Cite this article as:
Angela Coulter and Paul D. Cleary
Patients' Experiences With Hospital Care In Five Countries
*Health Affairs* 20, no.3 (2001):244-252
doi: 10.1377/hlthaff.20.3.244

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/20/3/244

For Reprints, Links & Permissions :  http://content.healthaffairs.org/1340_reprints.php

Email Alertings :  http://content.healthaffairs.org/subscriptions/etoc.dtl
To Subscribe :  https://fulfillment.healthaffairs.org

Not for commercial use or unauthorized distribution
Patients’ Experiences With Hospital Care In Five Countries

Patients’ assessments of hospital care are essential to improving its quality.

by Angela Coulter and Paul D. Cleary

ABSTRACT: Analysis of patient surveys carried out in Germany, Sweden, Switzerland, the United Kingdom, and the United States in 1998–2000 revealed high rates of problems during inpatient hospital stays. Problems with information and education, coordination of care, respect for patients’ preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transition were prevalent in all five countries. These dimensions of patients’ experience appear to be salient and relevant in each of the five countries, but attempts to develop international rankings based on this type of evidence will have to overcome a number of methodological problems.

The patient’s perspective on what constitutes high quality in health care is increasingly recognized as essential in quality assessment and improvement efforts. Attempts to define and measure this perspective are now being made at both the provider and system levels. Many national governments have developed performance frameworks that include indicators of responsiveness to patients. Recently, international agencies, such as the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD), have stressed its importance as a key component of system performance. WHO included an index of responsiveness to the expectations of consumers in its recent report on health systems around the world. This measure ranked countries’ health systems according to their performance on two dimensions: respect for persons (including dignity, confidentiality, and autonomy) and client orientation (including prompt attention, quality of amenities, access to social support, and freedom of choice of providers). The initial index, which has sparked a great deal of criticism, was based on the opinions of 1,791 “key informants” in thirty-five countries, the majority of whom were government...
“Problems identified in U.S.-derived survey instruments were echoed in responses from European patients.”

officials. The findings of this survey were then used to extrapolate responsiveness scores for the remaining countries in the WHO study. This year WHO plans to conduct more key-informant surveys, up to ten household surveys on these issues, and up to fifty mail surveys to elicit patients’ reports on their experiences with care in inpatient and outpatient settings.3

What can be learned from mail surveys of patients’ views on the quality of care? What type of problems do they reveal, and what methodological problems will have to be overcome if WHO’s next set of international rankings is to avoid the criticisms that greeted its first attempt? In this paper we describe the nature and frequency of problems reported by hospital patients in five countries—the United States, the United Kingdom, Germany, Sweden, and Switzerland—who responded to a standardized questionnaire asking about their experiences. This practical example of measuring patients’ hospital care experiences illustrates both the potential value of the approach and the methodological problems facing attempts to compare health systems across countries.

Measurement issues. Patient satisfaction surveys are frequently carried out, but these have often been conceptually flawed and methodologically weak.4 Patient satisfaction is essentially a subjective concept, crucially determined by expectations.5 These are likely to vary among countries and among different cultural groups within countries. The measurement of patients’ experiences, on the other hand, aims to elicit factual data that may be easier to interpret. Respondents are asked to report on “what happened” in relation to a specific episode of care, rather than “how satisfied were you?”

The Picker Institute has developed a series of self-completion survey instruments to obtain detailed reports of patients’ experience with specific dimensions of care. Topics covered in the questionnaires were derived from extensive research to determine which issues patients deemed particularly important.6 Survey instruments then were developed and extensively pilot-tested before being made available for routine use as a quality measurement tool. Picker surveys have been used since 1987 in U.S. hospitals and since 1998 in Germany, Sweden, Switzerland, and the United Kingdom. In this paper we present recent data from Picker surveys of hospital patients in each of these five countries.
Data Sources And Methods

Survey design. The conceptual basis and design of the questionnaires have been described elsewhere. In brief, the development of the instruments involved defining the scope of the survey with the help of an expert advisory group, carrying out a literature review, conducting in-depth interviews and focus groups with patients to determine their priorities, producing an initial draft questionnaire, testing the draft using cognitive interviews with patients, and re-drafting and piloting the questionnaire before producing a final version. The survey has been refined using data from two surveys of a national probability sample of hospitalized adults and data from hundreds of hospitals that routinely use Picker surveys.

