)

	Very good	Good	Moderate	Bad	Very bad	Average
Waiting time	48.5	28.2	12.5	4.9	6.0	4.1
Respect	58.5	30.8	7.3	2.4	1.0	4.4
Explanations	56.9	27.8	9.3	3.9	2.1	4.3
Decision-making	44.7	31.7	15.3	5.3	2.9	4.1
Privacy	45.7	34.5	12.4	5.0	2.4	4.2
Choice of provider	29.7	26.1	24.9	9.9	9.4	3.6
Cleanliness	45.9	31.4	15.8	4.4	2.4	4.1
Social support	55.8	33.7	6.7	2.1	1.6	4.4
Summary	48.2	30.5	13.0	4.7	3.5	4.2

Note: Ratings were made using a five point scale, where 5="very good" and 1="very bad."

Population Group (Arabs vs. Jews and Others)

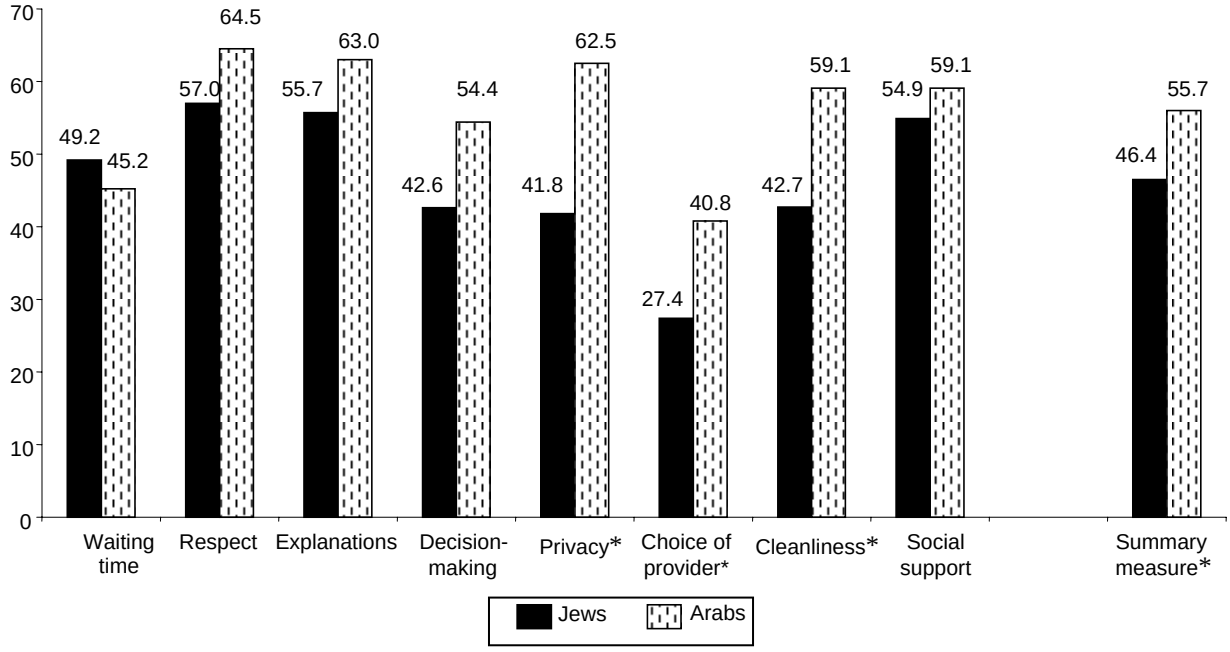
As shown in Figure 2, the responsiveness summary measure for inpatient care was higher among Arabs than among Jews and others.[7] Arabs rated most domains of responsiveness higher, with significant differences for privacy, choice of provider, and cleanliness. Jews rated waiting time higher than Arabs, but the difference was not significant.

It is unclear from these findings if the Arab population had better experiences during inpatient care, or if their expectations were lower, leading to higher ratings of responsiveness. Section 3.2, below, addresses the issue of differing expectations.

[7] A complementary picture emerges regarding Arab-Jewish differences in the percent of respondents with very low summary scores. In other words, a relatively high percent of Arabs tend to have very high summary scores, and a relatively low percent of Arabs tend to have very low summary scores.

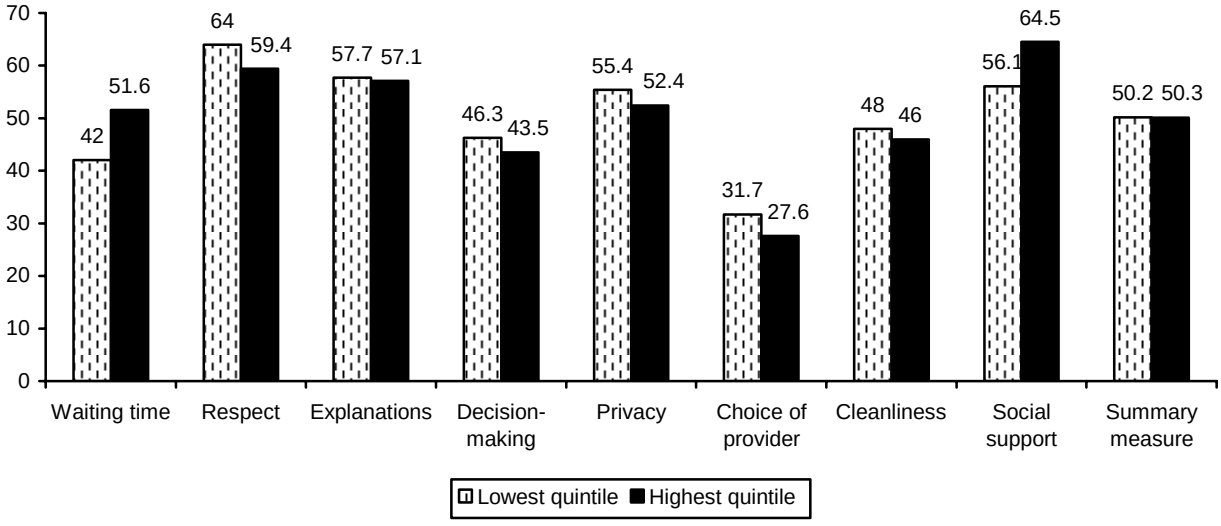
We carried out a series of regressions to explore the extent to which the difference in Arab-Jewish responsiveness scores could be attributed to demographic differences between the two groups (as presented in Appendix IV). We found that virtually none of the Arab-Jewish difference in inpatient responsiveness could be attributed to age, gender, or even education. The size of the gap did not change when controlling for these factors and the gaps remained statistically significant. The relevant table appears in Appendix V.

Figure 2: Hospitalization Responsiveness,"Very Good" Ratings, by Population Group (Percent)



* Indicates that the difference between the two groups is statistically significant at the .05 level.

Figure 3: Hospitalization Responsiveness, "Very Good" Ratings, by Income Quintile (Percent)



Income

As shown in Figure 3, there was no virtually no difference between income groups in overall responsiveness. The domains with relatively large (albeit not statistically significant) differences were waiting time and social support, which were rated higher by the highest quintile.

Summary of Link between the Summary Measure of Inpatient Responsiveness and Key Socio-demographic Variables

Table 3 summarizes responsiveness in inpatient care by selected demographic variables, using the simple average of the scores on the eight domains (using a five-point scale). The only differences that were statistically significant were between Jews and Arabs.

