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Patient Satisfaction Surveys in Colombia: Scope for Improvement

Encuestas de Satisfacción del Paciente en Colombia: Una Oportunidad para Mejorar

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Abstract

Objetive: *The study reviews whether the three major Colombian surveys meet the eight World Health Organization responsiveness criteria. The responsiveness framework is an internationally acknowledged standard that meets the challenge of evaluating patient satisfaction.*
Method: *After exploring patient evaluations practices that are internationally recognized, this study makes a comparative analysis of the Colombian surveys.*
Results: *Colombian surveys are concerned on evaluating patients' perception of quality. There are only few questions that have an equivalent assessment to the eight dimensions suggested by the World Health Organization.*
Conclusion: *By using this framework, the three major Colombian surveys, which deal with health and medical care, do not make accurate evaluation of patient satisfaction. This article suggests how to ameliorate the situation by taking advantage of Colombia's celebrated household survey infrastructure as well as its administrative requirements.*

Key words: Health care surveys; Colombia; Quality management.

Resumen

Objetivo: *Este artículo espera ayudar con el reto de alinear las encuestas colombianas con las mejores prácticas internacionales.*
Método: *Se analiza si las tres principales encuestas colombianas cumplen los ocho criterios de receptividad planteados por la Organización Mundial de la Salud. Este es un estándar internacional que responde a la necesidad de evaluar la satisfacción del paciente.*
Resultados: *Las encuestas colombianas se centran en evaluar la percepción de calidad que tiene el paciente. Son escasas las preguntas equivalentes a las ocho dimensiones propuestas por la organización mundial de la salud.*
Conclusiones: *Las tres principales encuestas colombianas, que evalúan salud y atención médica, no hacen una medición adecuada. Este artículo sugiere que la situación se puede compensar*

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tomando la ventaja que ofrece la infraestructura actual de encuesta a hogares, así como los requerimientos administrativos para estimar la satisfacción del paciente.

Palabras clave: Encuestas de atención en salud; Colombia; Gestión de Calidad.

INTRODUCTION

Patients are increasingly managing their own care. Growth in levels of income and education, on the one hand, and developments in information technology, on the other, empower patients with knowledge and information. Moreover, growth in non-communicable chronic conditions, force the individual to assume greater responsibility for his health (1). As a result, patient satisfaction has become a major goal in the universal coverage or publicly supported healthcare system (2) and manuals (3).

Unsatisfied patients can opt out of the system, with adverse consequences for equity, efficiency, sustainability, and ultimately for the system's legitimacy (4). Indeed, many countries now collect patient satisfaction data regularly, and researchers evaluate the outcomes of health reforms in terms of patient satisfaction (5).

In Colombia, the Ministry of Health requires all provider institutions (Instituciones Prestadoras de Salud, IPS) to report satisfaction monthly (6). These surveys are however designed and conducted individually by each institution, and do not comply with a consistent framework. In addition, Colombia makes a national assessment of patient satisfaction through national surveys, including household surveys. Such situation leads to various consequences. First, the patient satisfaction measures used in the surveys are not necessarily comparable, as they may lack a common definition. Second, as institutional or administrative surveys are conceived for self-evaluation purposes, they may over-represent positive experiences or focus on what is important for the institution, not for the system. Third, it is unclear whether the Colombian patient satisfaction measurements across all surveys are aligned with best practices.

The combination of these factors results in a challenge. The extent to which Colombian surveys concerning patient satisfaction are aligned with international standards is unclear. Additionally, by addressing this challenge, the Colombian healthcare system will be able to adequately measure patient satisfaction.

This paper aims to assist with this challenge by comparing the Colombian national surveys with international best practices. This will be accomplished by reviewing whether the three major national surveys meet the eight WHO responsiveness criteria, an international standard of patient satisfaction. By assessing the methodological quality of these measurements, the paper can contribute to inform policy making in Colombia.

