THE ADEQUACY OF HEALTH CARE AND CONSUMER SATISFACTION

A report from the programme on the Health Situation and Trend Assessment

WORLD HEALTH ORGANIZATION
Regional Office for Europe
COPENHAGEN

25532

THE ADEQUACY OF HEALTH CARE AND CONSUMER SATISFACTION

Report on a WHO Meeting

Copenhagen
23-25 April 1985

ICP/HST 103/s01
8174D
ORIGINAL: ENGLISH

1985

Note

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted, quoted or translated without the agreement of the World Health Organization Regional Office for Europe. Authors alone are responsible for views expressed in signed articles.

CONTENTS

Introduction

The WHO Regional Office for Europe sponsored the first meeting of a Working Group on the Measurement of the Adequacy of Health Care and Consumer Satisfaction, held in Copenhagen from 23 to 25 April 1985. The Working Group will develop guidelines for the measurement of the adequacy of health care and consumer satisfaction. This project will complement the preparation of a set of standardized methods for comparative analyses of health care programmes and services in the European Region.

Dr A. Romensky welcomed the participants on behalf of Dr J.E. Asvall, Regional Director for Europe. In this first short meeting, the Group discussed the aims and objectives of the project, elaborated the target areas to be measured, reviewed potential sources of data and divided future work among its members. The Group discussed six working papers; these are listed in Annex 2 and are available from the Epidemiology and Information Support unit of the Regional Office for Europe. The list of participants, who came from France, Greece, the Netherlands, Sweden, the United Kingdom and the USSR, can be found in Annex 3.

Aims and objectives

Guidelines to measure the adequacy of health care and consumer satisfaction will be developed to help health care administrators assess the ability of health care to meet the needs of the population, in both quantitative and qualitative terms.

An assessment of people's needs must consider both normative and perceived needs. The demand for medical services, resulting from needs, is partly only potential, not explicit. Explicit demand in its turn is only partly satisfied by the health care system or medical consumption. Information about underconsumption and

overconsumption of services would partly reveal the ability of the health care system to meet the needs of the population.

Wondering about the type and number of guidelines to be developed, the Working Group deliberated on the scope necessary for future studies about adequacy of health care and consumer satisfaction. Probably the scope of future research will differ among countries, because of their different levels of development in health care. For instance, the emphasis on primary health care varies widely among countries, as the adoption of new technology seems to do. At this preliminary stage of the preparation of guidelines, it is probably wise to examine all sectors of the health care system and to try to develop a variety of guidelines designed for specific problems.

Components of adequacy

The Working Group adopted tender loving care[a] as an additional component of adequacy, because it is not properly covered by the usual components: effectiveness and efficiency. To measure adequacy, one should not consider these three components separately, but should consider their interaction. In addition, the three components not only interact but also contain some of the same elements.

The following definition seems to be fruitful: health care is adequate when it reaches the people in need, does the most good and the least harm and is efficiently organized, from the viewpoint of the community and the people in need as well as in terms of organization.

---

[a] Cochrane, A.L. *Effectiveness and efficiency: random reflections on health services*. London, Nuffield Provincial Hospitals Trust, 1972.

Adequate health care reaches people in need when it is available, accessible, acceptable and known to them. In addition, the cost of services to patients affects both accessibility and acceptability.

Adequate health care does the most good and the least harm. This component covers both effectiveness and tender loving care, so effectiveness now has a wider meaning that includes the possible ill effects of treatment. The latter should include physical side effects, impact on social life and psychological and economic effects. This component is very broad, because effectiveness should not be measured without considering the various possible ill effects of health care.

Finally, adequate health care is efficienctly organized. All too often, efficiency is restricted to organizational efficiency, with little or no regard for its impact on patients and their relatives. Including the viewpoint of the community implies a subtle evaluation of the economics involved and that choices between institutional or community care, for instance, can only be made after the effects of the health care system on people's lives have been considered.

Target areas for measurement

The Working Group adopted a list of six broad target areas:

- the resources used for health care;
- all the activities related to health care (medical consumption);
- the health status of the population;
- the health education of the population;
- consumer satisfaction;
- organizational functioning.

The resources used for health care include manpower, knowledge, technology, material and financial means. The financial aspect includes the study of health insurance systems.

All the activities related to health care or medical consumption include inpatient and outpatient care, therapeutic actions and tender loving care, as well as activities promoting health, preventing illness and related to rehabilitation and maintenance.

The health status of the population includes surveys of perceptions of health, diseases and their consequences, indicators of mental health and weight related to height, along with morbidity and mortality statistics and vital statistics. Measuring the health status of the population, however, involves serious problems.