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

	Average
Total	4.2
Population group*	
Jews and others	4.1
Arabs	4.3
Income quintile	
1	4.3
2	4.1
3	4.2
4	4.0
5	4.2
Age group	
18–44	4.1
45–64	4.2
65+	4.3
Gender	
Men	4.1
Women	4.2
Residence	
Central	4.2
Periphery	4.1

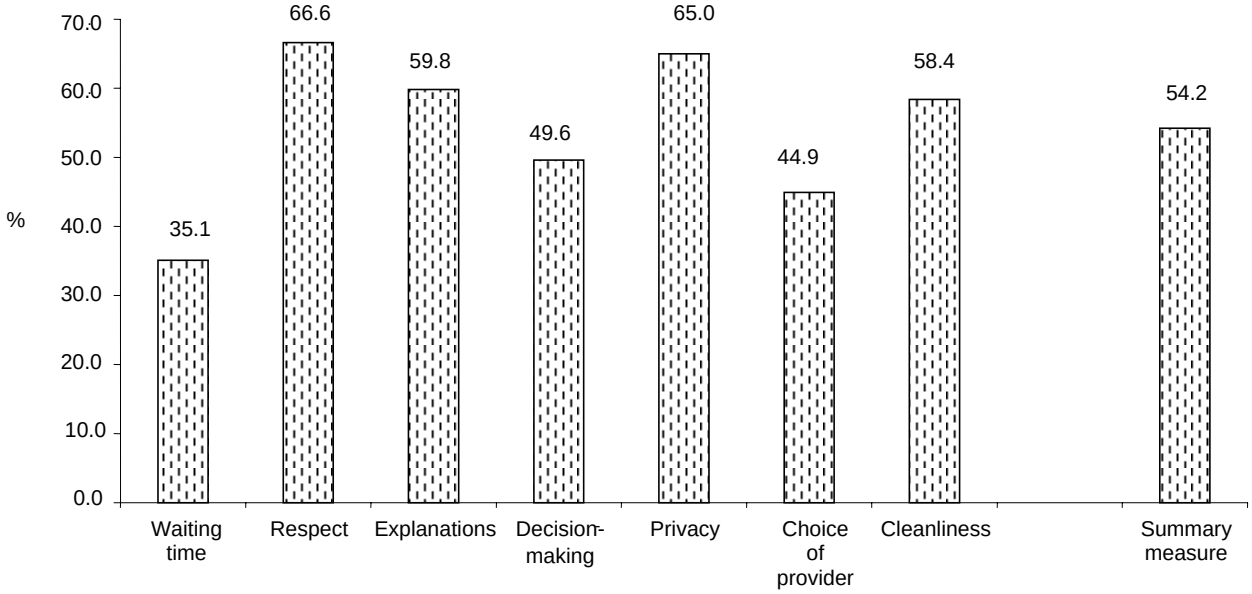
* $p < .05$

3.1.2 Ambulatory Visits[8]

Ambulatory health care refers to any type of medical or health care services received excluding inpatient care. This includes, but is not limited to, visits to family doctors, specialists (consultants), nurses, dentists, physiotherapists, chiropractors, and alternative medicine practitioners.

[8] As indicated in the methodology section, the set of respondents who answered the questions about ambulatory care are not fully representative of the population. In keeping with WHO guidelines, these questions were not put to respondents who had been hospitalized in the past five years, as they were asked questions about their inpatient care instead.

Figure 4: Ambulatory Visit Responsiveness, "Very Good" Ratings (Percent)



Overall, as shown in Figure 4 and Table 4, respect and privacy were rated highest among the responsiveness domains, while waiting time was rated the lowest. Thus, generally speaking, the highest and lowest domains were the same as in inpatient care; the fact that privacy was rated higher in the ambulatory setting is to be expected.

Table 4: Distribution of Ratings of Responsiveness in Ambulatory Visits and Average Ratings, by Domain (Percent)

	Very good	Good	Moderate	Bad	Very bad	Average
Waiting time	35.1	34.0	19.7	7.7	3.5	3.9
Respect	66.6	25.1	7.2	0.6	0.5	4.6
Explanations	59.8	26.7	11.6	0.8	1.1	4.4
Decision-making	49.6	28.3	17.7	2.4	2.1	4.2
Privacy	65.0	22.8	9.7	2.1	0.4	4.5
Choice of provider	44.9	29.0	15.8	6.3	4.0	4.0
Cleanliness	58.4	31.5	7.6	1.1	1.4	4.4
Summary	54.2	28.2	12.8	3.0	1.9	4.3

Note: Ratings were made using a five point scale, where 5="very good" and 1="very bad."

Population Group (Arabs vs. Jews and Others)

As shown in Figure 5, Arabs rated responsiveness higher than Jews in all responsiveness domains,[9] although the differences, with the exception of involvement in decision-making, were not statistically significant. It is important to note that the Arab group who responded to

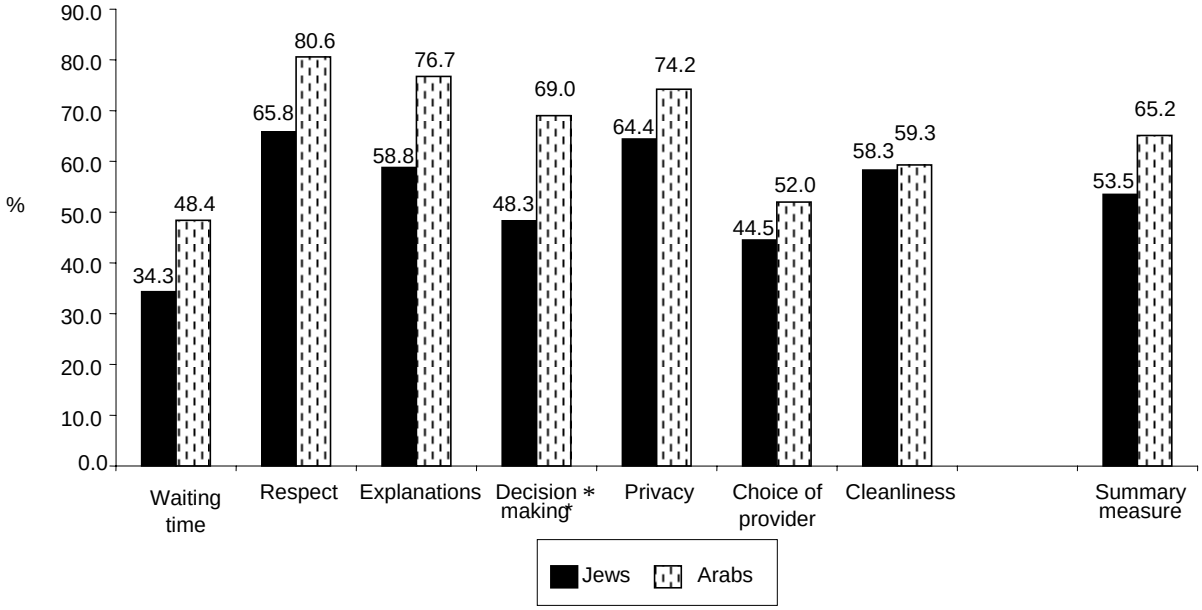
[9] A complementary picture emerges regarding Arab-Jewish differences in the percent of respondents with very low summary scores: a relatively high percentage of Arabs tend to have very high summary scores and a relatively low percentage of Arabs tend to have very low summary scores.

ambulatory visit questions was relatively small (30 respondents),[10] and this affected the power of the analysis (i.e., the ability to identify differences as statistically significant even when non-trivial differences exist).

Both Arabs and Jews rated respect the highest of the responsiveness domains and waiting time the lowest. As mentioned in the hospitalization section above, from the responsiveness scores alone it is unclear whether Arabs receive better service or if they have lower expectations and therefore rate responsiveness higher; this issue will be considered further in Section 3.2, after the vignette scores have been presented.

We carried out a series of regressions to explore the extent to which the difference in Arab-Jewish ambulatory responsiveness scores could be attributed to demographic differences between the two groups (as presented in Appendix IV). We found that controlling for age, actually *increased* the Arab-Jewish difference in ambulatory responsiveness, while controlling for gender and education did not affect the size of the Arab-Jewish differences. The relevant tables appear in Appendix V.

Figure 5: Ambulatory Visit Responsiveness, "Very Good" Ratings, by Population Group (Percent)



* Indicates that the difference between the two groups is statistically significant at the .05 level.

