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The added value of the Euro Health Consumer Index to existing mechanisms of national health care systems evaluation provided by the OECD and WHO

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1. Introduction

“Hot potato”. In such a way, the director of the Health Consumer Powerhouse Johan Hjertqvist defines healthcare in Europe (Hjertqvist, 2002, p.47). Nowadays, problems concerning health care systems and their evaluation are in the center of modern political discussion in many European countries and the EU institutions. The Euro Health Consumer Index was launched in Brussels at the Health Consumer Summit 2005 aiming at evaluating national health care systems. The Index is compiled from a combination of public statistics and independent research by Brussels-based think tank Health Consumer Powerhouse (Press Release, 2005). The company has moved from ‘the originally Swedish national level into a European identity’ (Index, 2005, p. 26). Moreover, the organization claims itself as “a Brussels “do-tank”, which provides not only inspiring ideas but also practical solutions for health consumer information” (Index, 2005, p. 26).

1.1. Existing Evaluation Systems

By the time of the Index publishing, there were some established evaluation systems which encompassed countries in Europe done by such well-known and solid organizations as, for example, the World Health Organization. In particular, under the auspices of the WHO, there is the European health for all database (HFA-DB). This database provides “independent, comparable and up-to-date basic health statistics” (European health for all database). Moreover, in 2001 the Organization for Economic Cooperation and Development launched the Health Care Quality Indicator (HCQI) Project to track health care quality across national borders (Tracking Health Care Quality). Furthermore, in 2003 the European Commission initiated its own project – in the framework of the Health Monitoring Program and the Community Public Health Program. The result of it is supposed to be a list of indicators for the public health field arranged according to a conceptual view on health and health determinants (Developing European Union health indicators). So, there were some systems which evaluate national health care systems.

1.2. The Euro Health Consumer Index

Nevertheless, the Euro Health Consumer Index (EHCI) was launched. It was as an attempt to rank national health care systems of 12 European countries in accordance with their friendliness to consumers (2005 Index). Since that time, it has been considerably developed and has undergone changes. It is published every year and now encompasses 29 European countries and Canada (2008 Index), and includes various indicators (See Figure 1). But the underlying ideas of the Index remain. It is possible to pick out, at least, two of them.

● = Good
 ○ = Intermediary
 ○ = Poor
 n.a = Data not available

		Austria	Belgium	Bulgaria	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	Germany	Greece	Hungary	Ireland	Italy	Latvia
Patient rights and information	Healthcare law based on Patients' Rights	○	●	○	●	○	●	○	●	●	○	●	●	○	○	○
	Patient org. involved in decision making?	○	○	○	○	○	○	●	○	○	○	○	○	●	○	○
	No-fault malpractice insurance	○	○	○	○	○	●	○	●	○	○	○	○	○	○	○
	Right to second opinion	●	●	○	○	○	●	●	○	●	●	○	○	○	○	○
	Access to own medical record	●	●	○	○	●	●	○	●	●	○	○	○	○	○	○
	Register of legit doctors	●	○	○	○	○	●	●	○	○	○	○	○	○	○	○
	Electronic Patient Record (% of GPs using)	○	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○
	Provider catalogue with quality ranking	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Web or 24/7 telephone healthcare info	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Sub-discipline score	17	16	13	15	16	25	20	22	20	15	14	14	16	15	11
Waiting times	Family doctor same day	●	●	○	●	●	○	○	○	●	●	○	●	○	○	○
	Direct access to specialist	●	●	○	●	○	○	○	○	●	●	●	○	○	○	○
	Major non-acute operations <90 days	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○
	Cancer therapy < 21 days	●	●	○	●	○	○	○	○	○	○	○	○	○	○	○
	MRI scan < 7days	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○
Sub-discipline score	14	15	9	13	10	9	7	8	13	14	9	8	6	7	7	
Outcomes	Heart infect mortality	●	○	n.a.	○	○	○	○	○	○	○	○	○	○	○	○
	Infant deaths/1000 live births	○	○	○	●	●	○	○	○	○	○	○	○	○	○	○
	Cancer 5-year survival	●	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○
	Avoidable deaths – Potential years of Life Lost (PYLL)/100,000	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	MRSA infections	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Sub-discipline score	13	9	5	8	9	10	9	12	11	11	8	5	10	10	6	
"Generosity" of public healthcare systems	Cataract operations per 100 000	○	●	○	n.a.	n.a.	○	○	○	○	○	○	○	○	○	n.a.
	Infant 4-disease vaccination	○	○	○	●	●	○	○	○	○	○	○	○	○	○	○
	Kidney transplants p.m.p.	●	○	○	n.a.	○	○	○	○	○	○	○	○	○	○	○
	Dental care in public healthcare system	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Sub-discipline score	9	8	5	6	9	7	9	11	11	10	7	11	7	8	7	
Pharmaceuticals	Rx subsidy %	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Layman-adapted pharmacopœia?	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	New cancer drugs deployment speed	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
	Access to new drugs (time to subsidy)	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Sub-discipline score	9	6	4	7	5	10	9	7	8	9	7	5	10	7	4	
TOTAL SCORE		806	701	445	629	612	712	633	719	786	767	561	513	592	580	435
RANK		1	10	28	13	15	9	12	8	3	5	22	24	16	18	29

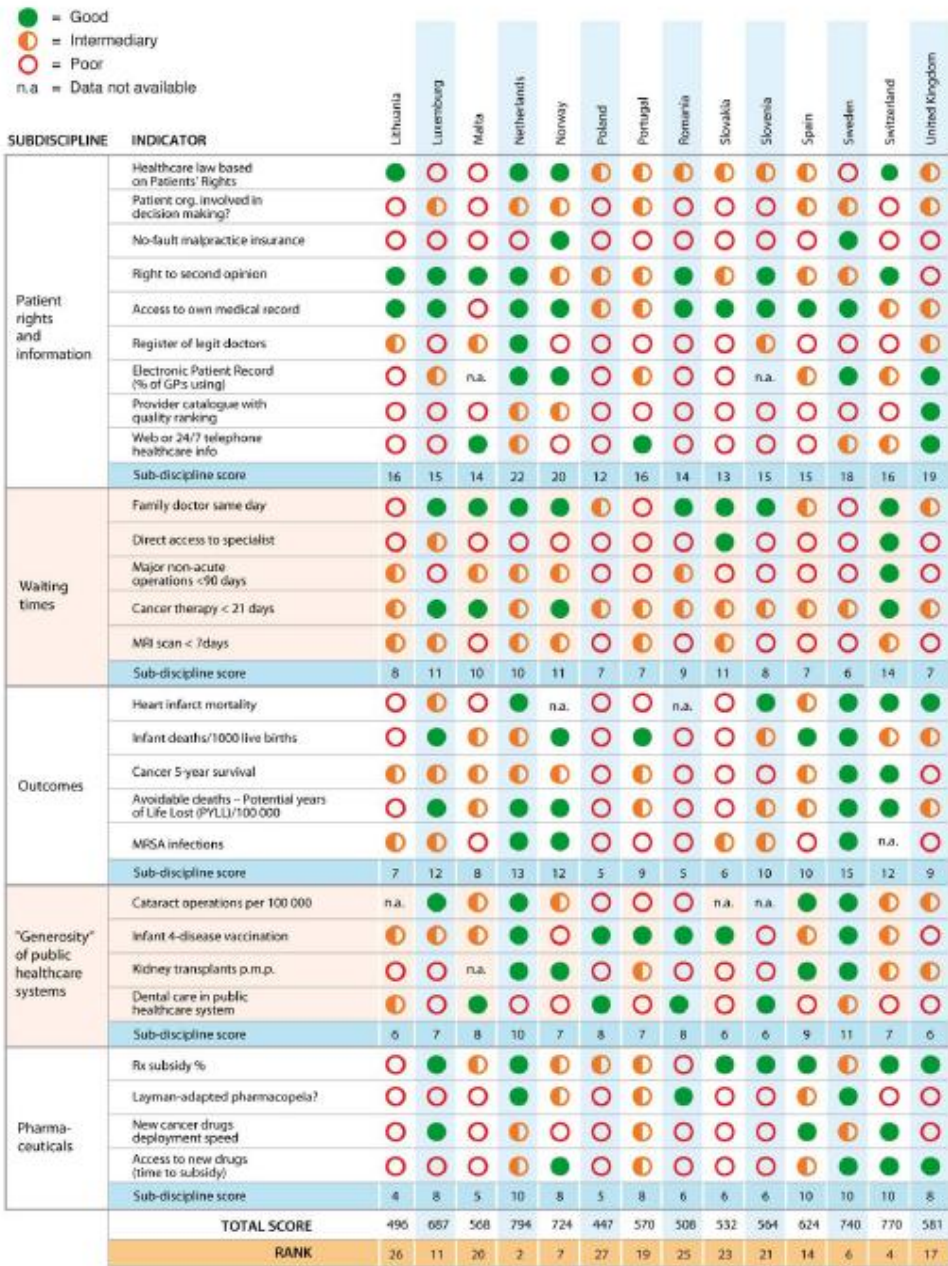


Figure 1. The Euro Health Consumer Index 2007.

Firstly, concentration on patients, consumers as the ultimate target of care systems is at stake. The director of Powerhouse believes that “consumer power has been increasingly recognized as an instigator of change, a tool for implementing necessary reforms, and an efficient indicator of low performing institutions”. For example, counting the number of surgical

gloves used seems less productive than ranking the probability of patients being rehabilitated by a certain therapy (Hjertqvist, 2002, p.52).

Thus, in the Index the health care systems are supposed to be reviewed in the light of effectiveness from consumer perspective; in other words, what patients get.

Secondly, in the context of EU integration, the question of comparative effectiveness of their national systems arises. According to Noll (2002, p. 47), “the process of European integration has stimulated the development of monitoring and reporting activities not only at the supranational, but also at national and sub-national levels”. So, the idea of rankings or league table appeared¹. A number of authors believe that despite national differences there is much more in common between care systems development. Thus, Belien (2000) notes that “for almost 2 decades the European nations have witnessed a continuous cycle of healthcare reform policies. Although each of these efforts to craft new public policy has been tailored to fit the specific political, social and cultural circumstances of each country, there are many striking similarities among these attempts”(p. 85). These commonalities evoke the discussion about “a new European model” (Belien, 2000). Hjertqvist defines this as “culture”, a set of values which are common to European health care systems and frame healthcare systems in Catholic as well as Protestant countries (2002, p. 27). The presence of this model allows assessing national systems and ranking them.

Yet, it is worth noting that the idea of countries’ ranking and cross-national comparison is disputable. In particular, Peabody and Liu (2007), drawing on findings of their research and other researches on cross-national clinical practice, argue that quality of care is inconsistently provided to large segments of the population. Moreover, they show that this observation is especially relevant for developed countries. Thus, the authors conclude that “this observation contradicts established notions that care is ‘better’ in some countries than in others. With so much variability within countries, variation among countries does not seem meaningful” (p. 295). In this respect, it is important to reveal the Index authors’ reasoning in ranking states further in the thesis.

However, present developments in the European Union again draw attention to the difference between countries within the Union. The European Court of Justice’s decision relates to the issue of patient rights. The ECJ rulings – the Smits/Peerbooms judgment (case C-157/99) and the Vanbraekel et al. judgment (C-368/98) from July 2001 year explicitly mention undue delay as a legitimization for cross-border care within the EU (Byrne, 2001, Brouwer et al., 2003). As European Commissioner for Health and Consumer Protection Mr. Byrne puts it:

¹ The term ranking is mostly used in the USA while league tables are utilized internationally (Dill & Soo, 2005). In this paper, the two terms will be used as synonyms.

“Patients’ freedom to receive normal and necessary treatments in other Member States cannot be arbitrarily refused” (Byrne, 2001, p. 4). Later, the European Commission adopted a health and consumer protection strategy that had as one of its objectives to “increase the ability of citizens to take better, informed decisions (“exercise real choice”) about their health and consumer interest” (Newman & Kuhlmann, 2007., p. 99). This demonstrates the commitment of the EU bodies to facilitate the process of getting information and choosing a health care provider, if necessary abroad.

In this context, the situation of Mr. Chiocca reveals the trend to search care abroad. Franco Chiocca, a London clothing wholesaler, could have had a hip replacement near his home, for free, through England's National Health Service. But he was unwilling to wait months or years. Instead, he researched his alternatives online and found a clinic in Germany. Hours after landing here, where he didn't speak the language, Chiocca, 52, lay on an operating table, was sedated and cut open by doctors he had just met. Eleven days later, he walked out of the Endo-Klinik on crutches with a plastic joint that cost him 9,300 Euros, or about \$12,340 (Goldsmith, 2005).

However, this example of Mr. Chiocca is not typical. As the research shows the barriers to mobility and, hence, to consumer freedom of choice still remain. According to Rich and Merrick (2006), the current volume of patient mobility is about 1% of public expenditure on healthcare. And as the research under the auspices of the European Commission shows, “only 4 percent of Europeans received medical treatment in another EU Member State over the past 12 months”, while more than half of EU citizens (54%) are open to travel to another EU country to seek medical treatment (Cross border health service in the EU, 2007).

1.3. Problem Statement and the Objective of the Thesis

One of these barriers of patients’ mobility is a lack of information. In this respect, documents of the European Parliament suggested provision of more information for consumers (as well as health care professionals and providers) which is more readily available” (Brief note, 2006). The Index is claimed to address this problem. Moreover, the Index is defined by its authors as “the best device to compare the evolvement of consumer – friendly healthcare around Europe” (Index, 2005, p. 1).

In this respect, the question arises whether the establishment of the Euro Health Consumer Index will add anything beneficial to the already existing evaluations by institutions like WHO and the OECD. Therefore, after having looked at the current evaluations provided by

the above-mentioned institutions, it is interesting to look at the actual benefits of the Index. This leads to the following research question:

What is the added value of the Euro Health Consumer Index for different stakeholders in respect to existing mechanisms of national health care systems evaluation provided by WHO and OECD?

The establishment of the EHCI has *value* when it contributes to the already existing evaluation systems put in place by the above-mentioned organizations. The *added value* is at stake when the Index' contribution is complementary to already existing systems. In this sense, 'complementary' means that the Index does not just displace information already mentioned in other evaluation reports, but interprets it in terms of the patient perspective and, thus, has its own novelty and topicality. In this context, Neufville (1975) does not consider 'duplication as a major problem'. He suggests that "it is not an unreasonable strategy to allow duplication. Statistical programs which grow out of the needs of the operating agencies can be the most relevant and usefully formulated of any data. Overlap may help to insure that we do end up with some that is useful" (p. 28-29).

In the thesis I will define the added value for the three main groups of stakeholders. First of all, these are consumers as individuals as the Index is claimed to take the consumer perspective. Then, I take a higher level of aggregation and investigate the question of an added value for patient organizations. The third group is policy makers at national level as the Euro Health Consumer Index 2007 compares national health care systems.

As the Index, its indicators and measures are subject to changes, it is important to mention that the thesis analyzes the Index 2007, its indicators and measures. Yet, for gaining a better understanding of the Health Consumer Powerhouse aims, I use also the Indices of earlier years (2005, 2006). At the same time, their indicators, measures of indicators are not the focus of this study.

To answer the main research question, it needs to be broken down into several sub questions that will be dealt with in the subsequent chapters of this thesis.

Firstly, it is necessary to reveal *what is the peculiarity of the consumer perspective which is emphasized by the Index authors.*

Secondly, to understand the inner logic of the Index and its possible influence, *the issue of the Index assessment including choice of indicators will be addressed.*

Thirdly, it is necessary to comparatively understand the nature of the Index itself, answering the question - *what are peculiarities of the Index in comparison to the established evaluation systems?*

1.4. Research design

The first chapter will address the issue about peculiarities of the consumer perspective. For this purpose, it is necessary to trace briefly development of health care logic - from weak professionals to professional sovereignty and from managed healthcare to consumerism. Special emphasis will be given to the reasons of professionals' power that allows to understand a later shift to the market mechanism as a way of cost reduction. Market mechanisms focus more attention on patients, their rights and, consequently, contributed to the development of consumerism and patient empowerment.

The second chapter will deal with the second research question and provide theoretical frameworks against which the Index will be assessed. This chapter will consist of three parts.

First, as the thesis is aimed at discovering possible added value for different actors, it is important to see how public statistics may influence different actors, namely consumers, patient organizations, policy makers. This part draws on the theory proposed by McRae (1986).

Second, it is important to see what criteria should be met by the Index. For this purpose, I introduce the theory for assessing of league tables. Gormley & David (1999) describe this theory as criteria for organizational cards. However, I argue, this theory can be applied on a higher level of aggregation. Cards are aimed at assessing not only specific organizations, but also "certain policy domains" in terms of Gormley & David (1999). The authors also suggest that "the states (in the USA) are very often themselves the subject of report cards in policy domains. For example, in the USA the Corporation for Enterprise Development, Washington, D.C., public policy advocacy and research group publishes an economic development card for the states every year. Working Mother Magazine publishes an annual report card on child quality, safety, availability, and commitment for all 50 states. And several organizations publish state-by-state summaries of environment protection efforts" (Gormley & David, 1999, p. 2). Thus, I argue, health care policy can also be viewed as a certain policy domain. Moreover, the criteria of Gormley & David (1999) proved to be useful for cross-national analysis of ranking, or league tables (Dill & Soo, 2005). Therefore, these criteria will also be used for the Index evaluation.

Third, the chapter will elaborate on the consumer perspective and the types of indicators associated with this perspective. Here, I propose a system based model of indicators as well as the discussion on objective/subjective indicators.

At the end of the chapter, based on the discussion on peculiarities of the consumer perspective and my theoretical frameworks, I will formulate some expectations on the Index approach in general and indicator in particular. These expectations are to be tested in the next empirical chapter.

The third chapter will give an answer to the third sub-question about the Index peculiarities in comparison to the WHO and OECD evaluation approaches. Such a comparison can be made only after understanding approaches provided by WHO and OECD. The next step should give insight into the Index specificity. And having done this, it is possible to make a solid comparison. Following this logic, the chapter will consist of the 3 parts.

In the first one, the OECD and WHO approaches should be briefly reviewed. *In the second part*, the Index will be in focus. Here, the Index quality in terms of choosing indicators, gathering information, and ranking should be discussed. Methodological evaluation of the Index against criteria stated in the theoretical part will be a key element in the empirical research as it will provide an answer whether the EHCI content corresponds to the claimed paradigm (the consumer approach) or not. At least, the Index' possible users, its target groups at different levels to which the research appeals, shall be clarified. The aim here is not to reveal the Index usage itself, but to look how it complies with the objectives claimed by its producers. In this context, the Index quality will be analyzed. *In the third part*, after having investigated peculiarities of the WHO and OECD approaches, on the one hand, and the Index, on the other, a comparative conclusion on their peculiarities will be drawn.

The fourth chapter will provide an answer on the main research question concerning the Index added value to the already existing mechanisms of evaluation of cross national health care systems. In this respect, some critical questions will be formulated. These questions could lead to possible improvement of the Index quality.

1.5. Methods

In this thesis the focus is placed on the Euro Health Consumer Index, its peculiarities and its assessment. In essence, the thesis utilizes *a case-study approach*. Moreover, as the Index is viewed in the context of the WHO and OECD approaches, *a comparison* of the Index and these approaches is suggested.

The thesis is based on *primary and secondary data analysis*. Primary data is used in several cases. Firstly, the Euro Health Consumer Index 2007 itself is assessed against theoretical frameworks in the third chapter. Secondly, sources of information which concern the context of the Index, i.e. press releases of the Health Consumer Powerhouse, press releases of the ministries (particularly, Malta and Ireland) are presented. Then, documents and news articles describing such aspects of health care as mobility and regulation by the European Court of justice (European Parliament Briefing Note, Analytical report by the Gallup Organization) are found on the internet. Thirdly, the World Health Organization Report 2000 and database as well as the

Organization for Economic Cooperation and Development documents which are available on the internet are used to demonstrate specificity of the organizations approach.

Secondary data analysis is utilized to describe the development of the dominant perspectives in health care systems in the first chapter. The chapter draws on both academic journals articles and books.

Further, meta-analysis is used for a critique of the WHO and OECD approaches. It draws on scientific articles which address some controversies of the approach. Such search engines as google scholar, scopus, and pubmed are used to identify these articles.