The fourth target area is the health education of the population. This item is listed separately because the level of the population's health education is presumed to have great influence on consumer satisfaction and use of medical care.

Consumer satisfaction includes consumers' evaluations of the availability, assessibility, acceptability, affordability and continuity of medical care, along with the quality of information given, and medical and nursing activities and their consequences.

A description of organizational functioning is still being made.

Only a limited number of the elements of the target areas can be studied in the near future. The Working Group will select elements for measurement at a future meeting to facilitate the start of the project.

Definition of consumer satisfaction

For the time being, the Working Group agreed on a provisional definition of consumer satisfaction. This definition probably needs further elaboration or refinement.

Consumer satisfaction or dissatisfaction is the result of evaluations made by individuals of discrepancies between perceived needs and received medical care. A measurement of the adequacy of health care is incomplete without an assessment of consumer satisfaction.

Aspects of the study of consumer satisfaction

What can be done with the knowledge gained about consumer satisfaction? Will the health care system respond to this information? These questions should be kept in mind.

To get meaningful results, the general concept of satisfaction has to be broken down, for research, into rates of satisfaction with several aspects of health care. First are the medical and technical aspects; the individual patient can hardly evaluate these. However, the patient must deal with the results and side effects of medical treatment and will certainly have opinions on them. Organizations of patients, assisted by professionals, do evaluate the medical and technical aspects of health care. Frequently, they behave like pressure groups, gaining benefits at the cost of the unorganized population. General research on satisfaction screens and protects the latter. There are also numerous nonmedical aspects of health care, such as the conditions of life in hospitals. That includes the invasion of privacy, the quality of information, emotional support, and relations with professionals.

Sources of data

Comprehensive information about the adequacy of health care and consumer satisfaction cannot be derived from any single source of data. For that reason, eight sources are listed, although their sequence does not indicate priority. Their potential contribution to the measurement of adequacy and satisfaction and their methodological limitations are mentioned briefly.

In some countries with centralized planning systems, professional surveys of the population, including medical examinations, have been used to estimate health status and the normative needs of the population. Medical examinations reveal the hidden part of the iceberg of morbidity, facilitating planning for future provision of health care.

Health interview surveys among the general population are made in a number of countries, and others are preparing to make them. Although the surveys differ in methods, they all contain items about health and perceptions of health, the complete range of medical consumption, and the proper demographic and socioeconomic variables. Data from these surveys can be used to measure adequacy and satisfaction. Presumably, the majority of health interview surveys are flexible enough to add extra questions about adequacy and satisfaction.

Mortality statistics are a classical measure of results and are extremely useful in a limited field. Sometimes problems arise with the definition and identification of the cause of death. Variations in mortality rates have been used as indicators of need in different areas or among different groups, but do such variations really reflect different needs? Higher mortality rates in men do not imply less need for health care in women. Variations in stillbirth and infant mortality rates can identify differences in social class that can suggest differences in needs and in the distribution of services.

Statistics from services show the distribution and use of services by different groups of the population. Statistics on hospital morbidity have been used as indicators of the need for services. To find proper indexes of adequacy, however, the statistics on services need to be considered along with information about needs of the population. Information about the cost of services can give insights into organizational functioning and efficiency.

Surveys of random samples of patients and potential patients provide data on the patients' knowledge about different types of care and on their perceived needs. In addition, such surveys can provide information about the accessibility and acceptability of frequently needed types of care. Many hospitals now survey their patients to collect information about satisfaction with various events occurring during hospital stay.

Studies of patients given particular types of care or no care include the classical randomized control trial, with various specific measures of outcome. Because of methodological problems, these trials are by no means easy to design. They must be kept in mind, however, because they offer possibilities of studying the effects of care on patients. Another type of study falling under this heading is the follow-up survey of patients who have received particular types of care. This approach seems to be undervalued and underused; it can give illuminating insights into the appropriateness of intervention and the patients' problems after care has been given.

Surveys and studies of professionals providing care can yield evidence of the existence of particular forms of care. For instance, to what extent do primary care physicians see preventive care as part of their role? Are they able and willing to give domiciliary care to the housebound? What part do they play in the organization of tender loving care for the terminally ill? Such

studies can also be used to audit the nature and quality of care provided. In addition, they can throw light on the organization of care.

Surveys of nonprofessional providers of care can be made, studying the relatives, friends and neighbours who provide so much day-to-day and tender loving care, particularly for chronically ill people. These surveys reveal the gaps and inadequacies of other types of care along with some of their strengths.