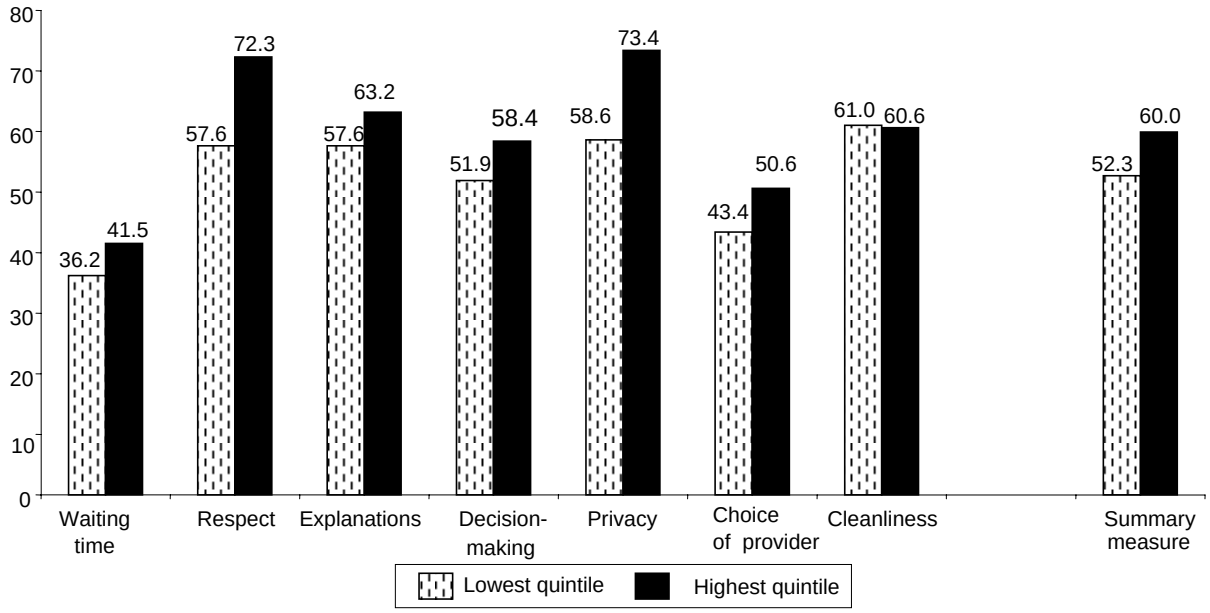
[10] This may be due, in part, to the relatively high rate of hospitalizations in the Arab population; persons who had been hospitalized in the five years preceding the survey answered questions on inpatient rather than ambulatory care.

Income

Figure 6 shows differences in ambulatory visit responsiveness between income quintiles. In the summary measure, the highest income quintile rated responsiveness in ambulatory visits higher on average, though the difference is not statistically significant. The highest income quintile also rated most of the domains higher, with the largest (albeit not statistically significant) differences being for respect and privacy.

The lowest income quintile rated cleanliness of facility the highest of the responsiveness domains, and the highest quintile rated privacy the highest. Both the lowest and highest quintiles rated waiting time the lowest.

Figure 6: Ambulatory Visit Responsiveness, "Very Good" Ratings, by Income Quintile (Percent)



Summary of Link between Ambulatory Responsiveness and Socio-demographic Variables

Table 5 summarizes responsiveness in ambulatory visits by selected demographic variables. There were differences among several of the groups examined, including between Jews and Arabs, among income quintiles, and among age groups. However, only the differences among the age groups were statistically significant.

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

	Average
Total	4.3
Population group	
Jews and others	4.3
Arabs	4.5
Income quintile	
1	4.3
2	4.2
3	4.2
4	4.4
5	4.4
Age group *	
18–44	4.2
45–64	4.4
65+	4.4
Gender	
Men	4.3
Women	4.3
Residence	
Center	4.3
Periphery	4.3

* P < .05

Hospital and Ambulatory Responsiveness

Though not fully comparable, it may be interesting to look at differences between responsiveness ratings in inpatient care and ambulatory visits.[11] As shown in Table 6, differences do exist. The highest rated domain for both inpatient care and ambulatory visits was respect. The lowest rated domain for inpatient care was choice of provider, while for ambulatory visits it was waiting time.

Overall, the summary measure was higher for ambulatory visits. Ambulatory visits were also rated higher in several specific domains: respect, privacy, choice of provider, and cleanliness of facility. Inpatient care was rated higher than ambulatory visits for waiting time. This may be due to the more urgent need for care in inpatient care.

[11] Again, it is important to bear in mind that the questions about ambulatory care were not posed to respondents who had been hospitalized in the past five years. One result was that the sample for the ambulatory visit questions contained a substantially smaller proportion of Arabs. Accordingly, we prepared a variant of Table 6 based on the Jewish respondents only. This reduced the percent "very good" by 1–3 percentage points for hospitalizations and left the numbers for ambulatory care essentially unchanged. However, the basic story presented above regarding the full population held true for the Jewish population as well.

Table 6: A Comparison of Responsiveness between Inpatient Care and Ambulatory Visits (Percentage Rated "Very Good")

	Inpatient care (n=491)	Ambulatory visits (n=508)
Waiting time	49	35
Respect	59	67
Explanations	57	60
Decision-making	45	50
Privacy	48	65
Choice of provider	30	45
Cleanliness	46	58
Social support	56	--
Summary measure	48	54

3.2 Vignette Scores: Expectations in the Responsiveness Domains

As noted in the Methodology section, in order to examine differences in expectations between groups, we analyzed ratings of the standardized vignettes for each responsiveness domain. As seen in Figure 7, the distribution of responses to the vignettes is different in each domain. We split these ratings into high/low categories to compare vignettes with personal experience. For most domain scores, we assigned a rating of "relatively high" if they averaged over 4 ("good"). In the domains of privacy and cleanliness, because so few respondents gave ratings of "good" or "very good" to the vignettes, we used a cutoff of 3 instead of 4 to distinguish "relatively high" scores.

We do not believe that it is appropriate to interpret the differences across domains in the vignette scores as indicative of differences in the importance attached to the various domains or to the extent to which consumers are "demanding" with regard to the various domains, as the questions posed for each domain were quite different. The survey did include a separate set of questions on the importance of various domains, and the responses to those questions will be reported in Section 3.3.

Vignette Scores by Population Group and Income

As can be seen in Table 7, the vignettes in the domains of waiting time, respect, explanations, and privacy were rated higher by Arabs than Jews, and the domains of choice of provider and social support (i.e., the ease with which friends and relatives could visit) were rated lower. According to the philosophy behind the vignettes, this implies that Arabs have lower expectations in those domains where they rated the vignettes relatively high and higher expectations in those domains where they rated the vignettes relatively low.

The vignettes for the domains of respect, explanations, and choice of provider were rated higher by the lowest quintile than the highest quintile, while waiting time and social support were rated lower. Here, too, higher vignette scores imply lower expectations.

Note that inter-group differences cannot be completely and conclusively attributed to differences in expectations, as differences in question interpretation or scale use may also be playing a role. However, for our purposes, it is not critical to differentiate between these three factors, as our main objective is to differentiate between the impact of "actual experience" and all other factors that could influence responsiveness scores. Accordingly, for simplicity of presentation, in what follows we shall use the term "expectations" as shorthand for the influence of all of these factors.