Finally, the interview with the Health Consumer Powerhouse researchers is supposed to clear out some aspects of the Index construction and its purposes, its potential beneficiaries.

2. Historical Outline of Dominant Perspectives Development in Health Care

In order to understand the specificity of the consumer perspective claimed in the Index, it is necessary to analyze consumerism in the context of health care development. Although it is not a part of the question, at the beginning, it is necessary to mention a general nature in the construction of this development. Then, consumerism should be viewed as a certain stage in the development. In this context, it is necessary to reveal factors and reasons that drove the transformation of dominant perspectives preceding consumerism. Having understood specificity of previous dominant logics, it would be possible to compare them with consumerism and, thus, to answer the first sub-question about peculiarities of the consumer approach.

Following this reasoning, a brief outline of professional and managed health care will be presented. In this analysis, attention will be given both to peculiarities and factors which spur changes in the approaches. Then, consumerism will be reviewed. Finally, a comparison between consumerism and previous perspectives will allow to draw a conclusion on specificity of the consumer perspective.

2.1. Possibility of Generalization

Every country has its own health care system which is characterized by specific features due to unique historical and cultural developments. Yet, it is possible to make some generalization and after Belien (2000) and Hjertvist (2002) to point out a “European model” or even speak about such a broad concept as a Western model which also includes Australia, New Zealand, Canada, and the USA (Taylor & Field, 2007; Kemp, 2007). Reflecting on the common model, authors usually point out a set of values: 1) “a special concern for equality” (Tharakan, 2003, p. 1417), 2) the guarantee of access to health care services (Elola at al., 1995, p. 1397), 3) a mixture of tax financing and patient fees in different proportion which are underpinned by ‘the role of the government, as lawmaker, co-funder, and supervisor of performance’ (Hjertvist, 2002, p. 47-48). Importantly, although the term “European model” is used; the authors recognize differences between members of the EU and give examples concerning only Western European states (Taylor & Field, 2007; Kemp, 2007; Scharpf, 2002; Hjertvist, 2002; Belien, 2000; Elola at al., 1995)

However, discussing the common logic of health care development, it is necessary to keep in mind differences even between Western countries. For instance, Elston (1991) draws attention to the fact that even the autonomous professional is described often as an Anglo-

American phenomenon (see, for example, Freidson, 1977) while Britain and the USA differ considerably in economic autonomy, i.e. NHS is the de facto monopoly buyer of health service.

Moreover, there are remarkable differences between West and East European countries. In particular, the Eastern European countries were a part of the Soviet system where “the average earnings of physicians were reported to be less than three-quarters of the average industrial wage” (Starr, 1982, p. 6). Considerable difference between Eastern and Western Europeans in health behavior (Stephoe & Wardle, 2001), in self-perceived health (Carlson, 1998) have been found. Although the Index encompasses both Western and European countries, development of their health care systems differs considerably. Yet, the East European countries joined the European Union and are following western logic of health care development. So, the current trend towards consumerism in health care can be defined as trans-European (Newman & Kuhlmann, 2007, p. 99).

Thus, the following discussion on health care logic 1) is aiming at tracing trends which are common mainly for Western countries and 2) does not focus on differences.

2.2. Professional Dominance

In Western industrial societies, the health care system underwent dramatic and deep transformation in its development. In its history there were different groups which dominated in the sphere and defined its development. In particular, Starr perceives “medicine as a world of power where some are more likely to receive the rewards... This power originates in dependence, and the power of the professions primarily originates in dependence upon their knowledge and competence” (1982, p. 4).

However, for a long time power belonged to elites which significantly dominated while professionals served them. For example, in “eighteenth-century England ... physicians stood only at the margins of the gentry class, struggling for the patronage of the rich in the hope of acquiring enough wealth to buy an estate and a title” (see, for more information Cunningham & French, 1990).

Since the nineteenth century, the positions of professionals changed and they were gaining more power (Taylor & Field, 2007). But only in the twentieth century, the professional logic started to dominate so significantly. By the example of America it is possible to see how medicine developed from a divided enterprise undertaken by a diverse array of sectarian practitioners of low regard whose therapies did more harm than good and mired in factionalism and sectarian conflicts, into the modern era, which saw the rise of a unified and powerful enterprise - “a sovereign profession and vast industry” as Wailoo et al. (2004) put it (p. 559)

The thesis of physician or medical dominance can be traced to the writings of Freidson who beginning in 1970 attempted to explain the rise of medicine to a position of professional dominance and autonomy (Barnet at al., 1998, p. 194). In the discussion of medical power, the concepts of autonomy and dominance are often used interchangeably. Particularly, Coburn derives autonomy from dominance (Barnett at al., 1998, p. 194) and Kemp (2007, p. 44) defines “medical dominance as social, cultural and professional autonomy”. According to Starr, medical authority includes two sources of effective control: legitimacy and dependence. Doctors and other professionals claim authority not as individuals but as members of a community that has objectively validated their competence. The professional offers judgment and advise not as “a personal act based on privately revealed or idiosyncratic criteria, but as a representative of a community of shared standards” (1982, p. 12).

However, a number of researchers differentiate between autonomy and dominance. Elston (1991) argues that *medical dominance* refers to medical authority over others while *professional autonomy* describes the legitimated control that the occupation exercises over the organization and terms of its work.

The transformation of medicine into an authoritative profession was driven by socioeconomic factors as well as by changes in the health care delivery system itself (Cicatiello, 2000, p. 18). The health care development here implies advancement of science. As Freidson argues, “scientific and technological change and especially the improved therapeutic competence of physicians” explain to a greater extent the rise of medical professionals’ authority (Starr, 1982, p.16). Yet, improvements in science do not mean necessarily that physicians would always remain in control. Thus, Starr points out that science might reduce professional autonomy. Modern medical practice requires huge capital investment and these investments make medical professionals vulnerable to control by whoever supplies the capital (1982, p. 16). In respect of internal development, Starr puts emphasis on the mechanisms of legitimation in terms of standardized education and doctor licensing rather than science. The changes in social environment lead to the situation when the mechanism of dependency on the professional also strengthened. Particularly, these mechanisms concern growing gate keeping functions and provision insurances (Starr, 1982 p. 20).

Moreover, the professionals managed to turn their authority into “social privilege, economic power, and political influence” (Starr, 1982, p.5). The achievement of economic power involved more than the creation of a monopoly in medical practice through the exclusion of alternative practitioners and limits on the supply of physicians. It entailed shaping the structure of hospitals, insurance, and other private institutions that impinge on medical practice and defining the limits and proper forms of public health activities (Starr, 1982, p. 25).

Generally, in terms of Coburn at al., profession dominance can be presented as a four-fold division of medical control over 1) the content of care, 2) clients, 3) other health occupations, 4) health care policy (Kemp, 2007). Particularly, in Britain when doctors negotiated with the architects of the NHS, they were in a powerful position to extract a number of important concessions from the government, including the right to treat private patients. The final agreement between the government and the medical profession:

1. guaranteed the professional autonomy and clinical freedom of doctors;
2. gave doctors a major voice in the allocation of health care resources
3. confirmed the power of doctors over other health workers, including nurses (Taylor & Field, 2007, p. 220).

Malin at al. (2002) views medical dominance in general and the regulation by NHS in particular as an obstacle for the potential of strong patient or consumer influence.

Thus, the last two centuries see the rise of professionals in health sector. Especially since the beginning of the twentieth century doctors dominated enjoying professional autonomy. They derived their power from their legitimacy and dependence provided by environmental needs and internal development of health care (gatekeeping functions and licensing, respectively). This logic of professional dominance implies that doctors defined rules and conditions in the sector, and exercised control over policy making. In this system, patients had little say in decision making.

2.3. Managed Health Care, or Proletarianization/Deprofessionalization

In the nineteen eighties there was a new stage in health care development. There was a growing realization that the returns of clinical medicine have not always matched the significantly increased level of investments. A number of research studies have suggested not only that medicine has done rather less to improve human health than was generally believed, but that it has also created iatrogenic disease. Public confidence in medicine has also been eroded by a number of high profile scandals about medical mismanagement, failures, abuses of power and unevenness of care between different regions and hospitals. The ever-increasing demand for health care has led successive governments to try to control costs and attempts to make clinicians more accountable for the resource they use (Taylor & Field, 2007, p. 220).

In terms of Light (2002, p. 213) the “buyers’ revolt” happened because those who had long paid the bills (insurers, governments, employers) became so fed up by the waste, excesses, and variability of service delivered under professional dominance that they started to take forceful action.

For example, in Britain in the early nineties the Conservative government initiated a program of reforms of the health service designed to transfer much of the decision making over resources from doctors to managers. The subsequent New Labor government adopted a different strategy. While devolving decisions from the centre to Primary Care Teams and hospitals, and appearing to give health professionals more discretion to make clinical judgments, these decisions had to operate within new systems of accountability and regulation set out by the government. Doctors and other professionals have become much more accountable to government for the resources they use, and their clinical activities are more closely monitored than ever before (Taylor & Field, 2007, p. 222-223). Across western countries similar reforms were implemented.

All these reforms and developments were theorized as proletarianization or deprofessionalization by sociologists. According to Elston (1991), both concepts imply 1) loss of privileged status by medicine on the basis of technical expertise; 2) these changes are developing and the process is not complete, 3) the trend away from independent, fee-for-service based, solo practice towards salaried practice carried out within complex bureaucratic organizations. Yet, there are considerable differences in stress they put on particular processes.

Calnan and Williams indicate that proletarianization involves “occupations becoming more subordinate to the requirements of production, and more concretely it involves an increased emphasis on managerial imperatives (productivity, cost efficiency) and greater specialization/deskilling with other health care workers (Barnett et al., 1998). Here, bureaucratization and corporatization play the main role in limits of medical control over the context and content of care. Yet, medicine does not lose its central position in health – but it is subject to re-stratification, where the clinical imperative is aligned in a corporatist system of health care provision (Kemp, 2007, p. 47).

Prior to this proletarianization, the physician’s role in the provision of health care was secured, as long as there was an ever-expanding system of professional autonomy, and as long as the public’s love affair with therapeutic medicine continued. Therapeutic devices increased the amount of activity devoted to each patient in the system. Physicians did not really have to consider the impact of their decisions on the public at large, and each was quite rightly secure of their own individual autonomy (and quite reassured of the prospects of living comfortably). However, the growth of the amount of funds devoted to health per physician slowed from 1973 to 1993 during the rise of managed care. Since then, the autonomous physician is finding himself or herself more frequently in the operations of large technologically integrated organizations (Kemp, 2007, p. 47).

The concept of proletarianization was criticized. Its opponents argue that its acceptance presupposes the validity of the general account of progressive proletarianization of virtually the entire labor force in advanced capitalist societies and the identification of this process with Weber's ideas about bureaucratization. This claim lets alone within the wider body of sociological theory. For example, theoretical debates about the development of a "service class" or the significance of educational credentials for class formation are ignored by proponents of proletarianization (Elston, 1991). The evidence presented is generally weak or ambiguous, particularly concerning physician behavior in these bureaucratic organizations. The same observations sometimes appear as both cause and effect of the proletarianization process. According to Elston (1991), proletarianization itself remains unarticulated as a concept, making its applicability to the medical profession unclear. In terms of Freidson, proletarianization is a slogan, rather than an analytic concept. Some limitation and ambiguity of the concept was also recognized in recent research (Barnett et al., 1998, Kemp, 2007).

Although the advocates of deprofessionalization are concerned with the sociological significance of the same general developments in health care, they identify different factors as the key changes. Whereas the proletarianization thesis places most emphasis on the changing work conditions of professionals, especially the growth of salaried practice and the alleged subordination to managerial control, deprofessionalization stresses changes in the relationship between physicians and their patients. Deprofessionalization refers to physicians' losses of both autonomy and authority. The growing prevalence of constraints on medical autonomy in the form of utilization review, contractual provisions, and other managed-care practices has been extensively studied (see for example, Schlesinger, 2002). Increased rationalization of medical practice and knowledge led to a decline in the cultural authority of medicine and the extent of monopoly over health-related knowledge.

Elston (1991) provides solid criticism of this concept. She points out that unlike the proletarianization thesis arguments for deprofessionalization do not explicitly draw on a general theory of social change. But the changes in medicine are seen as part of more general social trends of rationalization and codification of expert knowledge and the development of more critical public attitudes to professional experts' paternalism. The main limitations of the deprofessionalization thesis are similar to that of proletarianization, i.e. the lack of specificity makes it hard to test. The evidence proffered is limited, often leaving the significance of changes to be inferred rather than demonstrating it. For example, no direct evidence is present on whether increased use of computers in medicine brings about a demystification and routinization of medical procedures, rendering them more amenable to lay scrutiny. When claims of deprofessionalization are made, it is not always clear exactly what the end point of the process

would be. Does it refer to a radical democratization of knowledge and skills leading towards the elimination of a separate skilled cadre of healers or to diminution in collegiate control over medical work in favor of greater mediation by third parties or to the elimination of medicine's privileged position within the health division of labor?

Even proponents of the deprofessionalization thesis recognize its ambiguity. Thus, Schlesinger (2002, p. 188) admits that "there has been much speculation about whether this loss of autonomy was a cause or a consequence of the declines in medical authority; directly measuring attitudes related to medical authority has proven to be difficult, with findings that are less consistent than those related to professional autonomy".

According to Elston (1991), neither proletarianization nor deprofessionalization can be regarded as full-fledged "developed theories which are amenable to rigorous testing". However, these concepts draw attention to the issue of medical power declining due to changes within managed health care aiming at more efficient health care.

Indeed, the cost reduction consideration was at the front of such reforms in western countries. On the one hand, it is supposed to draw attention to patients' needs and requirements as an indicator of doctors' performance. Therefore, patients' position was supposed to get more prominent and became influential. On the other hand, Belien (2000) argues that introduction of managed health care was aimed only at limiting cost with market mechanisms. This scientist shows that the reform goal was an attempt to create managed competition or internal markets within a global budget. As the reform did not allow economic growth and expansion, the market becomes a perversity and consumers lose their options. The priority on reducing costs and becoming more efficient led to a greater extent to losing sight of patient (Cicatiello, 2000, p. 21). As Belien (2000, p. 86) put it, in managed healthcare/competition, "consumers have no say". Consequently, managed health care drew attention to patients but did not address the issue of their needs and requirements.

2.4. Consumerism

Contemporary societies see the rise of the ethic of consumerism. The development of consumerism can be viewed in terms of Robinson (2001) as "the volatile confluence" of several features.

First, it reflects a deeply rooted political culture. Individualization and the construction of an "autonomous-self" and reflective actor domain (Newman & Kuhlmann, 2007., p. 99) evoked skepticism with respect to professional, governmental, and corporate domains in health care (Robinson, 2001, p. 2625). Secondly, an extended period of economic prosperity led to the

situation when citizens believed “they had a right to unrestricted access to even more convenient, personalized, and high quality service” (Robinson, 2001, p. 2625). Thirdly, the phenomenal growth of the Internet technology enhanced and amplified the cultural changes towards consumerism unleashed by prosperity, individualism, and rising social expectation. All these contributed to shift from managed care and toward a health care system based on individual choice. Now patients increasingly arrive in their physicians’ offices armed with printouts, citation, etiological theories, referral requests, and suggested interventions (Robinson, 2001, p. 2626).

In the literature, the question whether consumerism replaced previous health care dominant logics or not is controversial. A number of authors answer this question positively drawing attention to the differences between managed care and consumerism approaches to the treatment. Particularly, Terry (2005) stresses the limits of patients’ choice and participation in decision making within the system of managed care, while under consumerism demands are managed “by educating employees about health care and cost and by ensuring that employees pay a more meaningful portion of the cost of care”. Thus, consumerism encourages patients “to make informed decisions about a broad range of health related issues” (p. 18). In terms of Robinson (2001), these changes contribute to “the end of managed care’. Yet, a group of researchers maintain that managed care logic is still strong nowadays. For instance, Scott et al. in the book “Institutional change and healthcare organizations: from professional dominance to managed care” describe the current state of health care development as “the era of managerial control and price competition” (Light, 2002, p. 17).

Furthermore, this question relates to professional dominance. Scientists mainly agree that there are significant changes in approaches to patients’ treatment. For example, authors tend to speak about “declining professional dominance” (Barnett, 1997), “decline in medical authority” (Schlesinger, 2002), “shifting in medical dominance” (Kemp, 2007). Moreover, consumerism is viewed sometimes as just “a challenge to medical dominance’ (Taylor&Field, 2007). So, although “traditional professional dominance in health care may, in some part, be disappearing or being rejected” (Imanaka, 1997, p. 395), the position of professionals is still prominent in decision making.

I argue that it is possible to identify a dominant logic in health care development for a certain period of time. Meanwhile, it is necessary to keep in mind that a present dominant logic is inevitably determined to a great extent by previous development. Here, the path dependence theory could be useful in explaining contradictions between scientists. According to a broad definition given by Sewell, “what happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time” (Pierson, 2004, p. 20). Thus, the development of health care is determined not only by consumerism but also by logic of

managed care and professional dominance. Consequently, current development of health care systems is characterized by features pertained to consumerism, managed care, and professional dominance. Therefore, I argue, consumerism is laid on both professional dominance and managed care logic, but did not replace them.

However, the logic of consumerism bears its own peculiarities and considerable changed health care practices.

Consumerism holds that as patterns of consumption in contemporary affluent societies are increasingly determined by choice, want, and preference rather than need, consumers have more power and authority at the expense of producers. Underpinning this view is the belief that the market always “knows” best, and that “success” depends on pleasing the consumer. These consumer values are now having a significant influence on the delivery of health care (Taylor & Field, 2007, p. 220). Moreover, according to Fenwick and Snape, consumerism is often seen as a tool to make management more responsive and accountable to those who use the service (Gilliant at al., 2000).

Consumerism implies that the role of patients in health care has changed. It concerns several aspirations (Newman & Kuhlmann, 2007., p. 100):

1. improvement of consumer participation in decision making in order to respond to citizens' claims of self-determination;
2. overcoming the “producer dominance” of health care systems by challenging professional power;
3. taking more responsibility by patients for their own health both to reduce their reliance on state service and to promote better health outcomes.

The mechanisms by which the aspirations might be operationalized are by undertaking consumer satisfaction surveys, formulating complaints procedures, providing mechanisms whereby patients can exercise some choice in deciding who should be their primary health care doctor (GP), publishing and distributing to the whole population what their rights are, and standards of service they should expect. See Figure 2 (Almond, 2001).

As Newman & Vildler (2006) show, these implemented aspirations can lead to construction of new forms of relationships and patterns of identification - the ‘empowered user’, the ‘expert patient’ and the ‘discriminating customer’, respectively.

This implies a fundamental shift in the role and status of health practitioners, one of which is that their knowledge and power lose some of their authoritative status. This aspect of consumerism in which the empowered user is constituted as knowledgeable and able to participate in treatment processes as well as to be responsible for their own good health - is therefore at the center of, and necessary to, a much wider program of modernization and reform.

Such images of empowerment tend, however, to draw on a zero-sum conception of power that has been widely criticized (Newman & Vildler, 2006, p. 197).

The assumption underpinning the image of the patient as '*discriminating customer*' is that people have become used to flexible, responsive, user-centered service delivered in the market place and want the same when they come to the NHS. It is possible to identify a few difficulties inherent in such an assumption. The first relates to whether or not consumers do actually get what they want from the commercial sector – much of which is increasingly based on the decidedly unfriendly relations with the call center. The second concerns whether people really do expect or want the NHS to behave like a company or whether it has a rather different place in the popular imagination. But the third, rather more serious, difficulty centers on the role and status of 'choice' in the reform program and the tensions between this and other political discourses – notably those of equality and need – that remain significant in Labor's political lexicon (Newman & Vildler, 2006, p. 197-198).

According to Newman & Vildler (2006) there is a slippery boundary between conceptions of the discriminating customer linked to choice and the empowered service user linked to knowledge (p. 203).

Ostergren (2006) utilizes slightly different terms – empowered patients and consumers to denote the situation which is very close to one described by Newman & Vildler. In Ostergren's opinion, the private consumer is associated with "the capacity to exit". The capacity to exit is the essential ability of the consumer in the market place. If the consumer is no longer satisfied with the goods or the service, she can vote with her feet by choosing to buy from another provider. One example of this is the Canadian model of 'service brokerage', where the service user is able to spend the money on the purchase of services from whomever she or he judges is most appropriate. Then Ostergren (2006) elaborates on the term - empowered patients. Here, more emphasis is given to the patient's 'voice'. In this approach the individual does not stand alone, nor is he/she dependent on professionals for the expression of wishes and choice, but is supported collectively by some degree of citizen advocacy.