The initial development work for the questionnaires used to collect the data reported here followed the pattern described above. Translations of the U.S. questionnaires were developed in each country, tested with patients for cultural and linguistic relevance and comparability of meaning, and adapted where necessary.

Data presented here came from mail surveys carried out in acute care hospitals in each of the five countries (Exhibit 1). Questionnaires were generally mailed to patients’ homes within one month of discharge from a hospital, either to all patients or to a random sample of those discharged during a defined period. Questionnaires cover seven dimensions of care: information and education, coordination of care, respect for patients’ preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transition. A total of forty items make up these dimensions, with each item coded as a dichotomous “problem score,” indicating the presence or absence of a reported problem. Each dimension is scored from 0 (no reported problems) to 100 (all items coded as a problem). In addition, two global assessments are included: a “satis-

<table>
<thead>
<tr>
<th>Country</th>
<th>Year surveyed</th>
<th>Number of hospitals</th>
<th>Total sample size</th>
<th>Exclusions (returned undelivered)</th>
<th>Response (completed questionnaires received)</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>1999/2000</td>
<td>6</td>
<td>3,716a</td>
<td>96</td>
<td>2,663</td>
<td>74%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1999</td>
<td>9</td>
<td>13,939</td>
<td>83</td>
<td>7,163</td>
<td>52</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1999</td>
<td>5</td>
<td>3,592</td>
<td>146</td>
<td>2,249</td>
<td>65</td>
</tr>
<tr>
<td>United States</td>
<td>1998/1999</td>
<td>272</td>
<td>103,426b</td>
<td>4,212</td>
<td>47,576</td>
<td>46</td>
</tr>
</tbody>
</table>

SOURCE: Picker Institute adult inpatient surveys.

a Includes only those patients who agreed to be surveyed.
b Data on exclusions not available in the United States; total eligible sample and exclusions estimated.
faction” item that asks patients to rate their overall evaluation of care on a five-point scale, and a “recommendation” item in which patients are asked if they would recommend the hospital to others. Response rates range from 46 percent in the United States to 74 percent in Germany.

■ Analysis. The analysis is restricted to data collected from inpatients over a twelve-month period in each of the countries during 1998–2000, with only the most recent survey from hospitals with multiple surveys included. Surveys of patients in outpatient departments, obstetric care, or primary care have been excluded. All data have been aggregated up to the country level.

Because of the longer establishment of the Picker Institute in the United States, the data set for the selected year was much larger there than in the European countries where the organization has commenced work relatively recently (Exhibit 1). There also were some differences among the country samples in hospital size and type, as well as some demographic differences (Exhibit 2).

Survey Results

The most striking finding is the extent to which the problems identified in these U.S.-derived survey instruments were echoed in the responses from patients in each of the European countries (Exhibit 3). While there were differences in the rates at which problems were reported in each of the countries, the patterns or relative frequencies were quite similar.

The most commonly reported problems in all five countries concerned continuity and transition. The items that make up this dimension include provision of information about the purpose of medicines and their side effects, information about danger signals to watch for at home, and advice about resumption of normal activities. Failure to involve family and friends in the details of care is also
likely to affect discharge arrangements; this dimension also revealed problems in each of the countries.

- **Information, coordination, and comfort.** A fairly high rate of problems was reported across the five countries on the information and education dimension, which included items such as communication in the emergency room, delays in bed allocation, and clarity of explanations provided by medical and nursing staff. Key items that contributed to negative evaluations of coordination of care included lack of organization of the admission process, not being given the name of the doctor in overall charge of care, scheduled tests and procedures not done on time, and conflicting information from staff. Physical comfort received lower (that is, better) scores in all five countries, but this does not necessarily mean that it was dealt with adequately in all cases. For example, in the U.S. sample 20 percent of patients said that they didn’t get help with going to the toilet when they needed it, and 16 percent said that staff didn’t do enough to control their pain.