Figure 7: Distribution of Responses, Standardized Vignettes (Percent)

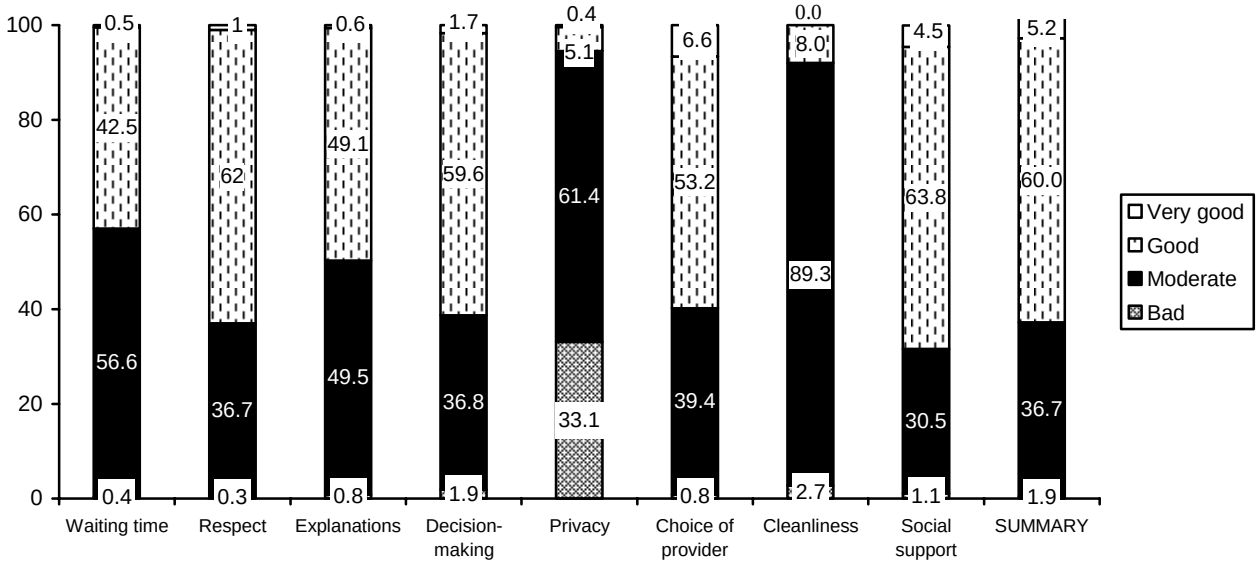


Table 7: Ratings on Standardized Vignettes, by Population Group and Income Group (Percent above Cutoff Level)

	Cutoff	Total	Arabs	Jews	Ratio A:J	Lowest quintile	Highest quintile	Ratio L:H
Waiting time	4	43.0	48.7	42.1	1.16	42.1	56.8	0.74
Respect	4	63.0	**84.6**	59.5	1.42	73.2	60.4	1.21
Explanations	4	49.7	**73.9**	46.6	1.59	**63.0**	30.2	2.09
Decision-making	4	61.3	62.5	61.0	1.02	66.6	61.5	1.08
Privacy	3	66.9	**83.7**	63.0	1.33	68.0	65.8	1.03
Choice of provider	4	59.8	53.1	61.5	0.86	**82.3**	52.6	1.56
Cleanliness	3	97.3	95.7	97.6	0.98	100.0	97.7	1.02
Social support	4	68.4	58.0	70.5	0.82	49.8	**82.7**	0.60
Summary	4	63.6	**70.0**	62.7	1.16	**68.1**	63.4	1.07

Data elements appearing in bold are significantly higher than the corresponding data element for the comparison group at the .05 level. No significance tests were available for the summary measure.

3.2.1 The Relationship between Standardized Vignettes and Personal Experiences

We next used these differences in vignette scores to explore a key issue raised in the previous section of this report: Are Arab-Jewish differences and low income-high income differences in assessments of the level of service received a product of real differences in the level of services provided or are they due to differences in expectations? This entailed comparing the Arab-Jewish and low-high income group gaps on the standardized vignette scores to the gaps on their assessment of their own experiences.

For the sake of clarity and concision, we will limit the following analysis to inpatient care. A similar analysis could be carried out with regard to ambulatory care (subject to limitations of sample size and sample representativeness discussed in the methodology section).

Population Group (Arabs vs. Jews and Others)

As shown in Table 8 and reported in section 3.1, in their assessment of personal experience, Arabs rated the summary responsiveness measure 9% higher than did Jews. From the summary measure, and from higher ratings by Arabs on seven of eight domains, it would appear at first glance that the Arab population is receiving better care than the Jewish population in all areas except for waiting time.

However, the data from the vignettes suggests that some of these differences may be due to differences in expectations rather than differences in actual service levels. For example, in the domain of explanations, although the Arab population assessed their personal experience as 13% higher than Jews, they rated the standardized vignettes 59% higher than the Jews. If both populations received the same standard of service, we would have expected personal assessment scores to differ by the same percentage – 59% – and not by "merely" 13%. Thus, it may be that in reality, Arabs are receiving less good service in this domain than Jews. A similar pattern emerged with regard to the respect and privacy domains.

A somewhat different pattern emerged with regard to waiting time. Arabs assessed their personal experience somewhat lower than did Jews and they rated the standardized vignettes higher than Jews. This may suggest that the true difference in actual service levels is larger than implied by the reported assessments, with Arabs receiving a far lower standard of service than the Jews do.

On the other hand, in the domains of autonomy, privacy, and choice, the Arab population rated their personal experience much higher than did Jews, while they rated the standardized vignettes only somewhat higher, or even lower than did Jews. This seems to suggest that in these areas the Arab population is indeed receiving better services than the Jews.

In yet a fourth pattern – obtained in the domain of cleanliness – the vignettes and personal experience scores were similar for Arabs and Jews.

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

	Assessment of personal experience (hospitalization)			Standardized vignettes		
	Arabs	Jews	Ratio A:J	Arabs	Jews	Ratio A:J
Waiting time	45.2	49.2	0.92	48.7	42.1	1.16
Respect	64.5	57.0	1.13	84.6	59.5	1.42
Explanations	63.0	55.7	1.13	73.9	46.6	1.59
Decision-making	54.4	42.6	1.28	62.5	61.0	1.02
Privacy	97.7	91.3	1.07	83.7	63.0	1.33
Choice of provider	40.8	27.4	1.49	53.1	61.5	0.86
Cleanliness	92.4	93.3	0.99	95.7	97.6	0.98
Social support	59.1	54.9	1.08	58.0	70.5	0.82
Summary	64.0	58.9	1.04	70.0	62.5	1.12

Income Group

A similar analysis of the relationship between assessments of personal experience and vignette scores was conducted among different income groups. As shown in Table 9 and reported in section 3.1, in their assessment of personal experience, the lowest and highest income groups rated the summary responsiveness measure the same. From the summary measure and from similar ratings among income groups in six of the eight domains, it would appear at first glance that there was no significant difference between income groups in the level of service received, with the exceptions of waiting time and social support, where the lowest income group reported receiving worse service.

However, the data from the vignettes suggest that these comparisons, which try to pick up differences in service levels, may be biased by differences in expectations. The lowest income group assessed overall responsiveness in the vignettes, as measured by the summary measure, 30% better than the highest income group. This may suggest that they are more inclined to give higher ratings in the same situations, perhaps due to lower expectations.

For example, in the domain of explanations, although the lowest income group assessed their personal experience as ***one*** percent higher than the highest income group, they rated the standardized vignettes ***109%*** higher than did the highest income group! If both populations received the same standard of service, we would have expected personal assessment scores to differ by the same percentage – 109%. Thus, it may be that in reality, the lowest income group is receiving significantly poorer service in this domain than the highest income group. A similar pattern emerged with regard to the respect and choice domains.

A somewhat different pattern emerged with regard to waiting time. The lowest income group rated their personal experience lower than the highest income group and rated the vignettes even lower, implying higher expectations. This may suggest that they are receiving the same or higher

level of service as the highest income group. This pattern can also be seen in the social support domain.

In the remaining domains of autonomy, privacy, and cleanliness, both the personal experience and vignettes were rated similarly by both income groups.