Again, in the literature there is no unanimous answer to the question how consumerism and empowerment relate to each other. On the one hand, a group of scientists (Gooijer, 2007; Almond, 2001; Fine, 2000; Ellis) depict empowerment as a part of consumerism. In particular, Almond (2001) describes empowerment of patients within health policies of consumerism.

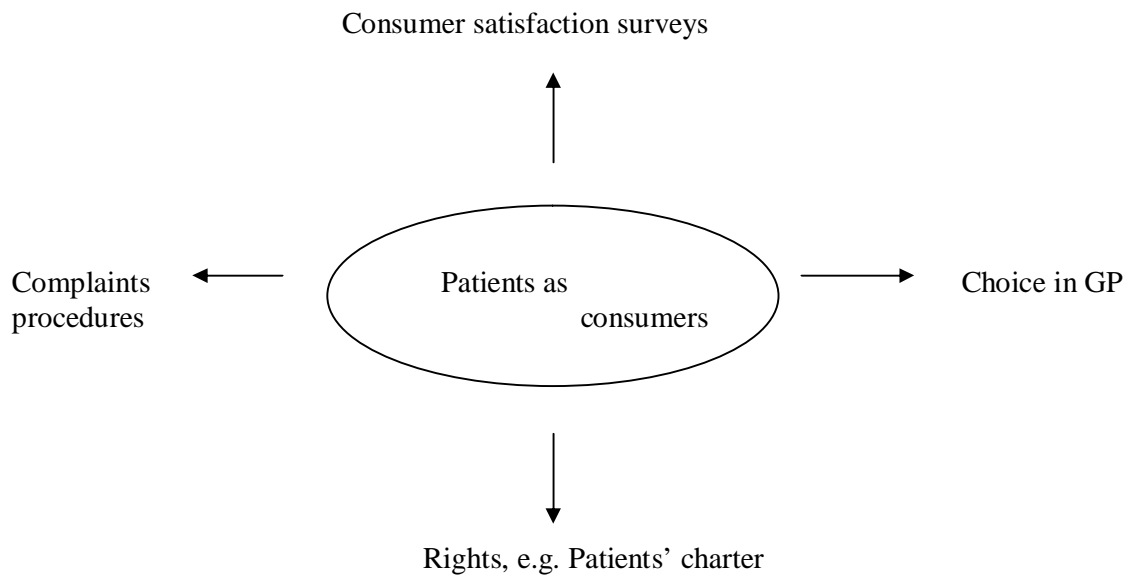


Figure 2. Summary of the consumerism in health policy (Almond, 2001, p. 895).

In terms of Fine (2000), “patients’ rights are a principal area consumerism focuses on”. According to Ellis, “consumerism power is the central force which will inevitably focus the attention of providers on individual needs and preferences” (Malin et al, 2002, p. 59). Thus, consumerism itself leads to the situation when patients have more rights and, consequently, to patient empowerment.

On the other hand, many differentiate between the concept of consumerism and empowerment. For instance, Malin et al. (2002) describe “the tensions between consumerism and empowerment as frameworks for user power” as one of the key debates in health and social policy. They draw on the origin of the concepts. The authors show that consumerism arose from Thatcher’s conception of the role of the individual in the market-oriented society, whereas the concept of empowerment is associated with the radical left. Moreover, they argue that “the patient as ‘consumer’ had very little power” in terms of both access to treatment and the nature of treatment (Malin et al. 2002, p. 39).

Definitions of empowerment are many and varied but generally the term is used to mean that service users have more control or power over the services or support they receive. Barnes and Bowl argue that it is appropriate to see empowerment as ‘a process in which people develop “power to” take decisions, take actions, make choices, or work with others which they were previously unable to do’. Such a definition helps to get over problems about whether people can be given or granted power by professionals. It is particularly applicable to circumstances where people may be too ill or distressed to act as ‘consumers’. One example of such empowerment is

the limited but growing use of advance directives, where people can make plans about what they wish to happen to them in the event of illness or incapacity.

Empowerment and consumerism may seem to have much in common. Both describe a relationship with services or other material goods. Consumerism is more market focused, however, and in welfare the word is frequently accompanied by other terms; quasi or citizens, active or passive, willing or coerced, to reflect the complexities of the transactions involved. Adams places empowerment within a historical time frame, drawing attention to aspects of self-help, mutual aid and political struggle in the nineteenth century which link to empowerment. Over the twentieth century, other important values such as self-determination have influenced empowerment. Empowerment, therefore, may not be only in respect of services but part of a move away from state or official support (Malin et al., 2002, p. 62).

Furthermore, Gilliat et al. (2000, p. 333) maintain that “such consumerism far from empowering the individual consumer, has served to co-opt service-users into management of scarcity, rationing, and/or technological change”. The policy of consumerism which is closely connected with greater responsibilities taken by consumers leads to producer empowerment rather than consumer empowerment.

Thus, there are points of commonality as well as difference between the two concepts.

The increasing similarity between seller-consumer and professional-patient relationships can be seen in a number of ways. Firstly, those selling goods and services in the free market have to find out what customers want through market research, and now the NHS has to do the same. In 1998 the labor government ordered the first national survey of the NHS and 150 000 people from every part of the country were asked for their views about the service. Doctors and nurses are now expected to research their patients’ lives and expectations in order to provide the “right” kind of service. Initiatives in medical and nurse education aimed at eliciting the “patient’s point of view” and modules aimed at developing better “communication skills” in health care are good examples of this process (Taylor & Field, 2007, p. 225).

Secondly, like any other customers, patients are now much freer to express any dissatisfaction through complaints and litigation. Patients have become more willing to challenge doctors’ authority, with written complaints about NHS hospital and family service.

Thirdly, just as the market uses the supposed expertise of the informed consumer, so health care has developed the idea of the “expert patient” who should be more active in the management of their own condition. For example, in Britain, Expert Patient Programs are based on the idea that patients’ expert knowledge of their own conditions is a valuable resource that has not been exploited enough in the care of chronically ill individuals. Nominated lay experts can empower other sufferers who would then operate in “partnership” with doctors and nurses.

In terms of Henwood et al. (2004), the consequence of this is lay skilling, when an increasing number of people (rightly or wrongly) feel they are better informed to question, challenge and increasingly complain about medical decision making.

As the patients are so well informed, they expect to participate in decisions that may affect their personal or family health. With organ transplants and sophisticated procedures in the treatment of diseases, there is definitely a greater need today for ethical, informed decision-making for patients and families. They expect to “be involved ... and understand the risks involved as well as prognosis” (Cicatiello, 2000, p. 21).

Yet, the issue about the patient’s role in decision making is debated. Many authors point out the limits of such involvement in particular and consumerism in general. For example, Lupton (1997) demonstrates that in their interactions with doctors and other health care workers, lay people may pursue both the ideal-type "consumerist" and the "passive patient" subject position simultaneously or variously, depending on the context and consumerism fail to recognize the complexity and changeable nature of the desires, emotions and needs that characterize the patient-doctor relationship (p. 373).

“When the highly paid specialist said the decision to have a fancy medical test was up to me, I knew "empowerment" had gone too far. I was paying him to make the decisions. But he was acting like the junior partner in my health care. I might have yelled "Power to the People" in some demo 20 years ago when he was clawing his way into the Macquarie Street medical establishment, but I didn't actually mean power to me over every technical decision that would crop up in my life. I didn't seek to be "empowered" in matters that bored me, like tax, or that totally baffled me, like expensive tests. I long for the old doctor-as-God, for the expert who would tell me what to do rather than lay out the odds” (Lupton, 1997).

Generally, the image of the consumer stands in the center of the health care system reform. The new health care consumers demand a strong personal influence over the organization of the health care system, because they are different from patients from the past. Hjertqvist (2002, p. 48) argues that “they are not only better educated, more integrated into social networks, and better off financially than earlier generations, but in general they are also more accustomed to making complicated, long-range decisions by themselves”.

The consumerist model of public service provision has attracted a number of political and academic critiques. Newman & Vildler (2006) review arguments used by opponents of the consumer concept. Some focus on the idea that the customer cannot be a “real” customer since he/she may not pay directly for the service, may be an unwilling involuntary user, or may have no choice due to the absence of real competition for most services. Others take a different approach. Writing on health, Pickstone has suggested that the displacement of a productionist model of health by a more consumerist model was driven by the 1960 emphasis on choice in

lifestyle, and the 1970 notion of the body as a sexual commodity for individual investment. He argues that this tends to exacerbate the inherent supply/demand mismatch in health by both increasing the level of demand and by delegitimizing attempts to ration care. Yet, others focus on the problems that consumerism might produce. Here, Newman & Vildler (2006) mention increasingly open distributive struggle between funders, clinicians and patients, Goering (1996) indicates segmentation in health care delivery and unfavorable position of the poor and minorities, focus on responsive rather than preventive services.

Meanwhile, many professionals draw attention of the public to problems caused by consumerism. Particularly, in 2005 *the Lancet's* editorial (one of the oldest peer-reviewed medical journals) criticized “naked consumerism” pointing out that patients’ trust in the medical profession had been seriously shaken by high-profile cases of medical negligence and crime. Instead of rebuilding the public’s trust in medicine, the government sent “divisive messages” – the NHS should be patient-led, patients need to complain more, people should have choice and control over the care they get, doctors are obstacles to this patient-friendly agenda. The article calls for “a mutual beneficial and effective patient-doctor partnership where medical expertise and knowledge is “accepted and valued” (Editorial, 2005, p. 343).

Furthermore, consumerism is fiercely criticized from a patient perspective. For example, consumerism produces many adverse effects. *Firstly*, Stone (2005) argues that people do not behave in accordance with the rational choice theory. In terms of Fine, “consumers are rational economic decision-makers who have complete sovereignty over the choice of how to use their resources to their best advantage, or to their maximum utility” (Lupton, 1997). Constrained by a limited budget, people choose the option with lowest short-term cost over the one with the lowest long-term or total cost. Another example of such a behavior is the situation when consumer-driven medical care decisions significantly undermine the basic tenets of preventive medicine: regular check-ups, monitoring. Thus, patients are forced to be “penny wise and pound foolish’. *Secondly*, cost-conscious health care decisions are often terrible clinical decisions because they substitute relatively uninformed lay decision makers for highly trained expert decision makers. *Thirdly*, patients mostly do not have access to all necessary information, or alternatively, experience information overload. Consequently, they cannot make an adequate decision (Stone, 2005). Later, patients face significant obstacles in understanding the quality and even the price of health insurance and health care service (Robinson, 2001, p. 2626). *Finally*, consumerism fits most comfortably the educated, healthy, and prosperous; and least comfortably the impoverished, ill and poorly educated. In particular, the latter do not have access to full information; the redistribution of income from rich to poor will be transparent and more difficult

and consumerism will complicate the pooling of insurance risk between consistently healthy citizens and those who are chronically ill (Robinson, 2001, p. 2626).

Generally, Stone shows that “consumer choice” and “consumer direction” are “glittery wrappings in which employers, insurers, and politicians package benefit reduction, program contractions, and budget cuts” (2005, p. 220).

Almond (2001) draws attention to the fact that nowadays at least in Britain the NHS avoids the term ‘consumer’; it uses terms such as ‘patients’, ‘users and public’, which are often conjoined with participation, partnership, involvement or collaboration. The emphasis has changed therefore from a patient’s rights based ethos to one of professionals and patients working in *partnership*. Almond (2001, p. 899) came to the conclusion that the term ‘consumerism’ may be considered as “an outdated concept which seems to have been replaced recently in the British NHS by terminologies such as partnership, public involvement, collaboration, advocacy and patient participation” (also Malien et al. 2002, p. 63).

Despite existing criticisms, the consumer perspective with its focus on patients and their needs dominate in the reform of governments (Gilliantt et al. 2000).

2.5. Implication for the Research

In summary, the current state of health care development which is described as consumerism differs from other perspectives in several relations. Firstly, it shifted attention from professionals (in contrast to professional dominance) and necessity of cost reduction and managers (in contrast to managed healthcare) to patients, their needs. Also changes took place in respect to consumer participation in decision making, patients’ rights protected by the law, lay knowledge contributed to overcoming the producer dominance. On the other hand, patients are required to be more responsible for their own health. Furthermore, these changes stimulate the utilization of new methods of research such as consumer surveys which reveal consumer needs and preferences.

This theoretical discussion on development of dominant perspective has an implication for the thesis. It reveals peculiarities of the consumer approach in health system in comparison to other logics in health care. Therefore, the Euro Health Consumer Index, which is claimed to be done from the consumer perspective, should have features pertaining to consumerism. Based on the discussion above, it is possible to identify several domains or dimensions where considerable changes have taken place. These are 1) dominance, 2) decision making or choice, 3) rights, 4) knowledge. They will be elaborated further in respect to the theories described in Chapter 3.

3. Theoretical Frameworks

This chapter represents theoretical frameworks for the thesis. At the beginning, it is important to understand what the Index and indicators are. For this purpose the chapter reflects on the terms of 'index', 'indicators' and 'measures'. Since the objective of the thesis is to define the added value of the Index for different actors, it is important to see how statistics contribute to decisions of various actors. Therefore, at the beginning, I introduce the theory of four types of action proposed by McRae (1986) for defining the Index position in respect to possible actors and their actions. As the Index itself requires assessment, the chapter elaborates on critical criteria for assessment of league tables. These criteria are closely connected with the question of choosing relevant indicators for ranking. As such, a discussion on incorporation of the consumer perspective in terms of subjective/objective indicators and a system based model of indicators will be discussed. At the end, the chapter will reflect on operationalization of the theories in application to the objective of the thesis.

3.1. Terminology

The public health/public policy literature generally distinguishes between *measures* and *indices*, and between the activities of *measuring* and *indexing*. *Measures* are generally used to refer to numbers (or categories) derived from a single data collection activity, and aggregated across cases. Thus, a radar survey of speed (*measuring* speed) yields a single datum for each car that can be aggregated across cars to yield a *measure* of speed (or compliance with speed limits). A measure may rely on a number of items or on a questionnaire or survey that are combined (usually according to either a simple additive model or an empirically developed set of weights) to yield a single datum per case (Klitzner, 2002, p. 4).

An *index* refers to a higher-level aggregation of data across measures that is either hypothesized or known to provide a more accurate measure of a construct than can be gained from any single datum available for each case. Thus, Morrissey, et al. and Cohen and Kennedy use a number of measures of interorganizational communication and cooperation (number of referrals, number of meetings, understanding of each other's organizational goals) to assess the extent to which health and mental health systems conform to a "systems of care" model. Here, no single measure is deemed adequate to capture the construct of a system of care. Rather, an index is needed. To *index* a construct is to create, implement, and combine a series of relevant measures (Klitzner, 2002, p. 4).

Klitzner (2002) specifies the term indicator. He argues that the term *indicator* is used to refer to a source of data collected for some reason other than research. Mortality and morbidity statistics, census data, and other information collected by public agencies can be used in various ways to construct measures of enforcement and compliance. They are not, however, primarily collected for use by researchers. The designation of a measure as an indicator carries an implicit red flag: Such data can be highly misleading and may fail to reflect reality for a variety of reasons (p. 4). In this paper the term indicator is used to denote “a measure which is justifiable used as a basis for public statistics” (McRae, 1986, p. 31).

3.2. Public Statistics Usage by Different Actors

The Index represents a kind of public statistics. McRae (1986) proposes a framework for analysis of public statistics usage by different actors. The information provided by public statistics can be used to aid several types of action. McRae (1986) differentiates between them on the basis of 2 criteria:

- 1) who makes the ultimate decision to act (Is the actor acting alone or participating in a collective decision?);
- 2) the motive for action (Is it done in private self-interest, or for ethical reasons connected with the general welfare or justice?).

Here, the actor may be an individual, group, or organization. A collective decision is a decision taken by a collection of actors and binding on the particular actor, for example, a governmental decision. A group as an actor may act alone, as in deciding to produce some good; or as a participant in a collective decision, as in lobbying. Further, McRae (1986) defines “ethical reasons” as those which can be used to justify a proposed act in terms of what ought to be done. These includes teleological justifications in terms of the consequences of acts, such as effects on the general welfare, and nonteleological justifications such as those based on rights or moral prohibitions related to the act itself. If an actor gives ethical reasons, his need for statistics in justification will be much the same regardless of whether the reason is sincere or hypocritical.

On the basis of these criteria, McRae differentiates between four types of action as shown in Figure 3.

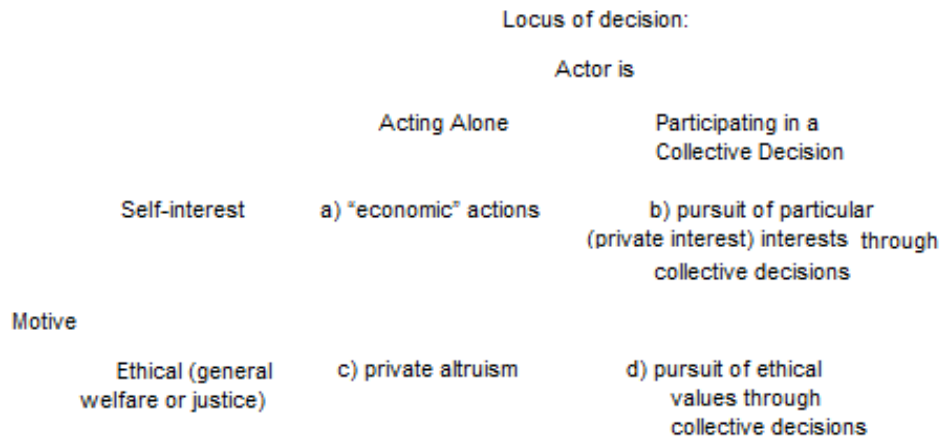


Figure 3. Types of decisions and motives (McRae, 1986, p. 16).

a) Information may be used in private market or nonmarket decisions (“economic” actions), in which the actor acts alone, seeks self-interest, and thus makes no effort to justify the action ethically. According to Hauser, an increase in crime may lead individuals to buy burglar alarms or exercise caution in walking at night; an impending energy shortage may lead individuals to buy energy-efficient automobiles or to lower their home temperatures in winter; an expected economic downturn may lead firms to reduce their inventories, or couples to change their plans about marriage or the timing of births. Jewelers’ need to anticipate demand for rings was an early source of demand for marriage statistics (McRae, 1986). These private decisions usually involve adaptation to the condition revealed by the statistics, rather than efforts to change these conditions through collective action. In aiding private action, a given statistics may describe a condition that different people value differently; a prediction of rain may be useful to farmers for planting and to vacationers for rescheduling their trips. Manufacturers of various products may use disaggregated statistics in different ways to plan their marketing. Parents choosing schools in a voucher system may use school data to choose in favor of art or science. The private values or tests that enter into decisions of this sort are usually taken as given and do not enter into public debate. Those who use this information need also to know the causal relations between their actions and the consequences, but the models of causal relations that they need to adapt to a given state of affairs are generally simpler than those involved in public policies for changing it.

These adaptations can create values (and disvalues) that contribute to the overall net benefit of providing the information. The private values served may be disparate and not subject to valuative discourse, but we (and our fellow citizens) can aggregate them, trade them off,

examine their distribution, and discuss their contribution to the general welfare or justice. Thus, Machlup concludes that an economic approach to knowledge and information is possible (McRae, 1986, p. 17). In this respect, information policy is public policy affecting private actions.

b) Actors can use information to pursue their particular interest (private, nonethical values) through collective decisions such as the formation of public policy. A decline in the real wages of an employee group may lead to their advocacy of public support for wage increases. A decline in the economic position of a domestic industry may lead to an appeal by the industry for price supports or tariffs. The individual member of such a group is then acting in the group's interest rather than simply in self-interest. Nevertheless, McRae (1986) refers to the groups' motive in such cases as "private", in contrast to the wider public interest.