Conclusions and recommendations

The Working Group did not complete its discussion of specific instruments for the measurement of adequacy and consumer satisfaction during its first meeting. The participants decided to provide complementary information on methods derived from their own experiences, to facilitate the start of the development of draft guidelines for measurement. Each member of the Group will cover two of the six target areas, giving the first of them priority. Dr Cartwright will cover consumer satisfaction and health status. Professor Katsouyannopoulos will cover health education and resources. Dr Novgorodcev will cover resources and health education. Dr Berggren will cover organizational functioning and activities. Dr Mizrahi will cover activities and health status. Dr van den Berg will cover health status and consumer satisfaction. The descriptions should reach the Regional Office by the end of June 1985. The participants were encouraged to consult each other whenever appropriate.

Two members of the Group will be selected to develop drafts of guidelines, and these should be available by the end of October 1985. They will be distributed to all the members of the Group before the end of this year. The members will look for opportunities for pilot tests of some of the guidelines in their countries.

The Group planned its next meeting for March 1986, to discuss, amend and complete the draft guidelines. Proposals for pilot studies will be reviewed during the second meeting, and some will be chosen for testing. The Group will also discuss the methodological and technical details of these pilot studies.

The pilot studies will take place between April 1986 and April 1987. Reports will be sent to the WHO Regional Office for Europe and then distributed among the participants.

The third meeting of the Working Group, according to present planning, will take place in September 1987, to discuss and amend the draft guidelines in light of the experiences and insights gained during the pilot studies. The resulting draft guidelines are scheduled to be issued by the Regional Office in 1987.

Countries in the European Region will be encouraged by WHO to test the guidelines during 1987-1989. Experiences gathered from this continued testing will probably necessitate a final meeting of the Working Group by 1990 to construct the final guidelines that will be officially issued in 1991.

To increase the size of the Working Group, some participants could be invited from countries not yet represented. The Regional Office will attempt to find new members, and the participants are also encouraged to suggest names of experts.

Annex 1

DEFINITIONS*

Consumption of medical care

The utilization of health services by an individual or a group of individuals.

Adequacy

The allocation of activities and resources in manner and quantity sufficient to permit the achievement of desired objectives.

It is basically considered as the measure of a programme's actual coverage in relation to its target population.

Consumer research

The collection, recording and analysis of information obtained from purchasers and users relating to specified products or services, together with their suggestions for making those products or services more suitable to their requirements.

The concept of consumer research may have an application in the field of health services, with the patient or user of services put in the place of the "consumer".

---

* Hogarth, J. *Glossary of health care terminology*. Copenhagen, WHO Regional Office for Europe, 1976 (Public Health in Europe, No. 4), pp. 21, 70, 71, 380.

Satisficing

The term implies that decision-making is not entirely a rational process because such factors as maximizing or optimizing are, in real life, not always possible. On the other hand, where an individual or an organization gains more satisfaction from a decision than had previously been achieved, without complete rational maximizing, this then is the concept of satisficing.

To satisfice is to do "well enough" but not necessarily "as well as possible".

Annex 2

WORKING PAPERS*

ICP/HST 103/s01/6	Target areas and specific instruments for measurement, by L. Berggren
ICP/HST 103/s01/7	Components of the adequacy of health care and approaches to the sources of data for measurement, by A. Cartwright
ICP/HST 103/s01/8	Planning of health resources for providing adequate medical care for the population, by G.A. Novgorodcev
ICP/HST 103/s01/9	Measurement of the adequacy of health care and consumer satisfaction, by V. Katsouyannopoulos
ICP/HST 103/s01/10	Measurement of the adequacy of health care and consumer satisfaction, by Andrée and Arié Mizrahi
ICP/HST 103/s01/11	Measurement of the adequacy of health care and consumer satisfaction, by J. van den Berg

* Copies available from the Epidemiology and Programme Support Unit, Regional Office for Europe, World Health Organization, 8 Scherfigsvej, DK-2100 Copenhagen Ø, Denmark.

Annex 3

PARTICIPANTS

Temporary Advisers

Mr J. van den Berg
Netherlands Central Bureau of Statistics, Department for Health Statistics, Heerlen, Netherlands (Rapporteur)

Mr L. Berggren
Head of Investigations, Planning Board of Health Care of the Swedish Western Region, Gothenburg, Sweden

Dr A. Cartwright
Institute for Social Studies in Medical Care, London, United Kingdom (Chairman)

Professor V. Katsouyannopoulos
Department of Hygiene, Medical School, University of Ioannina, Greece

Dr A. Mizrahi
Directeur, Centre de recherche d'etude et de documentation en economie de la santé (CREDES), Paris, France

Dr G.A. Novgorodcev
Semasko Institute of Social Hygiene and Public Health Organization, Ministry of Health of the USSR, Moscow, USSR

WHO Regional Office for Europe

Dr A. Romensky
Statistician, Epidemiology and Information Support