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

	Assessment of personal experience (hospitalization)			Standardized vignettes		
	Lowest quintile	Highest quintile	Ratio L:H	Lowest quintile	Highest quintile	Ratio L:H
Waiting time	42.0	51.6	0.81	42.1	56.8	0.74
Respect	64.0	59.4	1.08	73.2	60.4	1.21
Explanations	57.7	57.1	1.01	63.0	30.2	2.09
Decision-making	46.3	43.5	1.06	66.6	61.5	1.08
Privacy	92.4	92.0	1.06	68.0	65.8	1.03
Choice of provider	31.7	27.6	1.15	82.3	52.6	1.56
Cleanliness	91.9	92.0	1.04	100.0	97.7	1.02
Social support	56.1	64.5	0.87	49.8	82.7	0.60
Summary	60.3	60.9	0.99	68.1	63.5	1.07

Additional Analyses

An additional analysis looked at the differences between groups for each of the five vignettes used for each of the domains. In an analysis of the domains of respect and privacy, we found that in the extreme vignettes, where answers were mostly "very good" or "very bad," all groups – Arabs and Jews and lowest and highest quintiles – responded similarly. In the less extreme vignettes, for which answers were more spread out among the five possibilities, Arabs tended to give higher overall ratings than Jews. Among income groups there was some variation, but no prominent trend.

3.3 Importance of Responsiveness Domains

Each respondent was asked a set of questions about the importance of each of the eight responsiveness domains (without distinguishing between inpatient care and ambulatory visits). These questions serve two important purposes. First, they can help us think about how concerned we should be when a particular domain is found to be problematic in the responsiveness scores for either the population as a whole or a key population subgroup (as reported in section 3.1). If this domain is rated low in "importance" our concern will be less. Second, they lay the basis for more sophisticated summary measures of responsiveness than the simple averages we reported in section 3.1; they make it possible to weight domains by the importance attached to them by respondents.

Respondents were asked to rate the importance of the domains on a scale from 1 ("not at all important") to 5 ("very important"). The study team also calculated an average summary measure for overall responsiveness importance, so that when making inter-group comparisons we could easily identify whether certain groups tended to give higher "importance" scores.

In the entire population, the most important responsiveness domain was explanations, while the least important was choice of provider. Other highly rated domains were respect and cleanliness (Table 10).

Table 10: Importance of Responsiveness Domains

	% Very Important	Average Score
Waiting time	69.4	1.4
Respect	78.8	1.2
Explanations	83.5	1.1
Privacy	67.2	1.4
Choice of provider	52.5	1.5
Decision-making	62.9	1.4
Cleanliness	78.6	1.2
Social support	62.2	1.4
Summary measure	69.4	1.3

Population Group (Arabs vs. Jews and Others)

Figure 8 presents the percentage of respondents, by population group, who rated responsiveness domains as "very important." Arabs rated the summary measure six percentage points higher than Jews did. This underlying difference in response patterns should be taken into account when looking at the differences between these groups on the specific domains. Arabs rated most domains of responsiveness as more important than Jews, with particularly large differences for cleanliness, privacy, and waiting times. The difference with regard to cleanliness is not surprising, as it is a value that is emphasized in Islam. Arabs rated choice of provider much lower than did the Jews. This may be due to Arabs having a lower educational and socio-economic status and they may also be less used to choice in many areas of life. In addition, in the Arab population, individual choice may not be a high priority, as choice is often a familial or community matter and not an individual one. In the future, it will be useful to explore the extent to which the Arab-Jewish differences remain after controlling for differences in income, education, and other background variables.

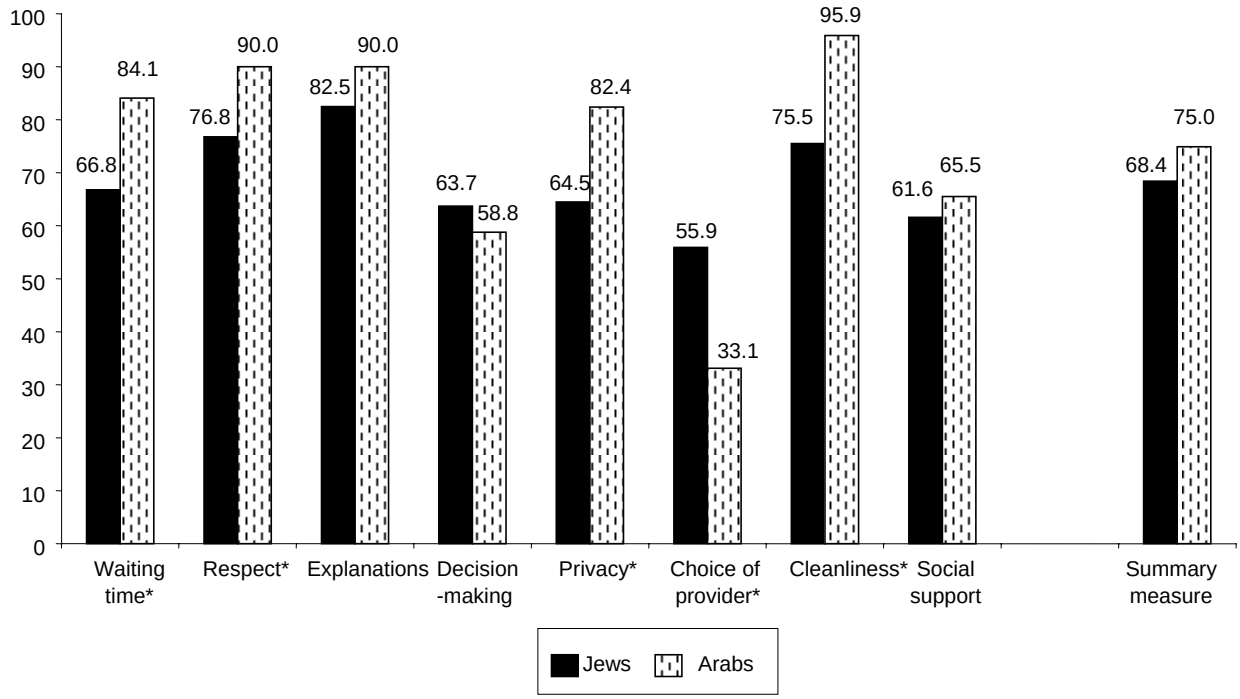
Jews rated explanations as the most important of the domains, while Arabs rated cleanliness of facility as most important. Both groups rated choice of provider the least important.

Income Group

As can be seen in Figure 9, the lowest quintile rated almost all domains of responsiveness as less important than the highest quintile; the key exceptions were cleanliness, which was rated significantly more important by the lowest income group. The summary measure was higher for the higher income group, though the difference was not large. The domain of explanations was rated significantly less important by the lowest quintile.

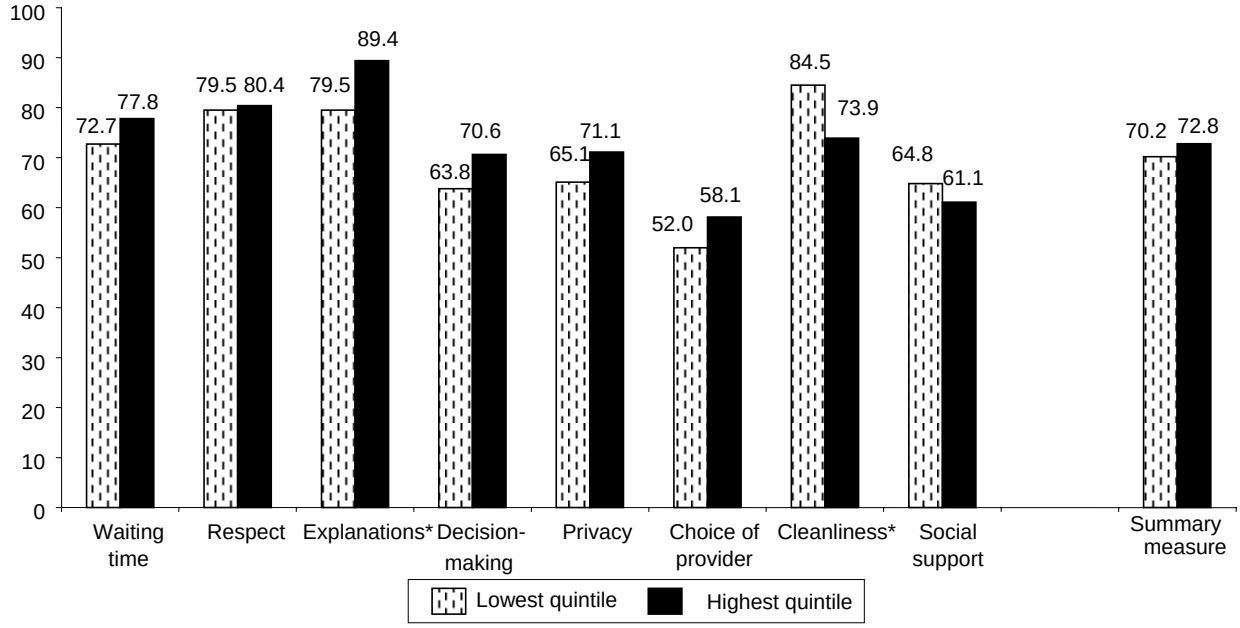
The lowest quintile rated cleanliness as most important of the domains, while the highest quintile rated explanations as most important. It is not clear to what extent the differences that were found are a result of income per se, as opposed to the higher concentration of Arabs and persons of limited education in the low-income group.