As Lindblom & Cohen note, a voter facing a choice about a town budget may "want only to understand 'what's in it for me?' (McRae, 1986, p. 17). The success of the Census Bureau, and later of the Bureau of Labor Statistics, in measuring the unemployment rate has depended in part on relations with opposed constituencies – business and labor – who use this information to serve their disparate interests (McRae, 1986, p. 17). The Census Bureau performs the same sort of service to opposed groups in furnishing population statistics that are used in allocating public resources, through its experiences increasing pressure as a result. Public officials may also respond to indicator statistics in seeking private goals such as material gain or reelection. Johnson and Lewin proposed that municipalities publish periodic reports with specific attention to the interests of diverse user groups (McRae, 1986).

These private actions affecting public policy may or may not further the general welfare. Exploitation of the public purse by public officials or private groups will presumably not do so. But when a group argues persuasively that it is needy or that its claims are just, and when this argument is supported by others, we may have difficulty in classifying its action. Thus, Coleman gives an example when marketlike competition and exchange by diverse interests in politics have also been seen by some as means for furthering the general welfare (McRae, 1986, p. 18).

Dibble maintains that members of a group seeking its particular interest through politics may support the group's actions by arguments within the group based on values that they share with their fellow members ("It will benefit us"); but when they seek to persuade outsiders in public terms rather than through private bargains, they must invoke more general ethical values, such as general welfare or justice, in their arguments (McRae, 1986). The use of these arguments requires statistics similar to those needed in cell d).

c) Actors acting alone and seeking to benefit others without increasing their own well-being (private altruism) may also make use of information. Information about poverty may

increase charitable donations. Knowledge of an impending disaster may lead to community aid. Information on discrimination in employment can aid private as well as public efforts to remedy it. Those who act in this way may try to persuade others by invoking general ethical values; but this persuasion is directed toward private actions rather than toward voting or other participation in collective decisions. In this respect, expert communities, universities, and foundations can use information in choices affecting the general welfare or justice without entering into the collective decisions of the larger political community. Therefore, McRae argues that recommending indicator variables and directions for research is aimed in considerable measure at these actors and not simply at governmental decisions.

d) Finally, information can be used by actors in their pursuit of ethical values such as the general welfare or justice, though collective decisions, e.g., through public policy. This use of information concerns what should be done for the good of society or as right action, in more or less general terms. In specific terms it can relate to particular values that are widely accepted in the community (e.g., traffic safety). In general terms it can call for comparisons or tradeoffs in terms of the general good among various particular values (How much health is worth how much education?) and groups (What benefit to the nonpoor is equivalent to a given benefit to the poor? What benefit to those now living is equivalent to a given benefit to the next generation?). These tradeoffs, in addition to the extensive causal information required, complicate the calculations required relative to those needed in cell a).

When public policy choice aimed at ethical values is involved, McRae refers to the public statistics that are useful for this choice as *policy indicator statistics*.

Choice or advocacy of public policies in view of ethical values is of special interest because it involves cooperative discourse between the political community (discussing these values and means to them) and expert communities. Self-interested decisions, in contrast, do not require public debate. For self-interested decisions, some of the information required is produced in response to market demand, as when newspapers publish price information or when candidates purchase opinion-survey data. Other information used in self-interested decisions is supplied partly by the market, as when private data processing organizations reinterpret and reanalyze governmental statistics for profit, or when the media publish them. But much of the collection and preparation of these data must be undertaken or supported by government; as a collective good they are inadequately supplied by the private market. For example, Brooks shows that systematic monitoring of conditions such as those of the environment is also unlikely to be done by basic scientific communities (McRae, 1986, p. 20).

Generally, McRae holds that there are two levels where ethical values are engaged. At the most abstract information policies are compared in view of these values; at the same time,

information policy aids other citizens in comparing possible policies in terms of their ethical values.

3.3. Criteria for Assessment of League Tables

Based on McRae theory on public statistics, Gormley and Weimer (1999) take a step further and investigate a question of criteria of public statistic. They investigate the question in application to organizations and report cards of organizations. However, their theory is proved to be valid on a higher level of aggregation. Particularly, Dill and Soo (2005) utilize these criteria for assessment of league tables. Thus, I argue that due to its origin (evaluation of public statistics) and proved positive tasting (by Dill and Soo (2005)) the theory of Gormley and Weimer (1999) can be applied to the Index and its aggregation on national level. Such criteria are necessary for the Index analysis, as without such “a solid normative foundation, policy analysis runs the risk of being either purely descriptive or prescriptive but ad hoc” (Gormley and Weimer, 1999, p. 36).

1. *Validity*. Information provided by a report card should be valid and should meet widely accepted standards of scientific practice. Among other things, it should focus on measures that are closely approximate, or are clearly linked to, outcomes.

2. *Comprehensiveness*. Information presented in a report card should be comprehensive in terms of important dimensions of organizational performance and should include a range of indicators. This is particularly important when the quality of organizational outcomes is multidimensional, as is often the case. The omission of key indicators yields a report card that is incomplete and potentially misleading.

3. *Comprehensibility*. The information presented in a report card should be comprehensible to potential users, including consumers and policy makers. The presentation of data as information, the amount and the form of information, and the media through which information is transmitted should all take the cognitive capacities and habits of potential users into account.

4. *Relevance*. The information provided by a report card should be relevant to the needs of potential users. In the case of consumers, it should take into account the dynamic of choice – specifically, how much flexibility consumers have to make particular choices, and when those choices must be made. It should also focus on the right unit of analysis – for example, whether consumers are choosing a physician or a hospital or a health plan. In the case of policymakers, it should take into account the budget cycle and, more broadly, the ebb and flow of political interest.

5. *Reasonableness*. A report card should be reasonable in the demand it places upon a target industry and its organizations. Among other things, this means that sufficient time should be allowed for submitting data and that paperwork requirements should be not unduly burdensome. In other words, the cost of compliance should not be excessive.

6. *Functionality*. A report card should be crafted in such a way that it convinces targeted organizations to engage in appropriate, rather than dysfunctional behavior. In particular, the report card's theoretical purposes should be compelling – organizations should be persuaded not simply to comply with technical requirements but, more importantly, to embrace the report card's implicit vision as their own.

Importantly, Gormley and Weimer (1999) recognize some difficulties in application of the above-mentioned criteria in practice. First, there is likely to be a trade-off between validity and comprehensibility when, for example, extensive data and a very sophisticated and conceptually valid methodology are used. Second, there is likely to be a trade-off between validity and scope of coverage. Larger units are more likely to involve heterogeneity that makes the focus on few indicators inappropriate. Third, there is a trade-off between validity and reasonableness. For example, the cost of supplying data on a sample of patients with a specific ailment is less than the cost of supplying data for the entire universe of patients. Fourth, there is a trade-off between validity and relevance. Outcome measures are highly appealing, but the most interesting outcomes are often those that take years to discover. It would be nice to know whether hospitals improve the ambulatory skills of patients who have had hip surgery, for example. As time passes, however, data become stale.

The authors conclude that that it is best to think about validity as the first, but not the only, value to be satisfied. Once some basic threshold of validity has been established, other values must come into play, such as comprehensibility, relevance, reasonableness, and functionality.

3.4. The Consumer Perspective

The discussion on assessment of league tables evokes the question on relevant indicators. These indicators are supposed to meet not only the above mentioned criteria, but also to be in line with the consumer perspective. In the literature, the consumer perspective is associated with two aspects. The first one is related to the idea of patients, what they get and the way of evaluation of the service/treatment they get. This leads to the system based model of indicators and the discussion on objective/subjective indicators.

3.4.1. The System Based Model of Indicators

According to Cambell at al. (2005), Donabedian was the first who proposed a systems-based framework of structure, process and outcome in 1966. However, since that time several systems models of health system indicators have been developed.

For the thesis one of the most suitable models is the one suggested by Carter at al. (1992). They differentiate between inputs, processes, outputs, and outcomes (see Figure 4).

Input indicators are the resources required to provide a service, including staff, personal qualification, personnel per patient, buildings, equipment, and consumables. Very often this dimension is also referred to as structure indicators (Ovretveit, 2001). Structural features of health care provide the opportunity for individuals to receive care but do not guarantee it. On the whole structures, whilst being able to increase or decrease the likelihood of receiving high quality care, are indirect and contingent influences on care. However, structural features within a systems based model of care can have a direct impact on processes and outcomes, e.g. if necessary equipment or skills are not available to undertake an effective examination (Cambell at al. (2005, p. 1612).

Process indicators identify the way in which a service is delivered, and involve some measurement of quality, perhaps by inspectorates or via consumer complaints. They also encompass such aspects as waiting times and medication errors (Ovretveit, 2001, p. 234).

Outputs are the activities of the organization, or the service it provides, such as the number of benefit claims processed or patients treated (Carter at al., 1992, p. 36).

Finally, *outcome* is the impact of the service – healthier or more knowledgeable individuals, a safer society, and so on (Carter at al., 1992, p. 36).

For the thesis, the patient perspective and a place of patient evaluation in this model is important. In the literature, user evaluation is related to both “assessment of outcome (symptom resolution, i.e. results of treatment) and/or processes of care (e.g. communication skills of the health professional, a way health care is delivered)” (Cambell at al., 2000, p. 1614).



Figure 4. The system based model of indicators (Carter at al., 1992, p. 36).

The system based model of indicators is used frequently for analysis of different aspects of health care: UK and US national performance assessments (Cambell at al., 2000), hospital performance assessment (Berg at al., 2005), and health system performance in general (Kruk &

Freedman, 2008). Although the authors differentiate in grouping of indicators (in particular, Kruk and Freedman (2008) take outputs and process indicator as a single category while the other researchers perceive them as different ones), they use the same model. Therefore, based on their works it is possible to point out some indicators which are usually attributed to certain aspects of the system (See Figure 5). This table is not aimed at mentioning all possible indicators, but rather providing examples of differentiating between indicators.

Input/structure	Process	Output	Outcome
Adult registered with dentist	Day surgery rate	Rate of hip fractures in facilities	Mortality rate for lowest income groups
Rate of use of ambulatory health service	Length of stay (maternity care)	Utilization of essential health services by disadvantaged groups	Patient satisfaction
Qualifications of physicians	Hospital readmission rates within 28 days	30 day mortality post myocardial infarction and post surgery	
Physicians' incentives to overtreat or undertreat	Mammography in target population		

Figure 5. Examples of differentiating between indicators according to the system based mode.

As Ovretveit (2001) argues input or structure indicators are less directly related to quality than process indicators, which in turn are less directly related to quality than outcome indicators (p. 234). Yet, in the literature, there has been a considerable debate about whether process or outcome should be assessed as measures of quality of care (Cambell at al., 2000). Mant (2001) points out advantages of both types of indicators. Particularly, process indicators are 1) more sensitive to differences in the quality of care, 2) easy to interpret. On the other hand, outcome indicators reflect all aspects of care (patient satisfaction indicator is often targeted at describing the whole process of care).

For the purpose of this thesis, I assume that input indicators are less correlated with the consumer perspective than the other types. Thus, I will differentiate between input/structure indicators and the others as the latter ones better reflect what, how and when patients get.

3.4.2. Objective/Subjective Indicators

Traditionally, performance in medicine is evaluated only by medical professionals themselves, and the inability of consumers to assess the quality of health care with validity and accuracy is one of the important factors for market failure in health services. However, with a greater focus on the consumer or patient perspective, patient satisfaction has been gaining more

and more attention among healthcare professionals (Imanaka, 1997, p. 396). Moreover, according to Hjertqvist (2002 p. 52), assessments made by the consumers should become the standard evaluation, rather than those with no bearing on either performance or outcome. Thus, incorporation of the consumer perspective into evaluation of health care systems raised the question about subject indicators.

Although Cleary & Edgman-Levitan (1997) hold that the availability of a range of quality indicators exceeds the number any existing health system could implement and use, they argue that there is a necessity to incorporate the consumer perspective in terms of subjective indicators. Moreover, in the literature the very presence of such indicators is associated with the consumer perspective (see, for example, Cleary & Edgman-Levitan, 1997, Hibbard et al., 2001, Nelson et al., 2006).

Veenhoven (2002) distinguishes several reasons to utilize subjective indicators in social policy. Here, I argue that health care policy is one of social policies (within governments, it is often one single department which is responsible for social and health policy). Therefore, I suggest it is possible to use Veenhoven's reasoning on indicators in application to social policy in general and health care as a sort of such policy in particular.

According to Veenhoven (2002), there are 5 reasons to use subjective indicators in social policy.

1. Social policy is never limited to merely material matters; it is also aimed at matters of mentality. These substantially subjective goals require subjective indicators;

2. Progress in material goals can not always be measured objectively. Subjective measurement is often better;

3. Inclusive measurement is problematic with objective substance. Current sum-scores make little sense. Using subjective satisfaction better indicates comprehensive quality;

4. Objective indicators do little to inform policy makers about public preferences. Since the political process also does not reflect public preferences too well, policy makers need additional information from opinion polls;

5. Policy makers must distinguish between 'wants' and 'needs'. Needs are not observable as such, but their gratification materialises in the length and happiness of peoples' lives. This final output criterion requires assessment of subjective appreciation of life-as-a-whole.

Veenhoven (2002) differentiates between subjective and objective indicators on the bases of two parameters.

Firstly, there is a difference in substance matter measured. Objective indicators are concerned with things, which exist independent of subjective awareness. For instance: someone

can be ill in an objective sense, because a tumor is spreading in the body, without that person knowing it. Likewise, Marxists maintain that workers are objectively underclass people, even if they see themselves rather as middle class. Both the doctor and the Marxist give more weight to the objective condition and will press for treatment even if the patient protests.

Secondly, there is a difference in assessment. Objective measurement is based on explicit criteria and performed by external observers. Illness can be measured objectively by the presence of antigens in the blood, and class membership by possession of means of production. Given these operational definitions, any impartial observer will come to the same conclusion. Yet subjective measurement involves self-reports based on implicit criteria. The ignorant cancer patient who reports to feel in good health may have based that appraisal on many cues and will not be really able to say how he came to that appraisal. The worker with false class-awareness fails to notice the whole point. The examples show that the differences in substance and measurement do not necessarily concur. The possible combinations are presented in Figure 6.

Substance	Assessment	
	<i>Objective</i>	<i>Subjective</i>
<i>Objective</i>		
<i>Subjective</i>		

Figure 6. Configuration of objective-subjective differences (Veenhoven, 2002, p. 36).

The two top quadrants concern extrinsic substance matters, such as physical condition, mental aptitudes and social position. The quadrant top left denotes the combination of objective substance and objective measurement. An example is the actual ‘wealth’ of a person when measured by her bank account. The top right quadrant also concerns objective substance, but now measured by self-estimate. An example is measuring wealth by perceived wealthiness.

The two bottom quadrants concern subjective matters, such as identity, happiness and trust. The bottom left quadrant combines subjective substance with objective measurement. An example is measuring happiness by a number of suicides. The bottom right quadrant measures subjective substance using subjective appraisal, for instance, measuring happiness by self-report.

3.5. Theory Operationalization and Expectations

Based on the discussion on the dominant perspectives in health care and theoretical frameworks, it is possible to formulate some expectations.

The first one is based on McRae (1986) and concerns stakeholders and possible influence of public statistics on them. If the Index 2007 has the added value for the stakeholders mentioned in the introduction, the Index is likely to lead to certain actions described by McRae (1986). The EHCI is expected to encourage consumers, patient organizations, and policy makers to take certain actions according to the scheme. In case of consumers, it is supposed to be “economic actions”. In case of patient organizations and policy makers it is expected to be collective decisions motivated by either particular interests or ethical values. So, it is necessary to see whether

- a) *the Index encourages certain actions by the above mentioned stakeholders.*

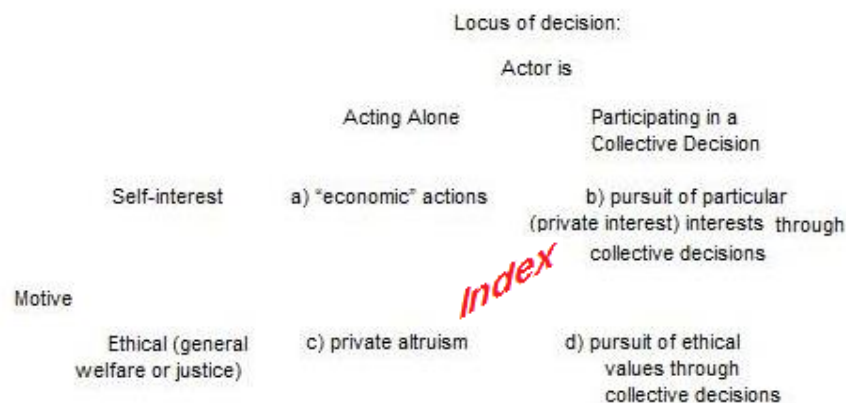


Figure 7. Possible influence of the Index on different stakeholders.

Second. It is possible to distinguish several features derived from the idea that the patient, his/her needs and requirements are supposed to be in the center of health care system and the Index itself. In the domains mentioned in the first chapter certain changes are expected.

1. Dominance. Patients, their opinions should be meaningful in defining health care priorities. A number of surveys (Wiseman at al., 2004; Oddsson, 2003; Litva at al., 2002, Shickle, 1997) show that *public preferences* often are different than priorities defined by professionals and managers (See Appendix 1). Therefore, it is important that public preferences are at least considered if not play the role of the main criterion both for those who are involved in policy making and for the Index producers. Thus, it is necessary to check out whether

b) *the Index considers consumers' preferences in defining priorities in health care systems;*

c) *the Index producers themselves consider consumers' preferences or based themselves on opinions of professionals and managers in giving weights to indicators.*

2. Decision making/choice. Patients are supposed to be involved in decision making. Then the Index is expected to take into account provision of mechanisms whereby patients exercise some choice. Here, the ECHI is expected to take into account whether

d) *there is a choice of GP;*

e) *complaints procedures are formulated in documents and implemented in practice.*

3. Rights. Patients are supposed to be informed about their right, possibility of choices, and standards of service. In this respect, the Index should consider whether

f) *there is literature, documents on patients' rights and standards of services which are available for consumers.*

4. Knowledge. Patients are supposed to have lay knowledge and are considered as "expert patient". Here, it is important for the Index measurement to see whether

g) *the government provides consumers with information concerning their diseases which contributes to understanding of their conditions.*

Third. There are considerable differences between the consumerist and managerial approaches to health care. While the latter puts emphasis on financial consideration (cost reduction), consumerism focuses only on what patients receive. Taking into account theoretical consideration on inputs, process, outputs and outcomes, I argue that process/outputs/outcomes indicators merge with consumerism. Thus, it is necessary to analyse whether

h) *the Index put higher priorities on process and outputs/outcomes indicators than on input ones.*

Further, the consumer perspective is associated with subjective indicators. While the professional logic puts emphasis on objective indicators, the consumer approach is supposed to reveal what patients' opinions. Therefore, it is important to check out whether

i) *the Index engages subjective indicators.*

I presume that the OECD and WHO approaches and evaluation system are based mainly on objective indicators. As the EHCI claims the consumer perspective, it is supposed to pay much attention to patients' needs, feelings and so on, i.e. engage subjective indicators. Therefore, it is necessary to see whether the Index makes a shift towards subjective indicators in comparison to the OECD and WHO approaches.

Substance	Assessment	
	<i>Objective</i>	<i>Subjective</i>
<i>Objective</i>		
<i>Subjective</i>		

Figure 8. Shift towards subjective indicators?

These expectations are to be tested in the next chapter.

4. Empirical Research

Where is the knowledge we have lost in information

T.S. Eliot

The chapter is aiming at the comparison between the existing evaluation systems worked out by the World Health Organization and the Organization for Economic Cooperation and Development on the one hand, and the Health Consumer Powerhouse, on the other. For this purpose *at the beginning*, the chapter will discuss peculiarities of WHO and OECD evaluation approaches in terms of their indicators. Also special attention will be given to the World Health Report 2000 - Health Systems: Improving Performance as the report presents the first attempt to rank health systems. *In the second part* of the chapter, the Euro Health Consumer Index will be assessed against theoretical framework introduced in the second chapter. Here, the expectations stated in the previous chapter will be tested. *Finally*, having understood specificity of the WHO and OECD evaluation systems as well as the Health Consumer Powerhouse, a comparison will be made.