- **Respect for patients and emotional support.** Some respondents reported failure to take account of their preferences, complaining that staff sometimes talked about them in their presence as if they weren’t there. The most commonly reported problem in the patient preference dimension was failure to involve patients in treatment decisions. The proportion responding negatively to the question about whether they felt sufficiently involved was 46 percent in Germany; Sweden, 54 percent; Switzerland, 36 percent; the United Kingdom, 59 percent; and the United States, 37 percent. Many patients felt that they received inadequate emotional support, reporting that it was difficult to discuss their anxieties and concerns with doctors or nurses and indicating that they lacked confidence in some of the health professionals responsible for their care.

- **Variation among hospitals.** The dimension scores reported in

---

**EXHIBIT 3**
**Dimension Scores: Problem Ratings As Reported By Patients On Specific Aspects Of Hospital Care, 1998–2000**

<table>
<thead>
<tr>
<th>Dimension of care</th>
<th>Germany</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and education</td>
<td>20.4</td>
<td>23.4</td>
<td>16.7</td>
<td>28.7</td>
<td>25.2</td>
</tr>
<tr>
<td>Coordination of care</td>
<td>17.2</td>
<td>-a</td>
<td>13.1</td>
<td>21.9</td>
<td>21.7</td>
</tr>
<tr>
<td>Physical comfort</td>
<td>6.7</td>
<td>4.0</td>
<td>2.6</td>
<td>8.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Emotional support</td>
<td>21.9</td>
<td>26.0</td>
<td>14.7</td>
<td>27.1</td>
<td>26.8</td>
</tr>
<tr>
<td>Respect for patients’ preferences</td>
<td>17.9</td>
<td>21.2</td>
<td>15.6</td>
<td>30.7</td>
<td>19.9</td>
</tr>
<tr>
<td>Involvement of family and friends</td>
<td>16.6</td>
<td>14.6</td>
<td>11.5</td>
<td>27.5</td>
<td>19.3</td>
</tr>
<tr>
<td>Continuity and transition</td>
<td>40.6</td>
<td>40.2</td>
<td>30.0</td>
<td>45.1</td>
<td>28.4</td>
</tr>
</tbody>
</table>

**SOURCE:** Picker Institute adult inpatient surveys.

**NOTES:** Rates are based on aggregate scores, where 0 = best and 100 = worst. Rates were adjusted for age and sex.

a Not included in Swedish surveys.
Exhibit 3 mask considerable variation between individual hospital problem scores. For example, among 272 U.S. hospitals included in the survey, the proportion of patients who said that they were given insufficient information in the emergency room ranged from 7 percent to 73 percent, those who said that test results were not clearly explained ranged from 7 percent to 44 percent, the proportion who said that they didn't have enough say in decisions about their treatment ranged from 17 percent to 57 percent, and those who said that they were not told about danger signals to watch for at home ranged from 15 percent to 60 percent.

Global assessment. Despite the frequency of problems reported when asked about specific aspects of their care, patients in all five countries tended to give positive ratings when asked for a global assessment (Exhibit 4), illustrating a well-known problem with this type of rating scale. Although patients reported many problems in relation to specific aspects of the process of care, few were willing to say that their care was not good overall or that they would not recommend the hospital to others. Even so, the highest satisfaction ratings were reported by patients in Switzerland and the lowest by patients in the United Kingdom. This mirrors the pattern for the dimension scores shown in Exhibit 3, where Switzerland had the best scores in every case and the United Kingdom had the worst for all dimensions except physical comfort, for which the United States achieved a worse score.

Difficulties Of Interpretation

It is tempting to use these data to produce a ranking, similar to those of WHO, from which one might conclude that the Swiss and German health systems are more responsive to patients than the British and American systems are, and that Sweden falls in the middle. This would be an invalid conclusion, however.