The paper is organized as follows. First, we describe the evolution of the patient satisfaction concept considering its main measurement frameworks. Second, we describe the Colombian surveys that evaluate patient satisfaction. Third, we compare these surveys to an international framework. Finally, we conclude emphasizing on the importance of having more systematic measurements of patient satisfaction.

PATIENT SATISFACTION

Despite common usage, the concept "patient satisfaction" remains difficult to define and measure. It captures the overall and rather intricate experience of a service encounter or the patient's feeling after receiving care (7). Patient satisfaction has been generally defined as the emotional consequence of the patient's perception of service quality (8).

It is important to differentiate between the patient perceptions of non-clinical service quality versus clinical care quality (9, 10). Service quality is a patient's evaluation of the service; it encompasses general service issues such as timeliness of attention, communication with the care provider, and characteristics of healthcare facilities. While these are important and easily quantifiable, they do not necessarily reflect quality of clinical care. Moreover, due to a lack of medical knowledge, patients cannot respond to many questions on clinical quality. Consequently, satisfaction surveys typically ask patients to rate their satisfaction with regards to service characteristics, such as professional competency, personnel qualities, resources, cost/financial issues, and access or convenience (11-13).

To evaluate these characteristics, other constructs, such as patient-centeredness and service responsiveness, have been developed. The Commonwealth Fund (CWF) has defined patient-centeredness as the "care delivered with the patient's needs and preferences in mind" (14-17). The Commonwealth Fund approach provides the most detailed and comprehensive measure of patient-centered care through eight dimensions: (a) respect for patient-centered values, preferences, and needs; (b) coordination and integration; (c) information, communication, and education; (d) physical comfort; (e) emotional support and alleviation of fear and anxiety; (f) involvement of family and friends; (g) transition and continuity; and (h) access to care. The previous dimensions suggest that the patient-centeredness construct encompasses both service quality (patient preferences) and clinical quality (patient needs). Given its usefulness, the patient-centeredness construct has been further developed by others (17).

The concept of responsiveness has also been developed to assess both service and care quality. The World Health Organization (WHO) has defined responsiveness as "the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognizant and respond appropriately to the universally legitimate expectations of individuals" (18). Thus, responsiveness extends the idea of satisfaction as an evaluation of an institution to the whole health system. The assessment of responsiveness includes eight domains: autonomy, choice, confidentiality, communication, dignity, prompt attention, basic amenities, and family and community support (19).

The patient-centeredness (CWF) and service responsiveness (WHO) constructs share key characteristics. First, both attempt to assess some aspects of clinical quality in addition to non-clinical service quality. Second, both concepts exclude financial affordability and health care effectiveness. Third, they both assess users' perception of care by evaluating procedural and interpersonal domains.

However, some differences between the constructs are worth noting. Whereas patient-centeredness focuses on the communication

between the patient and health professionals, responsiveness rather deals with autonomy, choice, and confidentiality. Second, responsiveness is more comprehensive, as it includes patient-centeredness concerns about patients' perceptions of health providers, and also interactional and contextual dimensions such as family and community support.

Finally—and most importantly—whereas the patient-centeredness construct has been developed and tested in the US, the responsiveness framework was developed for international use after extensive fielding and pretesting. The revised responsiveness instrument was finally implemented in a World Health Survey covering over seventy countries (19).

Hence, the WHO responsiveness dimensions provide an excellent framework to assess the patient satisfaction measurements of the major Colombian surveys.

THE COLOMBIAN SURVEYS

Colombia has three independent surveys that address the population's satisfaction with health services. The first of these surveys evaluates basic quality of life using the Living Standards Measurement Study (LSMS: Encuesta Nacional de Calidad de Vida). Since 2010, the LSMS is applied yearly and is representative of the nine largest regions of Colombia: Antioquia, Bogotá, Atlántica, Central, Oriental, Pacífica, San Andrés, Orinoquía-Amazonía, and Valle. The sample size for 2011, was of 92,188 persons that ware clustered in 25,364 households (2).