4.1. World Health Organization Evaluation

The World Health Organization provides rich information on health situation around the globe. Moreover, the production and dissemination of health statistics is defined by the organization itself as a core WHO activity mandated to WHO by its Member States in its Constitution. WHO depicts itself as "unbiased" (impartial and fair), global (not belonging to any camp), and technically competent (consulting leading research and policy institutions and individuals). WHO's multiple roles, including advocacy for health issues, monitoring and evaluation of health programs, provision of technical assistance to countries, requires that WHO works closely with countries to produce the best possible estimates of health statistics, and also add value in creating standards and assisting countries in applying those standards (WHO Program on Health Statistics, 2008).

4.1.1. Indicators of European Health for All Database

WHO has the Program on Health Statistics to strengthen country, regional and global health statistics for better policy making and program implementation. The major interactive

components are enhancing country capacity, promoting international harmonization and standardization, and improving the quality of statistics and evidence.

Furthermore, WHO receives information from Member States and then regional offices. In the mid-1980s, the Regional Office for Europe launched European **Health For All Database** (HFA-DB) which has become a central database of independent, comparable and up-to-date basic health statistics in Europe. HFA-DB is updated biannually and contains about 600 indicators for the 53 European WHO Member States. The indicators cover 8 areas:

- demographic and socio-economic indicators;
- mortality based indicators;
- morbidity, disability and hospital discharges;
- life style;
- environment;
- health care resources;
- health care utilization and expenditure;
- maternal and child health (HFA-DB, 2008).

Although this database contains much information about the countries, it provides little insight into their national health care systems as a huge number of indicators do not relate to health systems and their performance. Therefore, the question about performance and comparison between countries arises.

4.1.2. The World Health Organization Report

According to Jamison & Sandbu (2001) publication of robust, transparent, and valid indices of health system performance could lead to a greater political accountability and to evidence-based health policies. To this end, WHO published indices of health system performance for its 191 countries, in terms of Pedersen (2002) “a first brave attempt” of such a cross-national assessment.

The WHO report defines the boundaries of health system, based on the concept of health action. Health action is defined as “any set of activities whose primary intent is to improve or maintain health. Within these boundaries, the concept of performance is centered around three fundamental goals: improving *health*, enhancing *responsiveness* to the expectations of the population, and assuring *fairness of financial contribution*” (Murray & Frenk, 2000, p. 717). This rather broad definition allows “to include all individuals, groups, organizations, and associated resources whose primary intent is to improve health”. For example, this definition includes efforts to reduce road traffic fatalities by making roads safer, policy to change the

national diet, as well as personal health service and health interventions” (Murray & Frenk, 2001, p. 1698). I argue that such a broad definition may be misleading in identifying performance of health care systems as it involves many factors outside the system.

In accordance with the three goals of health care system, the WHO report’s authors identify indicators of these goals achievement.

Improving health means both increasing the average health status and reducing health inequalities. *Responsiveness* includes two major components: (a) respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health); and (b) client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider). *Fairness of financial contribution* means that every household pays a fair share of the total health bill for a country (which may mean that very poor households pay nothing at all). This implies that everyone is protected from financial risks due to health care. The measurement of performance relates goal attainment to the resources available. (Murray & Frenk, 2000, p. 717).

Accordingly, the level and distribution of health, the level and distribution of responsiveness, and the distribution of cost are of primary concern in the WHO report. For the purposes of global comparison of health system performance, the composite measure of health system goal attainment is calculated from these five indicators. The performance index for each goal as well as the composite measure is then evaluated by comparing them with the level of resources invested (Wilbulpolprasert & Tangcharoensathien, 2001, p. 489).

The WHO report indicators, the way they are measured and weighted are presented in Figure 9.

CONCEPT	WEIGHT (%)	DEFINITION
HEALTH LEVEL	25	Disability-adjusted life expectancy (adjusted to a 0→1 scale for the range 20→80 DALYs)
HEALTH DISTRIBUTION	25	Equality of child survival (an index of expected child survival up to the age of 5)
RESPONSIVENESS LEVEL, of which	12.5	A composite index of the items listed below
Respect for persons of which	(6.25)	
Dignity	2.08	Observation of basic human rights
Confidentiality	2.08	Privacy of consultation and records
Autonomy	2.08	Choice of treatment options
Client orientation of which	(6.25)	
Promptness	2.5	Accessibility and waiting times
Amenities	1.875	Cleanliness, food quality, etc
Support	1.25	From community & care agencies
Choice	0.625	Between providers at each level
RESPONSIVENESS DISTRIBUTION	12.5	Extent of differences in responsiveness by those population subgroups selected for each country individually by its own ‘key informants’
FAIR FINANCING	25	‘The way health is financed is perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status or their use of the health care system’
COMPOSITE INDEX	100	

Figure 9. The scoring system for measuring overall attainment of the WHO report 2000 (Williams, 2001, p. 95).

As the chapter is aimed at comparison between the Index 2007 and the WHO report, I suggest to look at the latter in the light of the questions addressed to the Index from the consumer perspective. In other words, I suggest to investigate how the WHO report addresses the issues concerning

- first of all, the consumer perspective (1) dominance in health care, 2) decision making and choice, 3) rights, 4) knowledge, i.e. the issues which are of the main concern for consumerism;

- secondly, indicators in terms of the system based model and subjective/objective indicators;

- thirdly, a possible usability of the WHO report in terms of actions.

First, I should investigate the question how the WHO report address the issue of consumerism in several domains which are of primary concern for it.

1. **Dominance** is defined in terms of considering preferences of consumers in both defining priorities within health systems and in construction of a research, i.e. putting weights to indicators.

- a) The WHO report does not address the question of public or consumer participation in setting priorities, involvement in decision making at the national level.

- b) The question of putting weights to indicators is quite interesting. On the one hand, the WHO report attempts to take into account preferences of ordinary people, to some extent. Particularly, the weights were derived from the responses of 1000 respondents to an internet-based questionnaire, about half of whom were WHO staff and half were volunteers from amongst people who had visited the WHO website. Furthermore, responsiveness of health systems was also evaluated on the basis of questionnaires filled in by informants.

On the other hand, Williams (2001) draws attention to different criteria for respondents assessing individual systems (equal sex composition and exclusion of government employees and) and those who assess weights of indicators - 1791 "key informants" drawn from 35 countries (half - volunteers and half - WHO staff). Stuyft and Unger (2000) point out a limited number of respondents and arguing for a "broader participation" and Almeida at al. (2001) suggest "a systematic process of choosing criteria for selecting key informants" (p. 1693). Furthermore, Blendon at al. (2001) argue that these informants' opinions were used at the experience of ordinary citizens and patients. In other words, the WHO report "prefers expert judgments" to public opinion (p. 11). Moreover, Blendon et al. (2001) show that for 17

industrialized countries the WHO ranking of performance does not correspond with a ranking based upon consumer satisfaction – a different but crucial systemic objective from the consumer perspective.

The question of public opinion and putting certain weights to indicators evokes the discussion about country differences in preferences. For instance, Richardson et al. (2003) hold that the WHO importance weights attached to the system objectives have not been validated. “Even if – contrary to expectation – there was agreement upon objectives it is highly unlikely that there will be agreement over the choice of weights as these reflect social or ethical rather than technical judgments. Countries with a strongly egalitarian or communitarian tradition are likely to place greater emphasis upon equity and less emphasis on responsiveness. Countries which place greater relative importance upon individualism will place greater relative importance upon responsiveness” (p. 365). This argument resonates with the discussion on possibilities of generalization and distinguishing the European health system model (see previous chapter). I argue, although generalization is possible, existence of differences between countries puts special emphasis on considering public preferences what is absent in the WHO report.

2. Decision making and choice imply that patients are free to choose GP and have a possibility of using complaints procedures.

In respect of decision making, the WHO report considers two indicators: choice of treatment options and choice between providers at each level (WHO report, 2000). Although choice of GP is not mentioned, the possibility of choosing a provider at each level is a broader term and includes GP.

As for complaints procedures, the WHO report does not address this aspect.

3. Rights. This domain is not address in the WHO report.

4. Knowledge. In respect of dissemination and encouraging of lay expertise and lay knowledge, the WHO report does not introduce any indicators.

Generally, in the WHO report there are some signs of incorporation of the consumer perspective in such dimensions as dominance (weights to indicators is based on opinions of respondents) and decision making and choice (possibility of choosing provider and treatment option). Yet, this attempt seems rather opaque (questionable choice of respondents). As for the other dimensions, the WHO report does not introduce relevant indicators.

Second. I should discuss the question of indicators from the system based model (whether focus is on input/structure or process/output/outcomes indicators) and subjectivity.

On the one hand, the authors of the WHO report claim that “our emphasis on outcomes is a radical shift from measurements of process, such as hospitals bed-days or consultation” and

that they pay attention to ‘three outcomes of health systems’ performance: health, responsiveness, and fairness in financial contribution” (Murray & Frenk, 2001, p. 1698).

On the other hand, the WHO report was criticized due to its approach in identifying performance.

At the beginning, it is necessary to mention that the WHO report uses the term “country performance” (WHO report, 2000). “Country performance” is connected with the broad definition of health system which was discussed above. “Country performance indicates how well a country is doing relative to what would be predicted from **income** (bold – mine, EG) and other determinants. That favorable country’s performance could result from multiple factors, high levels of health expenditure (good health system performance), favorable geography, good governance, or luck. To assess health system performance, as opposed to country performance, requires identifying how outcome for each country responds to a change in inputs. The WHO report simply assumes that system performance variation accounts for all outcome variation after controlling for levels of health expenditure and education. No outcome variation results from other determinants of health or from limitation in the underlying model” (Jamison & Sandbu, 2001, p. 1595).

A number of authors such as Stuyft and Unger (2000), McKee (2001) also draw attention to problem of a rather broad definition of the indicators measuring health system performance. Thus, high levels of *health attainment* in well performing countries may be a consequence of good fortune in geography, and, therefore, dietary habits, and success in the health effects of policies in other sectors. When assessed *in terms of achievements* that are more explicitly linked to health care, their performance may not be as good (Nolte & McKee, 2003).

Furthermore, some authors are rather skeptical in their estimations of “outcome indicators”. According to Wilbulpolprasert & Tangcharoensathien (2001), the WHO report ranks the health systems by relating goals attained to resources spent. Thus, the WHO report assumes that health care is the primary force responsible for the decline of mortality and morbidity in both developed and developing countries. That assumption is evident in statements such as “if Sweden enjoys better health than Uganda – life expectance is almost exactly twice as long – it is in large part because it spends exactly 35 times as much in its health system” (the WHO report, 2000, p. 40). The report concludes that what is needed to eradicate disease in less developed countries is a greater investment in health care: “with investment in health care of 12 dollars per person, one third of the disease burden in the world in 1990 would have been averted” (the WHO report, 2000, p. 9). In terms of Navarro (2002), such statements reveal a “medicalisation of the concept of health” and, consequently, reveal the professional approach of WHO.

All these contributed to the situation when at the top of the WHO's health-care league were countries such as Spain and Italy, whose health-care systems were rarely considered models of efficiency or effectiveness before. For example, Navarro (2000) describes the situation in Spain. The WHO report release, which ranked the Spanish system as the third best in Europe, after Italy and France, coincided with unprecedented demonstrations against the Spanish health-care authorities. Demonstrators were protesting against the long waiting lists for critical life-and-death interventions (which had been responsible for a large number of deaths) and the short consultation times in primary-care centers (an average of 3 mins per consultation). This state of affairs in the Spanish system had forced prominent professional associations, including the Spanish Association of Primary Care Physicians, to denounce the current situation as "intolerable". The growing popular protest had put Spain's Conservative government on the defensive, until the WHO brought out its report listing the Spanish system as the third best in Europe and the seventh best in the world. Spain's Conservative Minister of Health showed the WHO report to the protesters as proof of the unjustified nature of their complaints and demands.

As Navarro (2000, p. 1599) puts it "they are thus considered user-unfriendly but very effective nevertheless".

In sum, the authors of the WHO report make an attempt to focus on outcome indicators. Yet, the Report 2000 defines the framework too broad, and, consequently, it does give insight into performance of health system in a broad sense. In other words, the WHO report indicates not public health system performance, but rather public health. Further, according to some opponents, the WHO report puts emphasis on input indicators. I argue, that the stress on **input/structure indicators** could be attributed, to a greater extent, to medical or professional perspective which the authors of the WHO report took.

As for subjective/objective indicators, one of the report dimensions, namely responsiveness, was based purely on subjective one. Moreover, in accordance to Veenhoven's theory (2002), both substance and assessment of the indicators were subjective. However, as it has already been stated above, the choice of respondents is rather controversial (WHO officials). The other dimensions based on indicators which are objective in assessment and substance (See Figure 7, p. 41). Thus, while the WHO report utilizes both subjective and objective indicators, it puts emphasis on the objective ones.

Third, it is important to look at the WHO report in terms of possible actions taken by actors.

Some authors are rather skeptical about possible implication of the WHO report for policy making. In particular, Almeida at al. (2001) note that "each of the five component measures, reflecting the conceptually distinct issues of health status, fairness of health-care

financing, perceived responsiveness of health services, and inequalities in the distribution of both health and responsiveness, is complex and difficult to understand, addition to having important conceptual and methodological problems. The lack of transparency and intuitive meaningfulness is compounded by the combination of the elements into a single measure” (p. 1695). Another research done by Stuyft & Unger (2000) further elaborates on reasons of low usability of the WHO report’s indices: “their make-up compromises their validity; they ignore attitudes and performance of the actors at different levels; they neither identify processes nor structural elements that effectively and efficiently transform inputs into desirable health outcomes; they conceal the contributions of subsystems and attainments on specific goals and in specific dimensions; they entangle the complex interactions between exogenous and endogenous factors that condition the functioning of a health system; and they do not capture its specific contribution towards improving health” (p. 676). In general, as Pedersen (2002) notes the league table activity is not clearly related to the parts which are concerned with design elements of health systems. Thus, “one cannot deduce anything from the league table exercise about which elements of a particular health system explain the position of a country in the league table, for instance, stewardship or extensive use of cost-effectiveness analysis” (p. 94).

Thus, the opponents of the WHO report express clear doubts in its usability by policy makers.

On the one hand, the report gained many positive remarks. McKee (2001) points out several positive impacts of the report. Firstly, it provides a useful conceptual framework that begins to tease out the goals of health systems. Secondly, the paper emphasizes the need for a much better understanding of the impact of health systems on health. Thirdly, it has invoked the concept of stewardship, which implies a much more active involvement in promoting health than most governments have previously assumed.

Moreover, according to Pedersen (2002, p. 99), the WHO report is “a unique piece of research in the sense that, without much maturation, it has been spearheading the WHO policy of putting health system performance (and reform) on the agenda. From an organizational perspective this must have been a calculated risk. Whether it has been worth taking still reminds to be seen. From the point of view of positioning WHO as a science and evidence led organization, the WHO report undoubtedly damaged its reputation”.

I would agree that there are several considerable shortcomings of the WHO report from the consumer perspective. The report does not fully consider the interests of patients and what they get, neither in terms of indicators (especially in the domains of rights and knowledge, partly in dominance and decision making) nor the way of conducting the research (dominance of

objective indicators and officials' opinion). As for its usability, the report presents a mirror reflecting public health rather than a guide for policy makers, which indicates areas of concerns.

In the preface to WHO report, Director – General of the organization announced that the measurement of health systems performance would be a regular feature of all World Health Reports from now on. However, at the January meeting it was announced that it would be at two yearly intervals so that the next performance rating would be released in October 2002 (Pedersen, 2002). Since that time WHO did not publish any reports addressing the issue of health system performance and ranking states again. I suppose that it can be explained, to a great extent, by criticism, and concerns addressed to the WHO report.

4.2. The Organization for Economic Cooperation and Development Evaluation

The OECD carries out work on health data and indicators to improve international comparisons and economic analyses of health systems. The organization has its *OECD Health Data* database provided by member countries. The Health Division of the OECD carries out two types of projects - health data and health analytical ones. Two of them, related to health care system in general are of special interest for the thesis. Interestingly, in accordance with the National Health Performance Committee of Australia, “broad comparison shows much in common with frameworks used by WHO and the OECD” (National Report on Health Sector Performance Indicators, 2002, p. 61). Indeed, the approaches of these organizations have many in common, but still have their own specificity. The OECD approach will be revealed in the following discussion of its “key projects”.

4.2.1. The OECD Health Database

OECD Health Data is a key health data project, publications of which are released annually. It offers “the most comprehensive source of comparable statistics on health and health systems across OECD countries. It is an essential tool for health researchers and policy advisors in governments, the private sector and the academic community, to carry out comparative analyses and draw lessons from international comparisons of diverse health care systems” (OECD Health Data 2008: Statistics and Indicators for 30 Countries). The latest publication was released in July 2008. The database identifies some key dimensions:

- 1 - health status (including mortality and morbidity);
- 2 - health care resources (e.g. hospital beds, health education);

- 3 - health care utilization (e.g. immunization, surgical operation, consultation);
- 4 - long-term care resources and utilization (e.g. long-term care beds in nursing homes, long-term care recipients at home);
- 5 - expenditure on health (expenditure on personal health care, total expenditure on health);
- 6 - health care financing (health expenditure by financing agent/scheme);
- 7 - social protection social expenditure health care coverage;
- 8 - pharmaceutical market pharmaceutical industry activity pharmaceutical sales;
- 9 - non-medical determinants of health (environment: air quality life styles and behavior);
- 10 - demographic references;
- 11 - economic references.

Thus, this publication by the OECD represents database rather than a research on health care system performance. In fact, it is very close to HFA-DB provided by WHO. Yet, the OECD Health Data includes more complete information on member states' performance. Therefore, it is used more frequently as a source for a research and analysis than HFA-DB.

The OECD Health Care Quality Indicators Project (2001-2004) is also worth mentioning. The Project aims at developing consensus around what is essential to measure in health care quality internationally. The HCQI project involves extensive consensus building across the 32 participating countries and detailed analysis on the comparability of data across different country data sources (Kelly at al., 2006, p. 47). The participating countries and international organizations selected five priority areas (cardiac care, diabetes, mental health, patient safety, and primary care/prevention) and developed a conceptual framework to guide the project. As a result, a recommendation of 86 indicators was elaborated. Mattke, at al. (2006, p. 1) conclude that "this experience of the HCQI Project demonstrates that international consensus can be achieved in how to measure the quality of care in priority areas, suggesting substantial demand for and interest in comparative information at the health system level". Nevertheless, the authors recognize that "much additional work remains necessary before the project can supply policymakers and researchers with ongoing, comprehensive, and reliable data on the quality of care in industrialized countries" (Mattke, at al., 2006, p. 1).

4.2.2. The OECD Health Project (2001-2004)

Given the growing challenges facing health policy and health care systems, the OECD embarked on a three-year Health Project in spring 2001. The project focused on measuring and

analysing the performance of health care systems in member countries and factors affecting performance. The purpose of the analysis was to help decision-makers formulate *evidence-based policies* to improve their health systems' performance.

The OECD Health Project culminated in a meeting of OECD Health Ministers on May 2004. A final report to Ministers, *Towards High-Performing Health Systems* was disseminated at this meeting (OECD Health Project (2001-2004)).

According to information of the OECD site, the project includes the following main elements a) measuring and analyzing health system performance; b) explaining variations in performance; c) long-term care for older people; d) overall system assessment. In fact, the final report reveals the five aspects which are in focus 1) quality, 2) access to care, 3) satisfaction of patients/consumers, 4) health care spending, 5) value for money/efficiency (Docteur, 2004). I argue that this approach is remarkably close to the one proposed by WHO in the Report 2000.

Despite existing similarity, there are several considerable differences. First, the OECD takes a more patient - centered approach. In particular, the final report of Health Project 2001 - 2004 elaborates on policies that address waiting times for elective surgery, long term care that better meets the preferences and expectations of patients. Secondly, while policy implications of the WHO report are contestable, the Health Project 2001 - 2004 is primarily aimed at supporting policy makers. As the Secretary-General of the OECD puts it “there are no governments within the OECD or beyond which will not derive important benefits from this work as they all struggle to meet varying challenges in the field of health care...benchmarking within and across countries, and sharing information can bring new ideas together and help policy makers” (Docteur, 2004, p.3). The final report of Health Project 2001 - 2004 suggests some recommendations for improving health system performance.

Thus, the OECD provides database and works out framework for assessing certain aspects of health care systems. Consequently, its publications do not compare but represent a basis for further study and comparison between countries (e.g. Kelley, 2007; Hussey at al., 2004, Anderson & Hussey, 2001). The OECD approach is close to one taken by WHO. However, the former is aimed at supporting of policy makers and concentrates on financial issues.