Figure 8: Importance of the Responsiveness Domains, by Population Group (Percent)



* Indicates that the difference between the two groups is statistically significant at the .05 level.

Figure 9: Importance of the Responsiveness Domains, by Income Group (Percent)



* Indicates that the difference between the two groups is statistically significant at the .05 level.

3.4 Selected International Comparisons

In this section we compare average responsiveness scores for Israel with those of the 14 European countries that fielded the survey by phone. The countries included were: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Sweden, United Kingdom, and Israel.

Unfortunately, we are unable to compare vignette scores for Israel and Europe, as WHO has not yet published the scores for the European countries. Thus, we cannot assess to what extent the Israel-Europe differences in responsiveness scores are due to differences in expectations and/or response category cut points, as opposed to differences in care.

It is also important to note that, unlike the rest of the report, this section examines the percentage of respondents who responded either "good" or "very good." While we would have liked to report the percentage who responded "very good" alone, and thereby maintain consistency with the other chapters of the report, we are unable to do so because to date WHO has not released data for Europe that distinguishes between "good" and "very good."

Table 11 summarizes the comparative data regarding inpatient care. The Israeli and European scores are very similar, except in the areas of choice[12] and amenities (cleanliness), where Israel

[12] In the Israeli version of the questionnaire, the choice question clearly refers to the direct care provider (e.g., the physician). The English version of the questionnaire is more ambiguous and could be taken to mean either hospital or direct care provider. We are not sure to what extent this ambiguity was resolved in the translated questionnaires administered in the various European countries.

scores substantially lower (60% vs. 70%, and 79% vs. 87%, respectively). The rankings of the domains were very similar in Israel and Europe; respect received the highest score and choice the lowest. On average, the percentage of Europeans giving "very high" scores was 2 points higher than among the Israelis.

Table 11: Inpatient Responsiveness in Israel and Europe (Percent reporting "good" or "very good")

Responsiveness	Israel	Europe
Waiting time	76.8	80.8
Respect	90.0	88.8
Explanations	86.6	83.5
Decision-making	78.8	78.9
Privacy	82.5	80.7
Choice of provider	59.9	69.8
Cleanliness	79.1	86.9
Social support	90.7	91.9
Summary	80.6	82.7

Table 12 summarizes the comparative data regarding ambulatory care. Here, too, the Israeli and European scores are very similar for most responsiveness domains. The exception is choice, where Israel again scores substantially lower than Europe (77% vs. 97%).[13] The rankings of the domains were very similar in Israel and Europe, except that in Europe "choice" was ranked highest of all the domains, while it was ranked sixth in Israel. In both, waiting time is ranked lowest. On average, the percentage of Europeans giving "very high" scores was 4 points higher than among the Israelis.

Table 12: Ambulatory Care Responsiveness in Israel and Europe (Percent reporting "good" or "very good")

Responsiveness	Israel	Europe
Waiting time	69.2	72.1
Respect	91.7	90.0
Explanations	86.5	87.1
Decision-making	79.8	82.6
Privacy	88.0	88.7
Choice of provider	76.9	97.3
Cleanliness	90.2	90.8
Summary	83.2	87.0

[13] It appears that in both Israel and Europe, respondents related to the choice of the direct care provider, rather than the choice of health plan. In Israel, provider was translated in a manner which makes it clear that the intention is the direct care provider, while most European countries do not offer a choice among competing health plans.

4. Discussion

This report underscores the importance of interpreting client assessments of health care or other services in light of 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.

At the national level, the study made it possible to compare responsiveness scores both across domains within Israel as well as between Europe and Israel for each domain. As Table 13 demonstrates, 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 both inpatient and ambulatory care, the ratings they gave were similar to those assigned by Europeans to this domain. In addition, while on the inpatient side, Israelis rate choice of provider low both relative to other domains and to Europeans, on the ambulatory side the picture is more complicated.

Table 13: Domains with Relatively High and Relatively Low Responsiveness

	Relative to Other Domains in Israel	Relative to the Same Domain in Europe
a. Inpatient Care		
Relatively High	Respect Explanations Social support	None
Relatively Low	Choice of provider	Choice of provider
b. Ambulatory Care		
Relatively High	Respect Privacy	None
Relatively Low	Waiting time	Choice of provider

With regard to subgroups within Israel, the study makes it possible to compare the responsiveness scores (reflecting personal experience) and the scores assigned to standardized vignettes (reflecting responsiveness). As we have seen, Arabs tended to give higher responsiveness scores than Jews in most cases, but they also tended to give much higher vignette scores – implying a lower level of expectations. This suggests that Arabs are more "satisfied" with the care they receive, but it also suggests that Arabs may, in fact, be receiving a lower level of service. The difference in the situation for "satisfaction" and "level of service" may be due, in part, to differences in levels of expectation.

The differences among income groups, with regard to both assessments of care and the vignettes, tended to be smaller and less consistent.

Leading health policy experts are divided on which of these – satisfaction or level of service – is the truly important parameter. Murray et al. (2001) have emphasized the importance of level of service (arguing that the level of service is what actually influences patients' health), and that is what led them to develop the use of anchoring vignettes. Blendon et al. (2001) have emphasized the importance of satisfaction (as satisfaction is what consumers actually experience). Our own view is that it is very important to monitor both satisfaction and level of service.

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.

From that perspective, we want to summarize our thinking on the uses and limitations of vignettes as a mechanism for learning about levels of service. First, we note that there is an alternative way to learn about the level of service – to ask objective questions, such as "How long did you wait?" and "Did the physician introduce himself by name?" The long form of the WHS does indeed include such questions, as do many other national and international surveys of health system performance. The main limitation of this alternative approach is that coverage of a domain such as respect may require a large number of objective questions and even then important dimensions that matter to key population subgroups could be left out.

Second, we note that vignette scores can be used in one of two ways. One way, as demonstrated in this paper, is that inter-group differences in vignette scores can be presented alongside inter-group differences in responsiveness scores, in order to place the latter in a broader perspective. This approach suggests alternative interpretations of responsiveness data, but is neither conceptually conclusive nor numerically exact. The other, more ambitious, way in which vignettes might be used, is to make numerical adjustments to the raw responsiveness scores. Indeed, that is the way in which Murray et al. (2001) intended to use them, but to date they have not provided a clear explication and illustration of how this is to be done using responsiveness data.

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

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Appendix I: The Components and Domains of Responsiveness

Responsiveness is divided into two main components: respect for persons and client orientation. Each of these is further divided into four domains. This appendix elaborates on the meaning and significance of each domain.

Respect for Persons

Respect for persons comprises four aspects: dignity, confidentiality, communication, and autonomy.

