Social Science & Medicine 186 (2017) 139–147

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Patient-perceived responsiveness of primary care systems across Europe and the relationship with the health expenditure and remuneration systems of primary care doctors

Anna Maria Murante, PhD [a, *], Chiara Seghieri, PhD [a], Milena Vainieri, PhD [a], Willemijn L.A. Schäfer, PhD [b]

[a] Scuola Superiore Sant'Anna, Istituto di Management, Laboratorio Management e Sanità, Italy
[b] NIVEL – the Netherlands Institute for Health Services Research, The Netherlands

ARTICLE INFO

Article history:
Received 20 September 2016
Received in revised form
29 May 2017
Accepted 2 June 2017
Available online 6 June 2017

Keywords:
Primary care
Responsiveness
Remuneration and health expenditure

ABSTRACT

Background: Health systems are expected to be responsive, that is to provide services that are user-oriented and respectful of people. Several surveys have tried to measure all or some of the dimensions of the responsiveness (e.g. *autonomy*, *choice*, *clarity of communication, confidentiality, dignity, prompt attention*, *quality of basic amenities, and access to family and community support*), however there is little evidence regarding the level of responsiveness of primary care (PC) systems.
Methods: This work analyses the capacity of primary care systems to be responsive. Data collected from 32 PC systems were used to investigate whether a relationship exists between the responsiveness of PC systems and the PC doctor remuneration systems and domestic health expenditure.
Results: There appears to be a higher responsiveness of PC when doctors are paid via capitation than when they only receive a fee for services or a mixed payment method. In addition, countries that spend more on health services are associated with higher levels of dignity and autonomy.
Conclusion: Quality, as measured from the patient's perspective, does not necessarily overlap with PC performance based on structure and process indicators. The results could also stimulate a new debate on the role of economic resources and PC workforce payment mechanisms in the achievement of quality goals, in this case related to the capacity of PC systems to be responsive.

1. Introduction

Health systems are expected to achieve three specific goals: "Good health, responsiveness to the expectations of the population, and fairness of financial contribution" (World Health Organization, 2000). Here responsiveness means being able to ensure *autonomy*, *choice*, *clarity of communication, confidentiality, dignity, prompt attention*, *quality of basic amenities, and access to family and community support* (Valentine et al., 2003). This is especially true for primary care systems. In fact, over their lifetime the entire general population has more access to primary care (PC) than any other healthcare setting. PC is a universally accessible service for individuals, families and communities (Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978), and its tasks include ensuring the coordination of care provided in several settings (Starfield, 1998). It provides continuity of care throughout the lifetime of individuals by meeting their current or potential health and non-health needs (Starfield, 2011a). However, despite these PC goals being universally shared, how and to what extent they are achieved differs widely from country to country.

Our main aim was to provide new and more generalizable insights into the determinants of the variations in the levels of responsiveness of PC systems using data from 32 countries, which were collected through the QUALICOPC study funded by the European Commission. The 32 countries considered in the studies differ from each other in terms of their national health system, financing systems and definition/use of care setting. Due to these differences, we first expected to find a large variability in the capacity of PC systems to be responsive (*Hypothesis 1*).

The second aim was to identify the determinants of this variability at both individual and country levels. We hypothesized that

* Corresponding author. Piazza Martiri della Libertà 33, 56127 Pisa, Italy.
E-mail address: a.murante@sssup.it (A.M. Murante).

http://dx.doi.org/10.1016/j.socscimed.2017.06.005

part of this variability might be explained in terms of both patients and practices' characteristics due to both patient expectations and the heterogeneity in how practices work (*Hypothesis 2.1*). We also analyzed the relationship between PC responsiveness and the remuneration mechanisms of PC doctors (*Hypothesis 2.2*), the country total health expenditure (THE), and the private expenditure (PvtHE) (*Hypothesis 2.3*). Sections 2 and 3 describe the state of the art of the literature on the measurement of responsiveness in the healthcare sector, and whether there is any evidence of a relationship between responsiveness and economic conditions.

2. Primary care and health systems responsiveness

Little knowledge is available on the responsiveness of primary care systems, and in most cases it relates to a specific population or individual/few countries. Kerssens et al. analyzed the experience of a fragile population composed of more than 5000 patients with a disability, COPD or rheumatism and elderly patients from 12 different countries (Belarus, Denmark, Finland, Greece, Ireland, Israel, Italy, the Netherlands, Norway, Portugal, Ukraine, and the United Kingdom) (Kerssens et al., 2004). They found a heterogeneous performance among countries in relation to the domains: e.g. data showed a high level of respect for dignity (with a small variance at the patient level), but low scores for prompt attention (with a large variance at the patient level). However, due to the populations involved in the responsiveness measurement, this result cannot be generalized to the whole population assisted by PC professionals. Schoen and colleagues also showed different levels of responsiveness in five primary care systems (Australia, Canada, New Zealand, the United Kingdom, and the United States) based on Commonwealth Fund International Surveys (Schoen et al., 2004). Differences referred to doctor-patient communication, timeliness and choice of provider, with better experiences reported by patients from New Zealand and Australia. Ten years later, new data from the same survey (edition 2013, 2014) confirmed the across-country variability in ensuring prompt attention to population needs (Osborn et al., 2014; Schoen et al., 2013).