4.3. The Euro Health Consumer Index Assessment

Here, I should assess the Index against my theoretical framework and test some expectations formulated above. At the beginning, the Index will be analyzed from the consumer perspective as this perspective is claimed in the Index. Here, the aim is 1) to reveal its value from the consumer perspective. Then, 2) the EHCI will be analyzed in the light of the criteria for

league tables to reveal its quality. 3) Finally, having understood the Index value from the consumer perspective and its quality, I go to possible usage of the Index by the three stakeholders. I will follow the numeration of expectations which was introduced in my theoretical framework. The only exception is the expectation a) - actions encouraged by the Index which is closely connected with the criterion – functionality. Therefore, the expectation a) is tested in application to functionality and the numeration here starts with b).

4.3.1. The Index Assessment from the Consumer Perspective

1. Dominance is defined in terms of considering consumers' preferences within health care system and while conducting the Index construction.

b) Only one indicator concerning patient participation **in priorities setting** was found. It is *patient organization involvement in decision making*. I suggest that involvement implies that such organizations may play a role in defining priorities. However, the Index 2007 does not explain the indicator. Particularly, it is not clear what level is considered by the indicator (hospital, regional, national). Yet, the Index 2007 does not differentiate between them. Moreover, during the interview the HCP manager recognized the importance of this concern. He said that national level is meant.

I argue that all these three levels are important for the consumer perspective and, consequently, should be identified and considered.

Meanwhile, there are a number of surveys which identify consumer attitudes to the question of priority setting. As they show, the public overwhelmingly want their preferences to inform priority setting decisions in health care (Wiseman at al., 2002; Schickle, 1997). The findings of the 1998 Eurobarometer Survey which investigated public opinion in several countries also prove the importance of public participation in priority setting (Mossiaslos & King, 1999). Nevertheless, the Index 2007 does not address this issue.

c) The Index constructors are supposed to place the consumer in the center. It has implication both for **choosing indicators** and for **putting weight** for them.

Surprisingly, the Index 2007 states that “the indicators are developed through dialogue with *numerous stakeholders and the Index expert panel*” (Index, 2007, p. 47). Consequently, the Index is neither based on preferences of patients nor displaces aspects which are meaningful for them. The EHCI neither includes any mythological techniques for assessing the consumer preferences and what is important for them nor based on any studies (at least, there are no references in the text).

Importantly, there are several international (to be precisely, European) surveys which have already identified significant aspects of care for patients (van Campen at al., 1998, Grol at al., 1999; Groenwegen at al., 2005). For example, one of the most comprehensive studies – prepared by the European Task Force on Patient Evaluations of General Practice (EUROREP) was based on public opinion. Its results “suggest that patients across Europe hold remarkably similar views about what they want from primary care service. Top of a list of 38 possible priorities were *having enough time in the consultation, being able to get an appointment easily, getting a quick service in an emergency*, and having a *general practitioner who listens and provides helpful information* about patients’ illnesses and their treatment and encourages them to discuss all their problems. Also wanted was one who keeps up to date and meets their need for *confidentiality and advocacy*” (Richards, 1999, p. 277) (For the full list see Appendix 2). However, the EHCI ignores the findings of this survey. Only two aspects out of 10 most prioritized ones by the public are found in the ECHI 2007.

Another concern here is the way of putting weights to indicators (coefficients). The Index states on page 48 that “there are numerous surveys that show that patients generally value medical results quality and accessibility to healthcare” (Index 2007, p. 48). However, on page 10 the Index says that “the main candidates for higher weight coefficients based mainly on discussion with *expert panels* and experience from a number of patient survey studies” (Index 2007, p. 10). Yet, there are no references to these surveys. Therefore, I would assume that the coefficients are based on experts’ opinion. The panel 2007 consisted of 13 doctors and managers. I suggest that this approach is more typically for professionalism/managed health care rather than consumerism.

2. **Decision making/choice** was defied above in respect of choice of GP and availability of complaint procedures.

d) The Index 2007 does not use any indicators concerning choice of GPs or providers.

e) The EHCI does not have an indicator of complaint procedures. However, it does introduce the indicator “*the right to second opinion*” which can also give insight into the issue of choosing by the consumer. Yet, it is the only indicator on choice.

Patient organization involvement in decision making cannot be attributed to this dimension as it implies a high level of aggregation (national).

3. f) **Patient rights** taken together with information constitute the first sub-discipline of the Index. Although the two dimensions are close to each other, for the purpose of the thesis, I would analyze these two dimensions separately.

Patient rights have the following indicators: patients’ rights law, patient organization involvement in decision making, no fault multipractice insurance, right to second opinion. As it

has been discussed above, the indicator *patient organization involvement* is related closely to priority setting and has been analyzed in this section.

Generally, there are a considerable number of indicators on this dimension.

The EHCI 2007 defines *Patients' Rights law* in respect to the question – Is national health care legislation explicitly expressed in terms of patients' rights. A degree of its explicitness is defined in terms of “yes”, “various kinds of patient charters or similar by-laws”, and “no”. Here, the Index constructors differentiate between laws and patient charters but do not explain why.

4. g) **Knowledge** is defined above in respect how the government provides information to the consumers. Several indicators of the Index can be pointed out: readily accessible register of “legit”¹ doctors, provider catalog with quality ranking, web or 24/7 telephone healthcare info, and layman-adapted pharmacopoeia.

Some remarks are to be made on these indicators.

Readily accessible register of legit doctors implies not only a possibility (the existence of a database, I presume) but also time. Yet, the Index differentiates between green, amber, and red on the basis whether it is “awkward, costly or not frequently updated”. This interpretation shifts attention from patients and time to the database, its quality itself. Further, the Index constructors do not elaborate on the terms “awkward, costly, not frequently updated (once a week, month or year?)

Provider catalog with quality ranking is defined in the Index by benchmarking certain practices”. Particularly, the Index mentions UK experience with “Dr. Foster” as “the standard European qualification” for getting green and French one with “750 best clinics” published by LaPointe for getting amber. Benchmarking is in itself a good way of guidance. At the same time, the EHCI does not identify any criteria, parameters for assessment. Further, the Index did not elaborate what kind of providers is considered (practitioners, hospitals, both of the mentioned). In sum, it is completely vague how the Index constructors evaluate countries on this aspect. No wonder, only three countries got green (including the UK, of course). The case of Malta is pretty interesting. This country got red, i.e. it did not provide a health care provider catalog. However, the country has only one major public health hospital and, thus, the catalog is not applicable (Explanatory Statement by Ministry for health, the Elderly and Community Care, 2007, p. 3).

Another indicator of this section is *web or 24/7 telephone health care info*. Here, for getting amber the Index puts such criterion as “yes, but not generally available”. It is not clear what the Index authors mean by this. Is it possible that web or telephone line were not available generally?

¹ In terms of the EHCI it means “bona fide specialist” (Index, 2007, p. 12)

h) Drawing on the **system-based model of indicators**, I suggest that the emphasis on input/structure indicators is more typical for professionalism/managed healthcare logic while consumerism pays great attention to process/output/outcome indicators. The EHCI constructors are even more radical in their approach to indicators. The Index states:

*It was also decided to search for indicators on actual results in the form of **outcomes** rather than indicators depicting **procedures**, such as “needle time” (time between patient arrival to an A&E department and thrombolytic injection), percentage of heart patients thrombolysed or stented, etcetera (Index 2007, p. 7)*

*Healthcare systems operating more on an industrial basis have a natural inclination to focus monitoring on **output**, and also much more naturally relate measurements of costs to output factors in order to measure productivity, cost-effectiveness and quality. The EHCI project has endeavored to obtain data on the quality of actual healthcare provided. Doing this, the ambition has been to concentrate on indicators, where the contribution of actual healthcare provision is the main factor, and external factors such as lifestyle, food, alcohol or smoking are not heavily interfering. Thus, the EHCI has also avoided including public health parameters, which often tend to be less influenced by healthcare performance than by external factors (Index 2007, p. 38)*

Thus, the EHCI stresses the role of outcome/output indicators. Nevertheless, my analysis shows that the Index draws mainly on process and outputs indicators. For example, the sub-discipline *waiting times* entirely describes process but not outcomes or outputs. In general, the result of my analysis can be presented in the following table.

Sub-discipline	Indicator	Classification
Patient rights and information	Patients' Rights Law	input/structure
	Patient organizations involved in decision making	input/structure
	No fault malpractice insurance	process
	Right to second opinion	process
	Access to own medical record	input/structure
	Readily accessible register of legit doctors	input/structure
	Electronic Patient Record (EPR) penetration in primary care	process
	Provider catalog with quality ranking	input/structure
	Web or 24/7 telephone healthcare info	process
Waiting times	Family doctor same day	process
	Direct access to specialist care	process
	Major non-acute operations	process

	Cancer: radiation/chemotherapy (measured in days)	process
	MRI (magnetic resonance imaging) scan examination	process
Outcomes	Heart infarct mortality <28 days after getting to hospital	output
	Infant death/1000 live birth	output
	Cancer 5-year survival rates	output
	Avoidable death – Potential years of life lost (PYLL) 100 000	output
	MRSA (Methicillin resistant Staphylococcus aureus) infections	process
“Generosity” of public healthcare systems	Cataract operation rates per 100 000 citizens (age-adjusted)	output
	Infant 4-disease vaccination %	output
	Kidney transplants per million population	output
	Is dental care a part of the offering from public healthcare system?	input/structure
Pharmaceuticals	Rx subsidy %	input/structure
	Layman-adapted pharmacopoeia?	input/structure
	Speed of deployment of novel cancer drugs	process
	Access to new drugs	process

Figure 10. Analysis of the EHCI indicators drawing on the system based model.

I realize there is a difficulty to attribute an indicator to a particular part of the system. For instance, the indicator *Patient organizations involved in decision making* can be considered both as an indicator of structure and process. I do understand these difficulties. Yet, I argue, that there is a possibility of such classification. Moreover, the classification is helpful in answering the research question.

It is obvious from Figure 10 that despite the EHCI claims about preferences for outcome indicators, there is a strong prevalence for process indicators. Overall, the EHCI uses 8 input/structure indicators, 12 process indicators, and 7 output indicators. The number of input/structure

indicators is higher than output indicators. Thus, the Index claim of prevalence outcome indicators is not proved by this testing. At the same time, for consumerism it is important how the service/treatment is provided. Consequently, the consumer perspective pays great attention to process. Therefore, the Index approach is closer to consumerism rather than professionalism/managed healthcare.

i) Another expectation concerns **subjective/objective indicators**. As I suggested above, the consumer perspective is likely to engage subjective indicators. To test my expectation about the Index 2007, I divide the indicators according to the scheme of Veenhoven (2002). The result is presented in Figure 11.

From the Figure 11, it is evident that the Index uses mainly objective indicators. It does not consider subjective attitudes, feelings, and assessments of patients. Furthermore, some indicators (purely objective) which are supposed to be evaluated objectively, were put in the quadrant top right (subjective assessment). In particular, the indicators *the major non-acute operations, heart infarct mortality <28 days after getting to hospital, and cancer; radiation/chemotherapy* are drawn among others from “personal interviews with healthcare officials” (p. 13). I argue that this approach is rather questionable as the indicators are to be precise figures but not subjective interpretations of figures by officials. Moreover, all indicators of the quadrant top right were put there because they were drawn from personal interviews. Thus, the EHCI 2007 uses mainly the opinion of healthcare officials but not the general public, consumers. I argue that this approach is more typical for professionalism than consumerism.

Substance	Assessment	
	Objective	Subjective
Objective	1. Patients' Rights Law 2. No fault malpractice insurance 3. Readily accessible register of legit doctors 4. Electronic Patient Record (EPR) penetration in primary care 5. Provider catalog with quality ranking 6. Infant death/1000 live birth 7. Kidney transplants per million population 8. MRSA (Methicillin resistant Staphylococcus aureus) infections 9. Cataract operation rates per 100 000 citizens (age-adjusted) 10. Infant 4-disease vaccination % 11. Kidney transplants per million population	1. Patient organizations involved in decision making 2. Right to second opinion 3. Access to own medical record 4. Web or 24/7 telephone healthcare info 5. Family doctor same day 6. Direct access to specialist care 7. Major non-acute operations 8. Cancer: radiation/chemotherapy (measured in days) 9. MRI (magnetic resonance imaging) scan examination 10. Heart infarct mortality <28 days after getting to hospital 11. Layman-adapted pharmacopoeia

	12. Is dental care a part of the offering from public healthcare system? 13. Rx subsidy % 14. Speed of deployment of novel cancer drugs 15. Access to new drugs	
<i>Subjective</i>	1. Avoidable death – Potential years of life lost (PYLL) 100 000	

Figure 11. Analysis of the EHCI indicators drawing on differentiation between objective/subjective indicators by Veenhoven (2002).

In general, the Index 2007 assessment from the consumer perspective leaves rather controversial impression. On the one hand, some my expectations were conformed. In the domains of partly dominance, partly decision making/choice, rights, partly knowledge there are certain signs of the consumer perspective. Further, the Index 2007 employs mainly process indicators which are also typical for the consumer logic. On the other hand, the Index did not take into account the consumer preferences fully (just one indicator in dominance, complaint procedures). It ignores patients in setting priorities, making choice about GP or provider. In the domain knowledge many indicators are used by their interpretation is rather questionable. Furthermore, the Index constructors utilize mainly objective indicators.

Therefore, I would say that there are certain features of consumerism in the EHCI 2007, but consumerism does not dominate. Accordingly, the EHCI is hardly considered to be constructed from the consumer perspective.

4.3.2. The Index Assessment against the Criteria for League Tables

The criteria for assessment of league tables allow to look at the Index 2007 from another point of view. They engage the idea of the Index quality.

1. **Validity** is stated by Gormley and Weimer (1999) as a core criterion for league tables. In respect of the EHCI 2007 there are several points of concern.

a) 11 out of 27 indicators are based on the documents – Patients’ Perspectives of Healthcare Systems in Europe (survey commissioned by the HCP, 2006) and Patients’ Perspectives of Healthcare Waiting times in Europe (survey commissioned by the HCP, 2007). Yet, these documents are not available on the Internet. Moreover, during my visit to the office of the Health Consumer Powerhouse in Brussels I was rejected to have a look at the surveys. Consequently, it is hardly possible to speak about transparency of the Index.

b) Some indicators are drawn on the information which does not look sufficient for their construction. For instance, the indicator *no fault malpractice insurance* is drawn from only three sources - Swedish National Patient Insurance Co; www.hse.ie; www.hiqa.ie (Index 2007, p. 12). These sources can provide insight into this problem in Sweden and Ireland. But what about the other countries? Where did the data come from? This consideration is also relevant for other indicators (provider catalogue with quality ranking, electronic patient record penetration in primary care, heart infarct mortality).

c) 10 indicators are based on information which source is “personal interviews” or “personal interviews with healthcare officials”. The Index does not elaborate on interviewees, their positions. I found only one indirect reference to the interviews: “The weaknesses in European healthcare statistics described in previous EHCI reports can only be offset by in-depth discussions with key personnel at a national healthcare authority level” (Index 2007, p. 7). At the same time, it is not evident whether the EHCI is based on such interviews.

Meanwhile, it is very important for some indicators. For example, in case of the indicator *direct access to specialist care*, the difference in perspectives seems significant (speak with a patient, GPs, officials in hospitals or in ministries).

d) The data used by the Index constructors are “completely asymmetrical” in terms of the Project Manager for the EHCI 2007 (Interview, 2007). This means that the Index 2007 uses “latest available” statistics. In particular, the Index 2007 “compares cancer survival data from 1997 from one country with 2005 data from other countries”. Dr. Bjornberg, project manager, mentioned Belgium which had not reported its statistics to WHO since 1997 (Interview, 2008). He considered that this unavailability of data is not the problem of the Index, but a particular country.

Another prominent example here is Ireland. In 2006 the Department of Health and Children today challenged the validity of the Euro Health Consumer Index 2006 as the basis for a proper analysis and international comparison of the healthcare system in Ireland. One of the reasons was that “the data for Ireland would appear to be out of date” (Department of Health and Children challenges validity of survey on Irish healthcare, 2006). For the sake of fairness, it is necessary to say that “preliminary score sheets were sent out to Ministries of Health or state agencies of all 29 states, giving the opportunity to supply more recent data and/or higher quality data than what is available in the public domain” (Index, 2007, p. 16). Interestingly, in 2006 Ireland was depicted as a country which “provided the worst health care in Europe” (France is the 2006 winner of the Euro Health Consumer Index; Ireland and Lithuania provide the worst health care in Europe, 2006) and was ranked 26. Already next year, in 2007 Ireland was ranked 16 due to “closer collaboration” as Dr. Bjornberg puts it (Interview, 2008).

I argue that unavailability of data compromises the Index validity; consequently, it is a problem for the Index.

e) In the above mentioned example, Ireland improved its position very considerably (from 26 to 16). It took just one year. Obviously, during this year the government could not fully implement reforms that would lead to such improvements. Therefore, such dramatic changes in ranking produce doubts in reliability of the Index scoring.

e) One more point of concern is the way of scoring.

*The performance of the respective national healthcare systems were graded on a three-grade scale for each indicator, where the grades have the rather obvious meaning of Green = good, Amber = so-so and red = not-so-good). A green score earns 3 points, an amber score 2 points and a red score (or a “not available”) earns 1 point. In the EHCI 2005, the green **3**, amber **2** and red **1** were just added up to make up the country scores.*

For the 2006 Index a different methodology was used: For each of the five sub-disciplines, the country score was calculated as a percentage of the maximum possible (e.g. for Waiting times, the score for a state has been calculated as % of the maximum $3 \times 5 = 15$) (Index, 2007, p.18).

From this explanation, two aspects of special importance are derived.

The first one is related to defining an indicator threshold as it is really important for overall scoring. The Index 2007 states that “threshold levels have been set after studying the actual parameter value spreads, in order to avoid having indicators showing “all Green” or “totally Red”. Setting threshold values is typically done by studying a bar graph of country data values on an indicator sorted in ascending order. The usually “S”-shaped curve yielded by that is studied for notches in the curve, which can distinguish clusters of states, and such notches are often taken as starting values for scores” (p. 15). However, the EHCI does not include any bar graphs. Further, the construction of such graphs is deemed rather problematically for many indicators. In particular, it is difficult for such indicators as layman adapted pharmacopoeia, right to second opinion, web or 24/7 telephone healthcare info, provider catalog with quality ranking, i.e. indicators which are measured in a non-quantitative way. In case of these indicators, thresholds look rather vague:

yes, but not *really easily accessible* or *frequently consulted*

yes, but difficult to access due to *bad information*, bureaucracy or *doctor negativism*;

yes, but not *generally* available;

yes, but *awkward*, *costly* or not frequently updated (Index 2007, p. 12-13).

The Index 2007 does not elaborate what is meant by, for example the words ‘bad information’ or ‘awkward’. Further, it is quite problematical to measure ‘doctor negativism’ which is assessed, by the way, among others by healthcare officials (Index 2007, p. 12).

Secondly, under the Index system of scoring, numbers of indicators but not their importance and weights are significant (See Figure 12). For example, for the sub-discipline *patient rights and information* (9 indicators, 1.5. weight) the country can get 27 points while for outcomes (5 indicators, 2 weight) – only 15 points. Even after putting coefficients, the dominance of the first sub-discipline is evident (40.5 against 30). Accordingly, the country’s scoring is determined to a greater extent by numbers of indicators, but not their weights.