The difficulties of interpreting international comparisons are well known. When considering data such as these, it is important to be aware of demographic differences, potential translation problems, cultural and health system differences, and differences in the sam-
We have done our best to take account of these problems in designing this study. For example, there was a greater proportion of younger persons in the samples from Switzerland and Germany than in the other three countries (Exhibit 2), and younger persons are known to be more likely to report problems than older persons are.\textsuperscript{11} We therefore used direct standardization to adjust for age and sex differences among countries. We tested the questionnaires extensively to iron out translation problems and to ensure that topics covered were salient in each country. Also, the use of factual questions avoids some of the cultural problems we alluded to earlier. Samples were drawn in a similar way, and all questions were related to a specific recent episode of hospital care.

However, the hospitals included in the surveys reported here represent only a small, self-selected, and probably nonrepresentative sample from each country studied. We do not believe that it is appropriate, therefore, to use these data to generalize to all hospitals within a country or to make precise comparisons between countries. As we hope we have demonstrated, the country-level aggregations are interesting in themselves and demonstrate the relevance to patients of the dimensions studied, but the real value of these survey findings lies in their use to stimulate quality improvements. Even though the hospitals studied are not necessarily representative of all hospitals in the study countries, the results offer compelling evidence that there are major deficits in the quality of hospital care in all of the countries studied and variations within and between countries that might provide evidence about how organizations and providers could meet patients’ needs more effectively.

\textbf{Survey applications.} There are a number of reasons for conducting patient surveys. They can be used to assist in local quality improvement efforts; to facilitate the identification of poor-quality care for further investigation; to contribute to national performance assessment; to contribute to strategic policy making at the national and local levels; to build public confidence and accountability; to provide information to purchasers for contracting purposes; and to inform patients’ choices. Individual providers and provider groups have been undertaking patient surveys for some years; the introduction of national or systemwide surveys is relatively new. Examples of the latter include the U.S. Health Plan Employer Data and Information Set (HEDIS), which includes the Consumer Assessment of
Health Plans (CAHPS) survey, and the National Surveys of National Health Service (NHS) Patients launched in 1998 by the British Department of Health.12

**The WHO initiative.** The WHO initiative adds a further application—namely, to measure and monitor the performance of health systems. It is intended that WHO’s mail surveys should include reports on patients’ experiences of care in inpatient and outpatient settings.13 Our data demonstrate that it is possible to obtain meaningful reports from patients in different Western developed countries that could be used to compare health systems. To do this, however, responses must be obtained from representative populations in each of the countries in sufficient numbers to reflect the diversity of experience observed there. WHO plans to conduct postal surveys of population samples, not samples of recently hospitalized patients as in the study reported here. It seems most unlikely that their planned sample sizes of 2,000–3,000 will be sufficient to collect reliable data on recent hospital inpatient experiences because hospital admission is an infrequent occurrence for most persons. Ambulatory care may present less of a problem, however, simply because it is much more commonly used.

Patients’ views of appropriate care might differ greatly among countries. Those involved in the development of the Picker surveys have verified that the questions asked are salient and relevant in each of the countries studied. Furthermore, a study in eight European countries found that although patients in different cultures and health care systems have different views on certain aspects of care, they share similar expectations and values, particularly with respect to doctor/patient communication and accessibility of services.14 WHO’s survey scope is much wider, however. Before WHO embarks on surveys in different continents, it will be important to carry out firsthand research to explore patients’ views on what they consider important in relation to quality of care. The opinions of “key informants” drawn from professional groups alone will not be sufficient to ensure that the surveys provide a sound measure of health systems’ responsiveness to consumers.

An earlier version of this paper was presented at the Commonwealth Fund International Symposium on Health Care Policy, “Quality and Innovation: Issues, Strategies, and Implications for Policy,” in Washington, D.C., 11–13 October 2000. The authors are very grateful to Steve Bruster, Crispin Jenkinson, Michael Massagli, and Kathi Rossi-Roh for assistance with data management and analysis, and to Mark Merlis for comments on an earlier draft.
NOTES