More evidence on responsiveness comes from surveys investigating the responsiveness of the overall health care system (e.g. WHO's Multi-Country Survey Study on Health and Health System Responsiveness, the Commonwealth Fund International Health Policy Survey, World Health Survey, etc.) (Üstün et al., 2003; Ustun et al., 2001; Schoen et al., 2004; Robone et al., 2011). For example, the WHO survey highlights that prompt attention, dignity, and communication had the highest importance-rates across 35 and 41 countries, respectively and a summary of the responsiveness-score highlights a large variability worldwide (from 3.69 to 8.10, on a 0–10 scale) (World Health Organization, 2000; Valentine et al., 2008). Coulter et al., who focused on doctor-patient communication, treatment decisions and the choice of provider, found medium-low patient-reported experiences and a higher variability for patient involvement scores across eight countries (Germany, Italy, Poland, Slovenia, Spain, Sweden, Switzerland, and the UK) (Coulter and Jenkinson, 2005).

We contribute to the above literature by providing an explanation of the determinants of the variability in the responsiveness of PC systems.

3. Responsiveness and economic conditions

With regard to the impact of economic conditions and the responsiveness of PC systems, to the best of our knowledge, only a few studies have provided generalizable evidence on the relationship between the responsiveness of PC systems and health expenditure or workforce remuneration systems.

There appear to be no official and comparable data on PC health expenditures at the international level, and studies that attempt to measure it have reported very variable results (Kringos et al., 2013a), also due to the difficulties in collecting and recording this type of information. The published data are often collected by surveys conducted among patients or PC professionals and refer to their individual economic resources. For example, Schoen and Osborn's studies describe the per capita spending on health insurance or the out-of-pocket spending on medical expenses of an adult population (Osborn et al., 2014; Schoen et al., 2004, 2013). These studies also describe whether patients received prompt attention (e.g. a prompt appointment), however the authors did not analyze whether there is a relationship between prompt attention and the resources the patients invest in their health. It would seem that countries with a lower percentage of patients declaring high out-of-pocket medical expenses (i.e. $2000 or more) tend to have a higher level of prompt attention (the percentage of patients who obtain a prompt appointment), although with some exceptions such as Switzerland.

Other studies, based on WHO surveys, have investigated the association between health expenditure and the responsiveness of the overall health system (Valentine et al., 2012), (Busse et al., 2012), (Valentine et al., 2000). Analyzing the OECD country data, Anderson and Hussey observed that there is a strong positive relationship between health spending per capita and the overall WHO responsiveness score (Anderson and Hussey, 2001). De Silva (2000), who extended the above relationship for each dimension of responsiveness, found a positive association (i) between dignity, confidentiality, prompt attention, quality of amenities and GDP per capita; and (ii) between prompt attention, quality of amenities and per capita health expenditure. Finally, Robone et al. used data from a World Health Survey drawn from seventy countries who joined the survey between 2002 and 2003; for each country, the number of respondents varied from 600 to 10,000 (Robone et al., 2011). They concluded that health care expenditure is positively associated with all the dimensions of responsiveness, with the exception of prompt attention and choice of provider.

Several studies report an association between employment status and the remuneration system of the PC workforce with PC quality and outcomes (Donaldson and Gerard, 1989; Gerdtham et al., 1992; Gervas et al., 1994; Kringos et al., 2010a; Kringos et al., 2010b; Kuusela et al., 2004; Macinko et al., 2003; Starfield and Shi, 2002; Starfield Barbara, 2012, Starfield, 2011b; Van den Brink-Muinen et al., 2000). The employment status of PC doctors may influence the quality of care, especially in terms of communication and time spent with patients (Van den Brink-Muinen et al., 2000), and how PC doctors are paid may affect their professional practice (Gervas et al., 1994; Gosden et al., 2002; Kringos et al., 2013a,b,c). The few consistent results available in the literature highlight that capitation-based contracts improve accessibility to services and ensure interpersonal continuity and a better quality of care, however they also seem to be associated with less time dedicated to consultation compared to salaried contracts (Kringos et al., 2015).

In conclusion, the cited works provide evidence of an association between responsiveness and expenditure or doctors' remuneration systems. However, in some cases, they do not refer to PC systems or, in others they are based on a few countries or partially measure the responsiveness of PC systems. In our work, we aimed to fill these gaps by analyzing the performance of 32 PC systems.