Sub-discipline	Scoring			
	<i>Number of indicators</i>	<i>Maximum possible scoring</i>	<i>Coefficients</i>	<i>Maximum possible scoring with coefficients</i>
<i>Patient rights and information</i>	9	27	1.5	40.5
<i>Waiting times</i>	5	15	2.0	30
<i>Outcomes</i>	5	15	2.0	30
<i>“Generosity” of public health system</i>	4	12	1.0	12
<i>Pharmaceuticals</i>	4	12	1.0	12

Figure 12. Analysis of the Euro Health Consumer Index scoring system.

f) Some statements of the Index 2007 seem to be irrelevant to the reality. In particularly, the EHCI (2007, p. 47) states that “the comparative analyses provided by the Index are not delivered by other institutions” while, for instance, the WHO report 2000 *Health systems: improving performance* has a purely comparative approach.

g) The EHCI has two external expert panels. During the interview with Dr. Bjornberg, he explained that the panel tests a draft version of an index, whether it is corresponding to the actual situation or not. Here, the HCP were guided by two principles while recruiting the panel – geographical and gender. The panel members are affiliated with solid organizations. Yet, there is a point of concern. The Index 2006 cites some comments from the international expert panel members. Interestingly, they are solely laudable. For example, Dr. Kass defines the Index in terms of “*transparent and the best and most comprehensive* (italic mine – EG) tool of its type” (Index, 2006, p. 24). Furthermore, the Index 2007 replicates the same comments without any

new remarks. It leads to the question whether there were no concerns of the panel? And why does the Index 2007 replicate comments for 2006?

In general, considering the abovementioned concerns, I would say that the validity of the EHCI 2007 seems pretty questionable or, to put it mildly, the Index 2007 does not seem transparent that leads to doubts in its validity.

2. **Comprehensiveness** is defined in terms of important dimensions which are supposed to be described in the Index.

The authors of the Index 2007 suggest some starting points for choosing indicators. *First*, the Index is claimed to include “such indicators, which should be relevant for describing a healthcare system viewed from the consumer/patients’ angle” (Index, 2007, p. 18). As I have already demonstrated above the Index could be hardly considered as the one constructed from the consumer perspective. *Second*, the Index urges against “a situation, where the indicator becomes just another way of measuring national wealth (GDP/capita) (Index, 2007, p. 4). Therefore, in terms of the Index project manager Dr. Bjornberg, the Index is drawn on indicators which are not “capitalized”, require great considerable investment (Interview, 2008). *Third*, the interview with Dr. Bjornberg revealed another criterion in choosing indicators. He said that the Index 2007 considered primary “qualified service” (Interview, 2008). Thus, the choice of indicators seems well grounded at first glance.

Nevertheless, there are some concerns about indicators.

a. It does not seem reasonable that the Index 2007 intentionally avoids indicators correlated with capitalization. If the government invests in expensive healthcare services, patients might be better off and get more than patients in a country where there is no such investment. Obviously, investment is not the only reason of getting a better health service. At the same time, the Index overlooks “expensive services”, that is not justifiable both for patients who getting expensive services and for those who are not. Therefore, I argue for including both “expensive” and less GDP-correlated indicators. Only in this case it is possible to get a full picture of health system performance.

b. The choice of indicator is not adequately argued. For example, in the sub-discipline waiting times there are 5 indicators (Index, 2007, p. 13 -14):

family doctor same day service;

direct access to specialist care;

major non-acute operations;

cancer; radiation/chemotherapy;

MRI (magnetic resonance imaging) scan examination.

Here, the Index does not explain why these indicators are chosen. In particular, much more consumers visit dentists and think about waiting list problems to dentists, then about MRI scan examination. On this my concern, the Index project manager replied that there were differences from country to country and dental care was not always a part of health system. Therefore, the Index constructors did not consider dental care (Interview, 2008). The argument would seem acceptable, if the sub-discipline “generosity” had **not** included the following indicator – is dental care a part of the offering from public healthcare systems? (Index, 2007, p. 15). Further, the indicator MRI scan examination implies considerable investments in expensive machines that seems at odds with the second criterion proposed by Dr. Bjornberg.

Another example is the indicator – kidney transplants. The Index 2007 does not explain why it is concerned with kidney, but not heart, liver, lung transplantation while OECD health data provide information on all these aspects. This consideration is also relevant for the other sub-disciplines (outcomes, generosity, pharmaceuticals). Although the EHCI 2007 (p. 31) contains the section “9.1.1. the reasoning behind indicator selection”, it mentions only a list of possible indicators, but not argumentation of choosing.

Generally speaking, the Index 2007 by means of indicators focuses only on limited numbers of services or groups of consumers. Moreover, the Index does not offer convincing explanations of choosing these groups or services. Therefore, I would argue that the EHCI 2007 is not based on a systematic process of choosing criteria for selecting indicators and, thus, the Index 2007 does not meet the requirement of comprehensiveness.

3. **Comprehensibility** implies that the information in the Index 2007 is supposed to be understandable for its users.

The Index 2007 mentions importance that the users can understand information communicated in the Index (2007, p. 45):

“Although HCP communicates a great deal of relatively complex information, HCP does so in a condensed way, and in a format that illustrates clearly the good and the bad. In addition, the HCP is working to ensure our information is as consumer-friendly as possible. For professional services, which are often complex to explain, there is always the challenge of balancing between ease of understanding and being accused of ‘dumbing down’”

During the interview with the Index project manager, he also recognizes the importance of this criterion for the Index (Interview, 2008). Indeed, the Index provides information in a very user-friendly way. The paper is very well structured, delivered in small sections. Besides this, the Index has the section devoted to frequently asked questions about the EHCI and the Health Consumer Powerhouse. Another advantage in this respect is simple language but quite emotional, colorful, with interesting metaphors - “shining star” (p. 3), “hard facts” (p.7), the

Index “climbers” (p. 21) which stress particular aspects. The Index 2007 also contains many tables, graphs which contribute to the user-friendly visual presentation of information.

At the same time, there are points of improvement. In particular, the Index elaborates on its indicators in several places (first in section 4.2. Scope and content, then in section 5.2. Four indicators introduced, and in section 10.1. Medical outcomes indicators included in the EHCI). It seems justifiable if the discussion on the Index indicators will be presented in one place.

My second consideration is that the Index’s user-friendliness unreasonably compromises its scientific dimension. In particular, the Index is not based on many scientific articles and surveys. But the EHCI 2007 does not contain a reference list with even those few ones.

4. **Relevance** applies to two aspects: potential users’ needs and the right unit of analysis.

The Index 2007 identifies several potential users. First of all, the Index is claimed to be “an element of consumer empowerment” (p.4, 30). Ironically, the Index defines its main audiences not as consumers but as ‘those involved in health care policy formation – civil servants and clinicians and, of course, journalists” (p. 44).

*In the initial years of index building, **opinions brokers and policy makers** – like journalists, experts and politicians -- will be the key targets for the Index. Gradually, the health **consumer** could become main users as well as service providers, payors and authorities. Such a development will ask for user-friendly services and a deep knowledge of consumer values (Index, 2007, p.31).*

In respect of policy makers, the key target group, the unit of analysis is chosen adequately, i.e. national health care systems. The comparison at the national level with other states might draw attention to and address problems.

As for consumers, I presume that they are more concerned with performance in a particular hospital. In other words, to go shopping for health the consumer would need information on hospital ranking not on health systems. The Index suggests several ways in which consumers can use it: 1) to learn the strong and weak aspects of their national healthcare system; 2) as a foundation for making informed choices; for example if one needs to go abroad to find treatment; 3) in building action to demand better access, improved quality of care or increased levels of information (p. 46).

I would be rather skeptical in respect of the Index usage by consumers in the mentioned situations. The first one (knowledge) does not give anything to consumers. In case of informed choices, more detailed information will be of value (like the case of Mr. Chiocca described in the Introduction). During the Interview Mr. Björnberg mentioned “snow birding” when the retired from the north go to countries with warmer climate. He holds that in case of “snow birding”, the Index provides consumers with information which is helpful in choosing countries with a better

health care system (Interview, 2008). For me this argument does not seem convincing due to the little scope of people in Europe who change place guided by the desire to get better health care. In case of the third situation, i.e. demanding a better access, the EHCI could be useful, to some extent, for consumer organisations. Drawing on this reasoning, I argue that the Index unit of analysis (a national health care system) is not absolutely relevant to consumers' needs.

Speaking about relevance, it is worth mentioning that sometimes information presented in the Index seems controversial.

In particular, during the interview with Mr. Björnberg, project manager, he stated that they were not concerned about efficiency, how much governments spend on health care systems. At the same time, the EHCI 2007 introduces "Bang-for buck adjusted scores" (p. 27) which depicts exactly efficiency of the system. For the consumers it would be more interesting and important to see how efficient the system in relation to a consumer/family spending rather than in relation to GDP.

Secondly, the Index 2007 introduces not only the International Experts Panel but also the Swedish Panel which, as far as I understand, was not engaged in the Euro health Consumer Index evaluation (p. 37).

Thirdly, elaborating about medical outcomes indicators not included in the paper, the Index describes diabetes complication data for the USA. It seems not relevant as the USA is not included in the study. Fourthly, section 12.2. Useful links mentions sites with "useful complementary information" (p. 43). However, it is not clear whether the Index constructors use these information and if yes, how.

Finally, Annex 1 of the Index contains two tables on patients' rights laws and charters of the rights of patients. Surprisingly, among others, the tables mention such countries as Israel, Georgia, Russia, South Africa, Hong Kong that is obvious not relevant (p. 49-51). The only explanation of these countries' inclusion is that the tables were constructed initially not for this research. In fact, on the Internet I found a page with these tables and the same comments (Patients' Rights Laws in Europe). Unfortunately, in the Index there is no reference to this page.

5. **Reasonableness** implies such an idea as the cost of compliance with requirements of the study.

This means that it should take reasonable time for health care officials to fill in papers the HCP researchers send them for data adjustment. Unfortunately, the Index 2007 does not contain a sample of papers. However, there is an indirect indicator – the rate of responsiveness from ministries. In 2007 it was 16 states out of 29 (Index 2007, p. 16), i.e. about 55%. Taking into account bureaucratism and in some cases reluctance of healthcare officials to respond, I

would suggest that the score sheets were composed in accordance with the criterion of reasonableness.

Yet, there is one concern. The Index is aimed at assessing the system of health care which is quite a complicated structure. It takes time to implement changes and reforms. In respect to health system assessment by WHO, Wilbulpolprasert and Tangcharoensathien (2001) notes that “given the multifactoral nature of health determinants and the existing infrastructure within any given country, in the short run there can be no rapid improvement of health system performance...Hence, there is no need to make performance assessment frequently” (p. 489).

I suggest that this observation is also relevant for the case of the Index. For example, it takes time to bring changes in such sub-disciplines as outcomes (infant death), generosity (including dental care in a health system implies a long-term reform), waiting times (direct access to specialist suggests again a reform). At the same time, in the Index there are some indicators which are not so closely correlated with long-term changes (web or 24/7 telephone healthcare info). Yet, the Index is based mainly on the indicators measuring changes that could take place only in the long term. The Index 2007 indirectly confirms this suggestion. Thus, in the sub-section devoted to changes visible over time, the Index mentions patient rights, provider catalog, layman adapted pharmacopoeia, and improved access to health care. Except the last one, all the indicators imply changes which are possible in the short terms.

Thus, I argue, that the changes the EHCI is aiming to measure can be evident over more considerable period of time than a year. Consequently, it might be not so reasonable to carry out a research annually.

6. Functionality. This criterion is closely connected with the idea of public statistic usage by different actors proposed by McRae (1986). Therefore, it makes sense to consider functionality in application to the theory of McRae.

As it has been discussed above, the Index defines its primary target group as policy makers. Accordingly, the actor (policy makers or a government) is involved in a collective decision. Policy makers are to be guided by consumerism, i.e. the ethical motive prevails (See Figure 13)

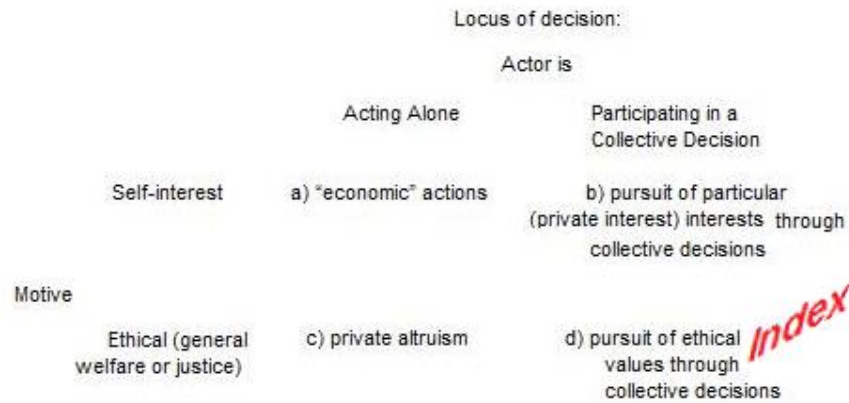


Figure 13. The Euro Health Consumer Index utilization by policy makers.

In the context of the theory of McRae (1996), it is evident that functionality for the Index will be defined how the Index stimulates policy makers to “pursuit consumer values”.

To encourage policy makers to take certain steps, the HCP publishes not only an index, but also a press release for each country with some recommendations. For instance, the press release for the United Kingdom “welcomed policy review on access to new cancer drugs” (Bleak performance by UK in the European Union consumer friendly healthcare rankings, 2007). Furthermore, the HCP publishes also a summary of recommendations for all countries. For the UK recommendations were phrased as “access should be granted to everyone and rapidly set in place” in respect of new cancer drugs and “better value for money than the UK service provides” (Recommendation paper, 2007, p.6). Here, I would like to point out that the suggested changes imply the long term perspective (longer than a year) which complies with the Index frequent publishing not very well. The second remark is that although the EHCI claims the consumer perspective, its recommendation (in particular, the focus on efficiency) is more typically for managed health care.

On the one hand, the index approach towards recommendations, i.e. the focus on one-two areas to be improved, clear targets, is quite promising and can be a helpful guide in policy making. The Index 2007 claims that in some countries there are significant changes due to the EHCI:

The index has made concrete improvements to healthcare investment in a number of countries, For instance, following on our 2006 Index the Danish government added more money to improve Danish healthcare. Last year in Ireland, the poor ranking caused a media outcry and intense political debate, pressuring for reform. In Sweden significant steps towards public ranking of healthcare have been taken following on our action (Index 2007, p. 47).

Nevertheless, I would be rather skeptical about the idea that the Index really influences governments so much. I presume the Index was not the only reason why the Danish government invested in the health care system. As for Ireland, the reform was already in place. Moreover, the media attention was so considerable because investments have been made and after that the country scored so poor in the EHCI.

To see the Index functionality, I would suggest to study most noticeable impact the Index had. During the interview, on my question Dr. Bjornberg did not point out any prominent examples. Therefore, I took two opposite examples of countries based on the criteria of media attention and information provided in the Index. After searching the Internet, Ireland was defined as a country where the Index evoked negative reaction. Estonia was chosen because the Index 2007 defines the country as “a climber” with good improvement.

In Ireland media attention was stimulated by the on-going health care reform. After “a modest scoring” in 2006, the Irish authorities pointed to drawbacks in data on the Irish health system. In 2007 Ireland cooperated with the HCP closer, and got a much higher rank (from 28 in 2006 to 16 in 2007).

In Estonia the country’s ranking was perceived very favorable. Some Estonian web-sites devoted to investment in country refer to the Index as a proof of development (Invest in Estonia, Positive Estonia). At the same time, I contacted the Ministry of Social Affairs of Estonia, in particular the Head of Health Information and Analysis Department, Liis Rooväli who was “the contact person for the Index for the last few years”. He denied that the Index had any impact: the Index neither influenced policy nor drew attention to new dimensions of health care.

Drawing on these examples and the fact that the Index does not present convincing results of its influence, I would be rather careful speaking about the Index functionality.

In general, the Index 2007 does not fully meet all criteria for league tables. There are many concerns in respect of functionality, reasonableness, comprehensiveness, and validity. The unit of analysis is relevant for the main target group, policy makers, but not for consumers. The Index is quite comprehensible for users; however, to reach this, the EHCI compromises its scientific component. Following Gormley and Weimer’s reasoning about the importance of validity as a key stone of any research, I would suggest that the EHCI 2007 should focus on improvement of this criterion, first of all.

4.5. Comparison between the ECHI and the OECD/WHO approaches

As it has been shown above, the approaches of the OECD and WHO are very close to each other and have many in common in terms of dimensions (see Figure 8, p. 49). As the OECD

does not carry out comparative studies in application to concrete countries, I will focus on the WHO report, and the comparison between the WHO report and the EHCI.

The Index claims that “HCP data is complementary to one of WHO. The WHO ... provides statistical information, which the HCP also uses, but HCP wants qualitative data also. Their focus is on overall public health, the focus of the EHCI is on providing consumer information” (Index, 2007, p. 47).

Indeed, the WHO report gave a broad definition of the health system and, consequently, measured public health rather than health system performance. In case of the EHCI, the idea was the opposite one, to focus only on those aspects which are important for consumers. Yet, from the analysis of the Index comprehensiveness and especially testing of expectations concerning consumerism, it is clear that the Index tends to overlook some issues. Therefore, it is complicated to answer on “complementarily”.

In the domain of *dominance*, neither the WHO nor the EHCI, use the consumer perspective. Moreover, the report 2000 seems even more in line with consumerism as it engages both general public and experts in assessing, while the Index solely relies on experts. In the domain – *decision making and choice*, the two approaches demonstrate elements of consumerism. In particular, the WHO report introduces indicators on choice of treatment and choice of providers while overlooking possibilities of complaint procedures. On the contrary, the EHCI considers the right to second opinion, but overlooks choice. The Index introduces a number of indicators on *rights* while the WHO report did not. The Index also addresses the issue of patient’s *knowledge* and how the government contributes to it in the form of providing information. On the whole, the comparison is presented in Figure 14.

Domain	The WHO report 2000	The EHCI 2007
Dominance - consumer preferences - priority setting	+/- (public & experts) -	- +
Decision making/choice - choice of GP - complaint procedures	+ (treatment, provider) -	- + (second opinion)
Rights	-	+
Knowledge - provision of information	-	+ (several indicators)

System indicators	input	process
Subjective/objective (dominate)	objective	objective
Functionality	questionable	questionable

Figure 14. The comparison between the WHO report 2000 and the EHCI 2007.

As it can be seen from Figure 14, the WHO and the EHCI approaches are complementary to each other in terms of indicators. However, in respect of methodology, both of them are likely to give preferences to methods associated with professionalism and managed care (stress on experts' opinion, objective content of indicators).

Although the WHO report does not introduce the idea of consumerism in evaluation of health care systems, it incorporates some features of consumerism and indicators which are typical for this health care logic. The Index, to the contrary, claims the assessment from the consumer perspective. Nevertheless, it overlooks many domains which embody consumerism.

Still, the two approaches differ considerable and, in certain sense, are complementary to each other: while the WHO report evaluate public health in general, the Index is likely to focus on a few aspects of the health care system.

5. Conclusion and Recommendations

The chapter is aimed at answering the main research question about the added value for the three groups of stakeholders defined in the Introduction. Based on my analysis of the Index from the consumer perspective and assessment against the criteria for league tables, I suggest some recommendations

5.1. The Added Value for the Stakeholders

In the Introduction, the added value of the Index is defined as complementary to the existing mechanisms of evaluation provided by the OECD and WHO.

To find out the added value, I investigated the question of the consumer perspective peculiarities, i.e. consumerism in comparison to other logics in health care - professionalism and managed healthcare. On the bases of literature analysis it is possible to distinguish several domains which are especially important for consumerism. Major changes associated with consumerism took place in these domains. These changes include patients' dominance and attention to their preferences and needs, patients' involvement in decision making, widening of patients' rights and lay knowledge. The Index was supposed to address these changes in the form of indicators. Furthermore, I distinguish several features of indicators which are typical for consumerism. In particular, emphasis on subjective indicators and dominance of process and output/outcome indicators in comparison to input indicators draw attention to patients' attitudes and what and how patient get from health systems, respectively.

After having understood peculiarities of the consumer perspective, it is logically to see how the existing evaluation systems established by the OECD and WHO as well as the EHCI itself incorporate this perspective.

Interestingly, both organizations (WHO & OECD) pay primarily attention to statistic database, providing statistics allowing researchers make comparisons and conclusions about national health systems. However, WHO issued the Report 2000 devoted to national health system performance while the OECD develops papers on frameworks for assessment of the system in general and particular aspects. As my analysis shows it is possible to speak about the common approach by the OECD and WHO to evaluation of health systems as these organizations emphasize the same elements and indicators. At the same time, the OECD is aimed at policy makers and, therefore, emphasizes efficiency.