The LSMS, conducted by the National Statistics Department (DANE), is a national quality of life survey that covers income and poverty indicators to evaluate the effectiveness of public programs and policies. Although it does not focus on health issues, the LSMS does include 105 questions on healthcare topics, such as utilization, satisfaction, perception, availability, affiliation and healthcare expenses. Therefore, this survey permits linking health information with various socioeconomic characteristics, and is amenable to healthcare related research (20). Of all surveys with health content, it is the survey with the best information on healthcare expenditures.

The second survey is the National Demography and Health Survey (DHS: Encuesta Nacional de Demografía y Salud). The 2010 edition has a sample size of 50,000 households and the analysis is done by regions (Caribe, Oriental, Bogotá, Pacifica, Orinoquía, and Amazonía) and subregions according to population density within the regions (18). This survey is conducted by Profamilia, a private organization that assesses individuals who require family planning, medical treatments related to sexual health and fertility issues. Thus, respondents and questions are oriented to the concerns mentioned above. The survey includes questions on quality of service, timeliness, trust in health professionals, and distance from the institution premises. The survey is administered in 259 municipalities in 33 departments of the country every 5 years.

The third is the National Health Survey (NHS: Encuesta Nacional de Salud). In 2007, it covered 41,543 households, 1,170 providers, and 123,917 users (21). The coverage and analysis of this survey is national. It is conducted by the Ministerio de Salud y Protección Social (Health and Social Protection Ministry) in association with the Departamento Administrativo de Ciencia, Tecnología e Innovación (Administrative Department of Science, Technology and Innovation), otherwise known as Colciencias.

The NHS evaluates patients' perception of the service, timeliness, trust in health professionals, and distance from the institution premises.

EVALUATION OF THE COLOMBIAN HEALTH CARE SURVEYS ON EIGHT DIMENSIONS OF CARE

Do the three surveys just discussed (LSMS, DHS and NHS) assess patient satisfaction according to international standards? To answer the question, these surveys are compared to two WHO surveys: World Health Survey (WHS) and Multi Country Cluster Survey (MCSS). Surveys are compared on their assessment of the eight key responsiveness dimensions proposed in the WHO responsiveness framework (19). These dimensions are: autonomy, choice, communication, confidentiality, dignity, quality of basic amenities, access and timeliness, and access to family and community support.

Autonomy is related to the freedom of choice the patient has in medical decisions (Table 1). Surveys include this concept asking about patients' involvement in the decision-making process concerning their care. Colombian surveys do not include this type of question.

Table 1. Autonomy

WHS[1]	MCSS[2]	LSMS[3]	DHS[4]	NHS[5]
How would you rate your experience of being involved in making decisions about your health care or treatment?	How often did doctors, nurses or other healthcare providers involve you in deciding about the care, treatment or tests?	NA	NA	NA
How would you rate your experience of getting information about other types of treatments or tests?	How often did doctors, nurses or other healthcare providers ask your permission before starting the treatment or tests?			
	Rate your experience of being involved in making decisions about your care or treatment.			

[1] The World Health Organization conducts the World Health Survey (WHS).
[2] The World Health Organization conducts the Multi-Country Survey Study (MCSS).
[3] DANE conducts the Living Standards Measurement Study (LSMS).
[4] Profamilia conducts the National Demography and Health Survey (DHS).
[5] The Health and Social Protection Ministry in association with Colciencias conducts the National Health Survey (NHS).

Choice is defined as the availability and opportunity patients have to choose a healthcare provider, either a physician or an institution. The WHO surveys ask patients to rate the difficulty of finding a provider and freedom in choosing that provider. From the Colombian surveys, only the LSMS includes this concept by asking (yes or no question) about the possibility of choosing a healthcare provider (Table 2).

Table 2. Choice

WHS	MCSS	LSMS	DHS	NHS
How would you rate your freedom of choice in selecting your healthcare provider?	Was it difficult to find a healthcare provider you were pleased with?	Do you or anyone from your household choose the institution (IPS) as your healthcare provider?	NA	NA
	Was it difficult to find a new healthcare provider?			
	Rate your experience of the selected healthcare provider.			