Dignity

Dignity may be defined as the right of a care seeker to be treated as an individual, rather than merely as a patient. Dignity includes safeguarding human rights, respectful treatment by health care staff, the ability to ask questions and receive information, and privacy during medical examinations and treatment.

Respect for patient dignity has been included in medical codes of ethics (Canadian Medical Association, 1996) and much of the literature on this topic refers to end-of-life issues. For example: "Dignity is often synonymous with dying well. The central notion is that of worthiness, elevation, honor, nobility …" (Johnson, 1998). In the WHS, dignity is assessed in a broader population and not just those who are near death.

Confidentiality

Confidentiality may be defined as keeping information relating to patients and their illnesses private, unless prior permission is received. The concept of confidentiality includes conducting consultations in a manner protecting privacy and safeguarding information learned from or about the patient within the course of evaluation or treatment. Under all circumstances, patients must determine who learns the details of their care and treatment.

Maintaining confidential relationships with patients provides a foundation for trust in the therapeutic relationship (Israel Medical Association, 1996; Kleinman et al., 1996). Without the understanding that their personal information be kept secret, patients may withhold vital facts. Confidentiality promotes the integrity of the physician-patient relationship and encourages the patient to be open about health problems, which is a prerequisite to care.

In Israel, the legal basis of medical confidentiality is governed by the following laws: Basic Law: Human Dignity and Liberty, 1992 (every person has the right to privacy); the Protection of Privacy Law 1981 (forbids interference with the privacy of an individual without prior consent); the Penal Law 1977 (information transmitted during the course of professional duties may not be disclosed); the Law of Evidence 1971 (physicians do not have to divulge confidential information under testimony); and disciplinary laws governing professional behavior (Kotler et al., 2000). In addition, the Patients Rights Law 1996 defines the physician's responsibility to preserve medical

confidentiality and the conditions under which a physician has the right or obligation to divulge medical information.

As noted above, the question that the respondents were asked was formulated in such a way as to reflect the ensuring of privacy during the consultation and did not explicitly relate to the broader issue of ensured confidentiality of information.

Communication

In the past, physicians used the medical interview primarily to obtain information from the patient. Today, in contrast, the interview includes two-way communication between patient and physician. Although attention has shifted from its earlier focus on the flow of information to the physician, there are many cases where adequate information is not communicated to the patients (Stoeckle, 1995).

Improved communication between patient and physician has been shown to improve satisfaction and biomedical outcomes. In a review of 21 randomized controlled trials and analytic studies of physician-patient communication, Stewart (1995) reported 16 significant correlations between communication and patient health, while five studies had insignificant or inconclusive results. The quality of communication both in the history-taking segment of the visit and during discussion of the management plan was found to influence patient health outcomes. The outcomes affected included emotional health, symptom resolution, function, physiologic measures (e.g., blood pressure and blood sugar level), and pain control.

Autonomy

Autonomy may be defined as self-directing freedom. With respect to medical treatment, autonomy includes the rights of an individual to information on his/her disease and alternative treatment options, the right to be consulted about treatment, informed consent in the context of testing and treatment, and the right to refuse treatment. For autonomy to prevail, the health care provider must disseminate information and leave decision-making to the patient. The importance of involving patients in decision-making is validated both by patient preference and ethical norms and by studies that show better medical outcomes in patients who have participated in decisions concerning their treatment than those who have not (Tidhar and Benbassat, 1995).

Some analysts argue that only in cases when patients are unwilling or incapable of making decisions should physicians refrain from facilitating patient decision-making (Madder, 1997). Others argue that additional factors may override patient autonomy, including scarce resources, perceived harm to the patient, or futility of the requested treatment and mental incompetence of the patient (Kerridge et al., 1995).

Another way of looking at autonomy is by examining different models of patient-physician relations. Emanuel and Emanuel (1992) discuss four models and their perception of patient autonomy:

1. Paternalistic: physicians use their skills to determine the patient's medical condition and to identify tests and treatment that are most likely to restore the patient's health and reduce pain. Patient autonomy is conceived to be patient assent to the physician's determination of what is best.
2. Informative: physicians provide all relevant information for the patient to select the intervention he wants. Patient autonomy is conceived to be patient control over medical decision-making.
3. Interpretive: the aim of the physician-patient relationship is to elucidate the patient's values and what he actually wants and to help the patient select the appropriate medical intervention.
4. Deliberative: physician helps the patient determine and choose the best health-related values through discussion, debate, critique, and resolution.

An additional model is the shared decision-making model, where physicians bring their medical training and knowledge, while patients bring knowledge of their subjective aims and values. Through this type of shared decision-making, risks and benefits of various treatment options can be evaluated. With this approach, selecting the best treatment requires the input of both patient and physician (Emanuel and Emanuel, 1992).

Another aspect of autonomy is consent – the autonomous authorization of medical intervention by an individual patient (Etchells et al., 1996). Obtaining valid consent requires that patients participate in problem solving as much as they wish, actively participate in decision-making, and authorize the decision.

Research among cancer patients and patients undergoing angiogram has found that patients prefer to participate in decision-making about their medical care and treatment, while preferring that the physician determine diagnosis, treatment options, and risks and benefits (Blanchard et al., 1988; Deber, 1994; Degner and Sloan, 1992; Vertinsky et al., 1974). Alternatively, however, Ende et al. (1989) found that as patients' illnesses increased in severity, their desire to make decisions declined and they preferred the physician to take a more prominent role as decision-maker. Another factor that may affect desire to participate in decision-making is the level of knowledge required for the decision (Thompson et al., 1993).

Israel is grappling with whether it can accommodate the idea of patient autonomy, and, if so, how. One of the first attempts at this is the Patient Rights Law 1996, which accords patients the right of informed consent while denying them the right of informed refusal (Gross, 1999; Weil, 1998). That is, patients cannot decide to refuse a treatment recommended by a physician. Treatment refusals are resolved by committees that are accorded juridical status to resolve patient-physician disputes and enforce treatment where necessary. The law assumes that refusal to accept medically indicated treatment is, in most cases, irrational and attributable to the patient's

ignorance or misunderstanding of important data. Israel is not the only country to limit autonomy in favor of preserving life (Glick, 1997).

Client Orientation

The second aspect of responsiveness, client orientation, comprises prompt attention, social support, basic quality of amenities, and choice of provider.

Prompt Attention

Receiving medical attention promptly has been found to be a major determinant of patient satisfaction with primary and hospital health care. Prompt attention includes both quick access to medical care and short waiting times at clinics. A study in an Israeli primary military clinic found that the "time factor," which includes time spent scheduling an appointment and waiting at the clinic, is a major determinant of overall satisfaction (Bar-Dayan et al., 2002). Another study of satisfaction with Veterans Affairs and county-funded health care systems in the United States found that shorter waiting times contributed to differences in patient satisfaction (Piette, 1999). Studies of satisfaction with emergency departments found that the total time spent waiting for the clinician or nurse was among the most significant predictors of patient satisfaction (Berg-Warman et al., 2001; Dansky and Miles, 1997).

Social Support

Social support describes the comfort, assistance, and/or information received through formal or informal contacts with individuals or groups. Previous research has shown that social support protects or buffers individuals from the negative consequences of stressors, that social supports may encourage or discourage use of health services, that there is a relationship between social support and adherence to medical instructions, and that social support is related to recovery from disease, rehabilitation, adaptation to chronic illness, and mortality (Wallston et al. 1983).

Basic Quality of Amenities

Amenities relates to such factors as the cleanliness of the facility, accessibility to showers and bathrooms, comfort of beds, and the quality of building maintenance. One study of over 5,000 discharged patients from general hospitals found basic amenities to be significantly associated with general satisfaction with the hospital (Yuval and Berg, 1997). Another study of over 3,000 patients discharged from emergency departments found a high correlation between satisfaction with cleanliness and other amenities and general satisfaction (Berg-Warman et al., 2001).