Communication is defined as the clarity of information to ensure that the patient understands the symptoms, issues, treatments, and implications of his/her illness. Both WHO surveys contain a clear and comprehensive assessment on this topic, signaling its relevance on a satisfaction assessment process (Table 3). On the Colombian surveys, only the one by Profamilia (DHS) includes this dimension by evaluating the quality of the assistance and information provided.

Table 3. Communication

WHS	MCSS	LSMS	DHS	NHS
Rate your experience of how clearly healthcare providers explained things to you.	How often did doctors, nurses or other healthcare providers carefully listen to you?	NA	Rate your opinion on your last visit regarding the orientation about family planning methods	NA
Were you given enough time to ask questions about your health problem or treatment? Rate your experience.	How often did doctors, nurses or other healthcare providers, explain things in a way you could understand?		Rate your opinion on your last visit regarding the information about the prescribed method	
	How often did doctors, nurses or other healthcare providers give you time to ask questions about your health problem or treatment?		Rate your opinion on your last visit regarding the way that administrative personnel/nurses/physician treated you	
	Rate your experience of how well healthcare providers communicated with you in the last 12 months.		Rate your opinion on your last visit regarding explanations provided by the physician	

Confidentiality means protecting personal information and ensuring that the patient is involved in the disclosure of such information. Confidentiality is a matter evaluated by WHO surveys. In the Colombian surveys, only Profamilia asks individuals to rate the level of privacy on a family planning orientation or treatment (Table 4).

Table 4. Confidentiality

WHS	MCSS	LSMS	DHS	NHS
How would you rate the way the health service ensured you could talk privately to health care providers?	How often were talks with your doctor, nurse or other healthcare provider done privately so other people who you did not want to hear could not overhear what was said?	NA	What is your opinion of the level of privacy of the treatment when they last prescribed you the planning method?	NA
How would you rate the way your personal information was kept confidential?	How often did your doctor, nurse or other healthcare provider keep your personal information confidential?			
	*This means that anyone whom you did not want informed could not find out about your medical conditions.			

Dignity is defined as the extent to which and individual feels that healthcare is provided in a respectful, caring, and non-discriminatory manner. Dignity is evaluated by the WHO surveys and by the Profamilia survey (Table 5).

Table 5. Dignity

WHS	MCSS	LSMS	DHS	NHS
How would you rate your experience of being respectfully greeted and addressed?	How often did doctors, nurses or other health care providers treat you with respect?	NA	Rate how administrative staff treated you	NA
How would you rate the way your privacy was respected during physical examinations and treatments?	How often were your physical examinations and treatments done in a way that your privacy was respected?		Rate how nurses treated you	
	How often did the office staff, such as receptionists or clerks, treat you with respect?		Rate how physicians treated you	
	How would you rate your experience of being respectfully treated?			

Quality of basic amenities is related to the characteristics offered by the physical infrastructure if the healthcare institution. Quality of basic amenities is evaluated by both WHO surveys and by two Colombian surveys. While the Profamilia survey asks the patient to evaluate only the waiting room, the LSMS survey includes infrastructure as one item of a multiple-choice list that determines the quality of treatment (Table 6).

Table 6. Quality of basic amenities

WHS	MCSS	LSMS	DHS	NHS
How would you rate the cleanliness of the rooms inside the healthcare facility, including the toilets?	How would you rate the quality of the waiting room, for example, space, seating and fresh air?	What aspect most influenced your perception of the quality of treatment? (ie: processing paperwork, treatment; staff ability, infrastructure)	Rate the comfort and cleanliness of the waiting room during you last visit	NA
How would you rate the amount of space you had in the healthcare facility?	How would you rate the cleanliness of the healthcare facility?			
	How would you rate the quality of the surroundings, for example, space, seating, fresh air and cleanliness of the health services?			

Access and timeliness are based on the concept of prompt attention in the WHO. These concepts are combined to determine if healthcare services are offered promptly and within easy travel distance. All international and Colombian surveys ask how long it takes for the patient to receive healthcare (Table 7). The three Colombian surveys, as well as one of the surveys by WHO (WHS), require information about traveling time to the facility.

Table 7. Access and timeliness

WHS	MCSS	LSMS	DHS	NHS
How would you rate the traveling time to the healthcare facility?	How often did you receive care as soon as you requested care?	How many days passed from the moment you requested the appointment to the appointment with the doctor or dentist?	The last time you had an appointment, how much time did it take for you to arrive at the doctor's office?	What is your main reason for not attending a doctor's appointment or looking for a solution to your health problem? i.e: waiting time, cost of appointment, paperwork, appointments are not available or not enough time; did not receive appointment or it was given for a future date; the healthcare was not covered or the treatment was not authorized; the healthcare facility is too far away
How would you rate the amount of time you waited before being attended to at the healthcare facility?	How would you rate your experience of getting prompt attention at the health service?	How many days passed from requesting the appointment to the appointment with the doctor or dentist (specialist)?	What was the main reason why (NAME) did not request or receive medical treatment? ie: the healthcare facility is far away; transportation is expensive; the service is expensive; too much paperwork; not available during appointment openings; delays in receiving appointments	

Continúa...

WHS	MCSS	LSMS	DHS	NHS
		What was the main reason for not requesting medical attention? : Distant health-care facility; bad service or the appointment is distant in time (+8 options un related to access/time).	What is your opinion about the treatment schedule and wait time when they last prescribed you the planning method	How much time did it take to arrive at the place where _____ was treated?
			How many days passed from when you requested the appointment to the appointment with the doctor?	In your last hospitalization, how much time did it take to get to the healthcare facility?
			Did you receive treatment in a timely or delayed manner?	

Access to family and community support is the feeling a patient has of being cared for by significant others; this perception tends to be positively associated to well-being. Only the WHO surveys assess this dimension.

Table 8. Access to family and community support

WHS	MCSS	LSMS	DHS	NHS
How would you rate the ease of having family and friends visit you at the healthcare facility?	While you were at the hospital, was it difficult for your family and friends to take care of your personal needs, such as bringing you your favorite food, soap, etc?	NA	NA	NA
How would you rate your experience of staying in contact with family and friends when you [your child] were [was] in the hospital?	Was it difficult to have the hospital grant you permission to practice religious or traditional observances (if you wanted to)?			
	Did the hospital make it difficult for you to interact with family and friends and continue your social life and/or religious customs? Rate your experience.			

Table 9. Patient satisfaction evaluation – example

How would you rate your experience of being involved in making decisions about your health care or treatment?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate your experience of getting information about other types of treatments or tests?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate your freedom of choice in selecting your healthcare provider?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
Rate your experience of how clearly healthcare providers explained things to you.	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
Were you given enough time to ask questions about your health problem or treatment? Rate your experience.	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the way the health service ensured you could talk privately to health care providers?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the way your personal information was kept confidential?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate your experience of being respectfully greeted and addressed?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the way your privacy was respected during physical examinations and treatments?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the cleanliness of the rooms inside the healthcare facility, including the toilets?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the amount of space you had in the healthcare facility?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the traveling time to the healthcare facility?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the amount of time you waited before being attended to at the healthcare facility?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the amount of time you waited before being attended to at the healthcare facility?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate the ease of having family and friends visit you at the healthcare facility?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad
How would you rate your experience of staying in contact with family and friends when you [your child] were [was] in the hospital?	1. Very good	2. Good	3. Moderate	4. Bad	5. Very bad

Note. Before these questions the survey must include an informed consent, sociodemographic information, and health state description. This example summarizes the dimensions of concern for this study, however the WHO survey is more extensive (23).