In the survey, respondents were asked to rate the cleanliness of the facility and were not asked about the overall quality of the amenities.

Choice of Provider

The issue of provider choice is relevant to both inpatient and ambulatory settings. In the inpatient setting, it can relate to either choice of hospital or choice of physician. In the ambulatory setting, it can relate to choice of health plan, choice of group practice, or choice of a particular physician.

Being able to choose one's health care plan has been shown to increase subsequent patient satisfaction with the plan. Similarly, the ability to choose one's primary care physician has also been found to influence subsequent satisfaction (Kersnik, 2001; Schmittdiel et al., 1997).

Appendix II: Responsiveness Questions

As explained in the report, in the domains of confidentiality and amenities, the questions that were put to the respondents referred to the more limited areas of privacy and cleanliness, respectively.

Personal Respect

Dignity

For your last hospital stay, how would you rate your experience of being greeted and talked to respectfully?

Confidentiality

For your last hospital stay, how would you rate the way the health services ensured you could talk privately to health care providers?

Clarity of Communication

For your last hospital stay, how would you rate your experience of having things explained to you how clearly by the health care providers explained things to you?

Autonomy

For your last hospital stay, how would you rate your experience of being involved in making decisions about your health care or treatment?

Client Orientation

Prompt Attention

For your last hospital stay, how would you rate the amount of time you waited before being attended to?

Social Support

For your last hospital stay, how would you rate the ease of having family and friends visit you?

Quality of Amenities

For your last hospital stay, how would you rate the cleanliness of the rooms inside the facility, including toilets?

Choice of Provider

For your last hospital stay, how would you rate the freedom you had to choose your health care providers?

Appendix III: Vignette Examples

The following five vignettes were presented regarding the dignity domain. The Hebrew names were replaced by typically Arabic names in the vignettes presented to the Arab population.

1. Elisheva took her baby for a vaccination. The nurse said "hello," but did not ask for Elisheva's name or that of the baby. The nurse also examined Elisheva and made her remove her shirt in the waiting room.
2. Leora had bad flu. She went to the clinic. The nurse expressed concern about Leora's cough and called the doctor, who gave Leora a full chest examination behind a large screen that hid her from the view of other patients.
3. Naomi was pregnant and went to the hospital coughing blood. A nurse welcomed her gently and helped her to a private room. A female doctor came to examine her and gave her a clean gown to replace her blood-stained clothes.
4. Shula went to a crowded clinic. At first, no-one greeted her but after waiting for five minutes a nurse called her to the examination area where she was examined behind a small screen that mostly hid her from the other patients.
5. Shifra has AIDS. When she goes to her health center, the nurses do not talk to her and deliberately ignore her. During examinations, her clothes are removed, and she is made to wait, half-naked, in the waiting room.

Each was followed by the question: How would you rate her experience of being greeted and talked to respectfully?

The following five vignettes were presented regarding the confidentiality domain.

1. Ruth was speaking to her doctor about an embarrassing problem. There was a friend and a neighbor of hers in the crowded waiting room and because of the noise the doctor had to shout when telling Ruth the treatment she needed.
2. Yaffa usually spoke to her doctor about her illness in complete privacy. Once Yaffa heard that the doctor had spoken to her friend about her illness. She asked her doctor not to do it again. He did not do it again.
3. Chana was asked to describe a serious health problem to the doctor in the middle of the waiting room. The doctor repeated everything to the nurse and all the other patients, many of whom knew her family, could hear everything.
4. Adina had her consultation in a small private room. During the consultation, a nurse occasionally walked in and listened to the conversation. Sometimes she forgot to close the door so people in the waiting room could overhear parts of their conversation.

5. Shifra visited the doctor regularly. Her doctor always took Shifra to a private room before discussing her illness. The doctor was aware that Shifra was very sensitive about her health condition and would never talk about it to anyone or in front of anyone without Shifra's permission.

Each was followed by the question: How would you rate the way the health services ensured she could talk privately to health care providers?

Appendix IV: Demographic Characteristics by Population Group

	Total	Jews and Others	Arabs
Population size (N)	4,273,070	3,630,300	642,770
Sample size (n)	1,266	1,050	186
Gender (%)*			
Men	48.3	47.9	50.4
Women	51.7	52.1	49.6
Age (%)*			
18-44	58.1	55.1	58.1
45-64	27.2	28.6	27.2
65+	14.8	16.3	14.8
Education (%)*			
0-8 years	10.1	7.7	23.5
9-12 years	42.9	40.8	54.7
13+ years	47.0	51.5	21.8
Region (%)*			
Central	67.4	66.7	70.9
Periphery	32.6	33.3	29.1
Work status (%)*			
Works	62.6	65.0	48.4
Does not work	37.4	35.0	51.6
Of those: unemployed*	12.7	13.6	9.4
Health plan (%)*			
Clalit	53.3	51.1	66.1
Maccabi	20.6	23.1	6.5
Meuhedet	11.7	12.0	9.8
Leumit	10.8	9.6	17.6
Other	3.5	4.2	--
Mean number of persons per household*	3.8	3.6	5.2

* $p < 0.05$ between Jews and others and Arabs

Appendix V: Multivariate Analyses

As shown in Appendix II, the Arab population is younger and less well-educated than the Jewish population. Ordinary least squares regressions were used to explore the extent to which Arab-Jewish differences in average responsiveness and vignette scores are associated with differences in the age, gender, and education mix between the two groups.

The dependent variable in the analyses was a dummy variable, that assumed the value "1" if the respondent's summary responsiveness score was at least 4.33, and "0" otherwise.

As can be seen in Table V-1, we found that virtually none of the Arab-Jewish difference in inpatient responsiveness could be attributed to age, gender, or even education. Table V-2 indicates that that when it comes to ambulatory responsiveness, controlling for age, actually *increased* the Arab-Jewish difference, while controlling for gender and education, did not affect the size of the Arab-Jewish differences.

These findings indicate that variable "population group" has a strong independent effect on ratings of personal experience with responsiveness. This makes the exploration of whether the Arab-Jewish differences in personal experience rates could be attributable to differences in expectations – the primary subject of the main body of this paper – all the more important.

Note that even if, contrary to the actual findings, we had found that the Arab-Jewish differences in vignette scores were completely attributable to differences in age, gender, and/or education, it would still be important to explore whether the Arab-Jewish differences in responsiveness scores were due to differences in actual experience or differences in expectations. Even in that it case it would have been possible that expectations were playing an important role.

We considered using multivariate analysis to explore the extent to which Arab-Jewish differences in ratings of personal experience could be attributed to differences in vignette scores (i.e., by adding vignette scores as explanatory variables to the regressions presented in Tables V-1 and V-2). However, we were precluded from doing so by the fact that each respondent rated vignettes for only two of the domains, with the result that only a very small sample of Arabs rated the vignettes for each particular domain. It would be most useful to carry out such an analysis in future studies with larger samples.

Table V-1

Linear Regression Results Dependent Variable: Inpatient Responsiveness			
Model #	1	2	3
Arab	**0.22**	**0.23**	**0.21**
Age			
18-24		**-0.21**	**-0.20**
45-64		0.03	**0.03**
65+		0.04	0.03
Gender		-0.03	-0.03
Education			
9-12			-0.14
13+			-0.10
Constant	4.12	4.14	4.26
R-squared	0.13	0.20	0.21

Note: Parameters that appear in bold were found to be statistically significant at the .05 level.

Table V-2

Linear Regression Results Dependent Variable: Ambulatory Responsiveness			
Model #	1	2	3
Arab	0.21	**0.29**	**0.30**
Age			
18-24		**-0.28**	**-0.29**
45-64		**-0.07**	**-0.07**
65+		-0.01	0.00
Gender		0.07	-0.03
Education			
9-12			0.19
13+			0.19
Constant	4.29	4.29	4.13
R-squared	0.08	0.18	0.20

Note: Parameters that appear in bold were found to be statistically significant at the .05 level.