Quality of service is not one of the dimensions in the WHO surveys. This last table outlines an important set of questions included on the three Colombian surveys. However, patients' true assessment of these questions is difficult, if not impossible, because patients do not have access to the process or have the healthcare knowledge to provide an accurate response. Some examples of these quality of service questions are: a) in general, how would you rate the quality of treatment you received? (LSMS); b) In general, how would you rate the quality of treatment you received? (DHS); what is the main reason for not scheduling a doctor's appointment or seeking a solution to the health problem? i.e.: poor treatment; did not trust the doctors or nurses/did not believe they could assist you (NHS).

The analysis suggests that the Colombian surveys do not meet the WHO responsiveness dimensions. Therefore, these surveys may not provide adequate assessments of the complex concept of patient satisfaction for several reasons.

First, satisfaction with care is not assessed through stand-alone questions, but rather through a set of conceptually mixed questions. For example, to the question "what was the main reason for not demanding healthcare attention?" the patient should respond using a list of 18 options (from the NHS survey). This list not only does include some items related to the quality of healthcare services, but also others that are unrelated to the service itself.

Second, available responses in the survey combine personal with institutional issues. Personal reasons for not seeking care include having a mild case, not having time, and lack of money; these are all unrelated to the services provided. Such practices result in unspecific wording, which makes it challenging to assess the real extent of patient satisfaction. Third, another challenge that patients have when they respond to these surveys, is their lack of or little knowledge about the items related to quality of service.

Finally, and perhaps most importantly, the Colombian surveys do not include many of the eight WHO responsiveness dimensions. The concepts of autonomy and support by others are not included in any survey. Communication, confidentiality, dignity and choice are only included in one of the surveys; these are the first three in the DHS and choice is only asked about in the LSMS. Quality of basic amenities is included in two surveys (DHS and LSMS). Indeed, of the nine dimensions reviewed, only access and timeliness are consistently included in all three Colombian surveys.

CONCLUSIONS

Patient satisfaction is a key challenge of modern healthcare systems, including the Colombian (22). In this general context, the article evaluates the Colombian household surveys, which deal with patients' satisfaction, by the WHO standard and best practice as it is based on a validated methodology and has been developed for international settings. Table 9 offers an example of how to approach the evaluation of patients' satisfaction; it includes the eight dimensions of the WHO survey that were previously discussed. The WHO questions are preferred over the MCSS because these have a more consistent response scale throughout the questionnaire and there are fewer questions to capture each dimension (23). This second characteristic facilitates an easier and faster response from patients; consistently, this fact also reduces

costs. Individuals or institutions that are motivated to use this survey must review its guide to administration and understand the rationale of its questionnaire (24).

The study concludes that the Colombian surveys deviate from the international standards of measuring the complex concept of patient satisfaction. By implication at least, this article suggests to use international standards to evaluate patients' satisfaction, taking advantage of Colombia's household survey infrastructure, as well as its administrative requirements to evaluate patient satisfaction. This survey infrastructure also enables access and usage of patient satisfaction results for policy and organizational decision making.

Thus, a more systematic measurement of patient satisfaction by the celebrated and well-conducted Colombian surveys can lead to a more informed reform debate and improved healthcare policy, planning and management. Moreover, alignment of the administrative requirements of the Ministry of Health with the international standard could contribute even further to these goals, which would improve its health system's goals and the system's legitimacy. Enhanced patient satisfaction measurement can lead to improved healthcare policy, planning and management, for a better performing healthcare system that benefits from the legitimacy of the people it serves.

From a broader perspective, using an international tool facilitates making comparisons with international quality of life standards. Which, in the long run, raises institutional requirements for implementing better healthcare procedures and practices.

LIMITATIONS AND FUTURE RESEARCH

Although we argue that patient satisfaction measurement can be improved, and we show which could be an appropriate standard, we do not measure to what extent this proposal can make a valid and reliable measure. This empirical evaluation is recommended for future research (25-27).

Finally, changing the type or number of questions in the national assessment of healthcare has financial implications because it affects survey fieldwork and logistics. A second financial consequence may be observed by avoiding the duplicity of work that different institutions are bearing by having similar surveys. This paper does not make this analysis, but it is possible to assume that reducing the number of questions and surveys, by making a more precise assessment, would ease financial costs.

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