My analysis shows that the WHO/OECD approach which is most explicit in the Report 2000 is mainly typical for professionalism. The Report includes only a few indicators (choice of treatment options and choice between providers) measuring possible changes in the domains

which are important for consumerism. Moreover, although the WHO experts make an attempt to concentrate on output indicators, the Report 2000 defines the health system very broad, that leads to describing public health rather than health system performance. Further, although only one dimension (responsiveness) of the WHO report is based on subjective indicators, i.e. there is a strong dominance of objective indicators. This is again typical for professionalism/managed care. Thus, the approach taken by the OECD and WHO is based on the logics of professionalism and managed healthcare.

To the contrary, the EHCI claims the consumer perspective. Thus, to have the added value, the EHCI is supposed 1) to address the issues which are overlooked by the OECD and WHO; 2) to meet certain standards of quality that is to meet the criteria for assessment of league tables.

As far as the consumer perspective is concerned, the EHCI does not fully incorporate it. On the one hand, the Index introduces some relevant indicators in every domain (partly dominance, partly decision making/choice, rights, partly knowledge) and process indicators prevail over input/structure ones. At the same time, the Index 2007 sometimes takes even a more pro-professional approach than WHO. For instance, putting weights to indicators was made on the basis of experts' opinions while the Report 2000 takes into account public opinion. Further, despite the consumer perspective claims, the Index is based primarily on objective indicators, thus, overlooking feelings of and evaluations made by consumers.

In the Index 2007 there are serious shortcomings in respect of quality. The most acute concerns are about the Index validity. The Index 2007 is neither transparent (does not elaborate on choice of indicators and their meaning) nor based on relevant information (limited sources of information, irrelevant to the reality statements). As the systematic process of indicators choosing is absent, the Index touches upon only specific services and particular groups of patients. Thus, standards of comprehensiveness are not met. There are concerns in respect of relevance and reasonable. The Index overlooks consumers because takes a high level of aggregation - national health care systems, but not the level of hospitals. For policy makers the Index also seems not reasonable as it is published annually and it is just impossible to implement and achieve considerable changes.

So, generally, we have quite a paradoxical situation. Although the ECHI addresses the issues which are not mentioned in the WHO report, it is difficult to speak about its added value for the stakeholders.

As it was defined in the introduction, there are three groups of stakeholders – policy makers, consumers, and patient organizations which might be interested in the Index findings.

From the analysis it is evident that the primary target group is policy makers at the national level. Although the EHCI is complimentary to the WHO approach, policy makers do not hurry up to utilize it as a guide for “collective actions” in terms of McRae (1986). The Index provides insight what particular groups of consumers get from a limited numbers of services provided by the health system. I argue that the Index limitations in respect of its quality prevent from the more active use of the EHCI by policy makers. Therefore, the added value of the EHCI for policy makers is low.

While the Index claims the consumer perspective, it does not even define consumers as a target group. Indeed, the EHCI limitations of relevance in respect of consumers (unit of analysis is health care systems in general, but not particular hospitals) seriously undermine its possible added value for consumers.

Finally, patient organizations might be benefited from the EHCI. In terms of McRae (1986), the Index might encourage patient organizations participation in “collective actions”. At the same time, the Interview with the Index project manager showed that the health Consumer Powerhouse does not maintain contacts with patient organizations. Also, searching on the Internet I did not find any reference to the EHCI usage by patient organizations in advocacy activities. However, this issue requires further research.

In general, although the EHCI is complementary to the OECD/WHO approaches, serious limitations in validity, comprehensiveness, relevance and functionality considerable undermines its added value for policy makers and consumers.

5.2. Critical Questions

There are certain points of improvements in respect of indicators choice, conducting a research, and argumentation of the approach in the paper. But the first step is to define conceptual frameworks for the Index. I think that the Health Consumer Powerhouse has two options: 1) to focus on performance of the health system or 2) to assess the health care from the consumer perspective. I argue that these approaches differ from each other. In particular, in the first case, the Index constructors are supposed to measure outcomes and efficiency. The issue of consumers (preferences, satisfaction) will not be so pronounced here. In the case of the second approach, the attention should be paid to consumers, their needs and, consequently, dimensions which are important for consumers. I argue that in both cases, the conceptual framework should be based on relevant studies.

In general, the Index is supposed to improve its reliability and potential effectiveness, or in terms of Gormley and Weimer (1999) improve its validity and functionality, respectively. In

respect of these dimensions, the conceptual framework should address questions and concerns of the Index 2007.

1) The Index does not identify indicators associated with the consumer perspective and introduce them. In fact, this exercise leads to identifying main domains, aspects of health care which are important for consumers and associated with consumerism. In the thesis, I have already mentioned dominance, knowledge, rights, and choice/decision making. However, experience of European and international organization could also be useful. For example, the Committee of Ministers of the EU adopted recommendations to member states – The Development of Structures for Citizen and Patient Participation in the Decision Making Process Affecting Health Care. So, some important indicators can be drawn from this paper. In particular, the paper recommends to “create legal structures and policies that support the promotion of citizen participation and patients’ rights” (The Development of Structures, 2000). Another example is the OECD paper on “Selecting indicators for patient safety at the health systems level in OECD countries” (2004). Here, the paper not only introduces indicators but also discusses importance of an indicator, scientific soundness, as well as feasibility in terms of data availability and reporting burden (p. 8).

2) The Index is supposed to argue the choice of indicators which is missing in the EHCI 2007.

3) The Index 2007 does not elaborate how indicators are measured (e.g. patient organizations involvement but not clear at what level). However, the way of measurement can seriously influence on the result.

4) The Index 2007 does not seem like incorporating the consumer perspective in its methodological dimension. In particular, these include several aspects a) putting weights to indicators without considering patients’ opinion; b) the Index panel consists only of professionals and managers while it is logical to include representatives of patients’ organizations or to create the second panel consisting of patient organizations’ representatives; c) interviews are conducted only with national health care authorities while consumers and patient organizations are ignored.

5) The Index is published annually which does not seem reasonable as many indicators evoke changes in the long run. At first sight, the EHCI should be published not so often. On the other, this is a case of trade off pertinent to “boundary work”. The researchers are supposed to find the golden mean between scientific reasonableness and the ability to be visible in society, in decision making process.

6) The Index 2007 does not mention cooperation with any patient organizations. But it is patient organizations that are interested in promotion of the consumer perspective. In other

words, patient organizations are a natural ally of the Health Consumer Powerhouse. Therefore, if the EHCI constructors and managers pay more attention to patient organizations to patient organizations, it could considerable improve the Index functionality.

Generally, these critical questions can be bases for the conceptual framework development and, consequently, improvement of the Index functionality and validity.

Reference

Almeida, C., Braveman, P., Gold, M.R., Szwarcwald, C.L., Ribeiro, J.M., Miglionico, A., Millar, J.S., Porto, S., Costa, N.R., Rubio, V.O., Segall, M., Starfield, B., Travessos, C., Uga, A., Valente, J., Viacava, F. (2001) Methodological concerns and recommendations on policy consequences of the World Health Report 2000. *Lancet*. Vol. 357, Issue 9269.

Almond, P. (2001) What is consumerism and has it had an impact on health visiting provision? A literature review. *Journal of advanced nursing*. Vol. 35. Issue 6.

Anderson, G. & Hussey, P.S. (2001) Comparing Health System Performance in OECD Countries. *Health Affairs*. Vol. 20, No.3.

Barnett, J. R.; Barnett, P. and Kearns, R. A. (1998) Declining Professional Dominance? Trends in the Proletarianization of Primary Care in New Zealand. *Social Science & Medicine*. Vol. 46. No. 2.

Bekker, M. (2007) The Politics of Healthy Policies: Redesigning Health Impact Assessment to Integrate Health in Public Policy. Eburon Uitgeverij B.V

Belien, P. (2000) Health care systems. A New European Model? *Pharmaeconomics*, 18 Supplement.

Berg, M., Meijerink, Y., Gras, M., Goossensen, A., Schellekens, W., Haeck, J., Kallewaard, M., Kingma, H. (2005) Feasibility first: Developing public performance indicators on patient safety and clinical effectiveness for Dutch hospitals. *Health Policy*. Vol. 75.

Bleak performance by UK in the European Union consumer friendly healthcare rankings (2007) Press release.

http://www.healthpowerhouse.com/files/press_releases/UK%202007%20EHCI.pdf (accessed 03.09.08)

Blendon, R. J., Kim, M., Benson, J. M. (2001) The Public Versus the World Health Organization on Health System Performance. *Health Affairs*. Vol. 20, No. 3

Bocking, S. (2004) Nature's Experts: Science, Politics, and the Environment. Rutgers University Press. New Brunswick, New Jersey.

Brouwer, W., Exel van J., Hermans B., Stoop, A. (2003) Should I stay or should I go? Waiting lists and cross-border care in the Netherlands. *Health Policy*. No. 63.

Byrne, D. (2001) Public health in the European Union. Breaking down barriers. *Eurohealth*. Vol. 7, No. 4.

Campbell, S.M., Roland, M.O., Buetow, S.A. (2000) Defining quality of care. *Social Science and Medicine*. Vol. 51, Issue 11.

van Campen, C., Sixma, J.J., Kerssens, L., Peters, L., Rasker, J.J. (1998) Assessing Patients' Priorities and Perceptions of the Quality of Health Care: the Development of the Quote-Rheumatic-Patients Instrument. *British Journal of Rheumatology*. Vol. 37.

Carlson, P. (1998) Self-perceived health in East and West Europe: another European health divide. *Social Science & Medicine*. Vol. 46, Issue 10.

Carter, N., Klein, R., Day, P. (1992) How organizations measure success. The Use of Performance Indicators in Government. Routledge. London and New York.

Cicatiello, J. (2000) A Perspective of Health Care in the Past—Insights and Challenges for a Health Care System in the New Millennium. *Nursing Administration: Then, Now, and Tomorrow*. Vol. 25, Issue 1.

Cleary, P. D. & Edgman-Levin, S. (1997) Health Care Quality: Incorporating Consumer Perspective. *JAMA*. Vol. 278, No. 19.

Cross-border health services in the EU. Analytical report. (2007) Conducted by The Gallup Organization, Hungary upon the request of the Health and Consumer Protection Directorate-General (DG SANCO), Health Strategy Unit (C5). Survey organized and managed by the Eurobarometer Team of Directorate-General “Communication”.

http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf (accessed 03.09.08)

Cunningham, A. & French, R. (1990) The medical enlightenment of the eighteenth century. Cambridge University Press.

Department of Health and Children challenges validity of survey on Irish healthcare (2006)

<http://www.dohc.ie/press/releases/2006/20060627.html> (accessed 03.09.08)

Developing European Union health indicators.

http://ec.europa.eu/health/ph_information/indicators/indic_data_en.htm (accessed 03.09.08)

Dill, D.D. & Soo, M. (2005) Academic quality, league tables, and public policy: A cross-national analysis of university ranking systems. *Higher Education*. Vol. 49, No. 4.

Docteur, E. (2004) Towards High-Performing Health Systems: The OECD Health Project. OECD Publishing.

http://books.google.com/books?id=Qh0GKiwcrcBYC&dq=Towards+High-Performing+Health+Systems&source=gbs_summary_s&cad=0 (accessed 03.09.08)

Editorial. (2005) Will consumerism lead to better health? *The Lancet*. Vol. 366, Issue 9483.

Elola, J., Daponte, A., Navaroo, V. (1995) Health Indicators and the Organization of Health Care Systems in Western Europe. *American Journal of Public Health*. Vol. 85, No. 10.

Elston, M. A. (1991) The politics of professional power: medicine in a changing health service. In *The sociology of health service* (Ed. Gabe, J., Calnas, M., and Bury, M.). Routledge.

European health for all database.

<http://www.euro.who.int/hfadb> (accessed 03.09.08)

Explanatory Statement by Ministry for health, the Elderly and Community Care (2007)

<http://www.sahha.gov.mt/showdoc.aspx?id=748&filesource=4&file=pr1478.pdf> (accessed 03.09.08)

Field, D. & Taylor, S. (2007) Health care in contemporary Britain. In *Sociology of health and health care* (Ed. by Taylor, S. & Field, D.) Forth edition. Blackwell Publishing.

Fine, A. (2000) Big Ideas. Consumerism: Who's Buying It? *Hospitals & Health Networks*. Vol. 74, Issue 12.

France is the 2006 winner of the Euro Health Consumer Index; Ireland and Lithuania provide the worst health care in Europe (2006) *Finfacts Team*. June 26.
http://www.finfacts.ie/irelandbusinessnews/publish/article_10006355.shtml (accessed 03.09.08)

Freidson, E. (1977) *The Futures Of Professionalization. Health and the Division of Labor*. Watson Publication for International Studies.

Gilliatt, S., Fenwick, J., Alford, D. (2000) Public Service and the Consumer: Empowerment or Control? *Social Policy & Administration*. Vol. 34, No. 3.

Goering, S. (1996) Patient consumerism and health care reform: Compromise without commodification. *Health Care Analysis*. Vol. 4, No. 4.

Goldsmith, R. (2005) Europe: Shopping for health care. *The Seattle Times*. Thursday, February. 10
http://seattletimes.nwsourc.com/html/nationworld/2002175968_euromed09.html (accessed 03.09.08)

Gooijer, W. de (2007) *Trends in EU Health Care Systems*. Springer.

Gormley, W. T. & Weimer, D. L. (1999) *Organizational Report Cards*. Cambridge, Harvard University Press.

Groenewegen, P. P., Kerssens, J.J, Sixma, H.J., Eijk, I. van der, Boerma, W.G.W. (2005) What is important in evaluating health care quality? An international comparison of user views. *BMC Health Services Research*, Vol. 5, No. 16.

Grol, R., Wensing, M., Mainz, J., Ferreira, P., Hearnshaw, H., Hjortdahl, P., Olesen, F., Ribacke, M., Spenser, T., Szécsényi, J. (1999) Patients' priorities with respect to general practice care: an international comparison. *Family Practice*. Vol. 16, No.1.

Health for all database (HFA-DB) World Health Organization Regional Office for Europe. 2008.
<http://data.euro.who.int/hfad/index.php?lang=en> (accessed 03.09.08)

Henwood F, Wyatt S, Hart A, Smith J. (2003) 'Ignorance is bliss sometimes': constraints on the emergence of the 'informed patient' in the changing landscapes of health information. *Sociology of Health & Illness*. Vol. 25, No. 6.

Hjetqvist, J. (2002) Meeting the Changes to European Healthcare. Lessons learned from the "Stockholm Revolution". *Pharmaeconomics*, 20 Supplement. 3.

Hibbard, J. H, Slovic, P., Jewett, J.J. (2001) Informing Consumer Decisions in Health Care: Implications from Decision-Making Research. *Milbank Quarterly*. Vol. 75, Issue 3.

Hussey, P.S., Anderson, G.A., Osborn, R., Feek, C., McLaughlin, V., Millar, J., Epstein, A. (2004) How Does The Quality of Care Compare in Five Countries? *Health Affairs*. Vol. 23, No.3.

Jamison, D. T. & Sandbu, M. (2001) WHO Ranking of Health System Performance. *Science's Compass*. Vol. 293, No. 5535.

Kelley, E. (2007) Health, spending and the effort to improve quality in OECD countries: a review of the data. *The Journal of the Royal Society for the Promotion of Health*. Vol. 127, No. 2

Kelley, E.T., Arispe, I., Holmes, J. (2006) Beyond the initial indicators: Lessons from the OECD Health Care Quality Indicators Project and the US National Healthcare Quality Report. *International Journal for Quality in Health Care*. Vol. 18, No. 1.

Kemp, R. (2007) Medical Dominance and Institutional Change in the Delivery of Health Care Services. *Forum for Social Economics*. Vol. 36, No. 1.

Klitzner, M. (2002) Literature Review and Analysis: Public Health and Public Perspectives on Measuring Alcohol Policy Enforcement and Compliance. Paper prepared for the National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH), U.S. Department of Health and Human Services (HHS).

http://alcoholpolicy.niaaa.nih.gov/vertical/Sites/%7BC69AF337-ECC4-4E34-B283-7DD12A8AE057%7D/uploads/PH-PP_paper_12_20_07.pdf (accessed 03.09.08)

Krug, M.E. & Freedman, L.P. (2008) Assessing health system performance in developing countries: A review of the literature. *Health Policy*. Vol. 85

Imanaka, Y. (1997) Professionalism and Consumerism: Can They Grow Together? *International Journal for Quality in Health Care*. Vol. 9, No. 6.

Invest in Estonia

<http://www.investinestonia.com/index.php?option=displaypage&Itemid=78&op=page&SubMenu> (accessed 03.09.08)

Light, D.W. (2002) Institutional change and healthcare organizations: from professional dominance to managed care. Book review. *International Journal of Integrated Care*. Vol. 2.

Litva, A., Coast, J., Donovan, J., Eyles, J., Shepherd, M., Tacchif, J., Abelson, J., Morgane, K. (2002) 'The public is too subjective': public involvement at different levels of health-care decision making. *Social Science & Medicine*. Vol. 54, Issue 12.

Lupton, D. (1997) Consumerism, Reflexivity and the Medical Encounter. *Social Science and Medicine*. Vol. 45, No. 3.

McRae, D. (1985) Policy Indicators. Links between Social Science and Public Debate. The University of North Carolina Press. Chapel Hill. London.

McKee, M. (2001) Measuring the efficiency of health systems. *British Medical Journal*. Vol. 323, Issue 7308.

Malin, N., Stephen, W., Manthorpe, J. (2002) Key Concepts and Debates in Health and Social Policy. Open University Press.

Mant, J. (2001) Process versus outcome indicators in the assessment of quality of health care. *International Journal for Quality in Health Care*. Vol. 13, No. 6.

Mattke, S., Epstein, A.M., Leatherman, S. (2006) The OECD Health Quality Indicators Project; history and background. *International Journal for Quality in Health Care*. Vol. 18, No. 1.

Murray, C. & Frenk, J. (2001) World Health Report 2000: a step towards evidence-based health policy. *The Lancet*. Vol. 357, Issue 9269.

Murray, C. & Frenk, J. (2000) A framework for assessing the performance of health systems. *Bulletin of the World Health Organization*. Vol. 78, No. 6.

National Report on Health Sector Performance Indicators 2001 (2002) by the National Health Performance Committee. A report to the Australian Health Ministers' Conference.
http://www.health.qld.gov.au/nathlthrpt/performance_indicators/natrpt.pdf (accessed 03.09.08)

Navarro, V. (2002) Can Health Care Systems Be Compared Using a Single Measure of Performance. *American Journal of Public Health*. Vol. 92, No. 1.

Navarro, V. (2000) Assessment of the World Health Report 2000. *Lancet*. Vol. 356, Issue 9241.

Nelson, G., Wiltshire, C., Hall, G.B., Peirson, P, Walsh-Bower, R. (2006) Psychiatric consumer/survivors' quality of life: Quantitative and qualitative perspectives. *Journal of Community Psychology*. Vol. 23, Issue 3.

Newman, J. & Kuhlmann, E. (2007) Consumers enter the political stage? The modernization of health care in Britain and Germany. *Journal of European Social Policy*. Vol. 17, No. 2.

Newman, J. & Vidler, E. (2006) Discriminating Customers, Responsible Patients, Empowered Users: Consumerism and the Modernization of Health Care. *Journal of Social Policy*. Vol. 35, No. 2.

Neufville, J. I (1975) *Social Indicators and Public Policy. Interactive Processes of Design and Application*. Elsevier Scientific Publishing Company. Amsterdam. Oxford. New York.

Noll, H-H. (2002) Towards a European system of social indicators: theoretical framework and system architecture. In *Assessing Quality of Life and Living Conditions to Guide National Policy. The State of the Art*. (Ed. by M. R. Hagerty, J. Vogel & V. Møller) Kluwer Academic Publishers.

Nolte, E. & McKee, M. (2003) Measuring the health of nations: analysis of mortality amenable to health care. *British Medical Journal*. Vol. 327, No. 1129.

OECD Health Data 2008: Statistics and Indicators for 30 Countries
http://www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_1,00.html
(accessed 03.09.08)

OECD Health Project (2001-2004)
http://www.oecd.org/document/28/0,3343,en_2649_33929_2536540_1_1_1_1,00.html#why
(accessed 03.09.08)

Oddsson, K. (2003) Assessing attitude towards prioritizing in healthcare in Iceland. *Health Policy*. Vol. 66, Issue 2.

- Østergren, K. (2006) The Institutional Construction of Consumerism: a Study of Implementing Quality Indicators. *Financial Accountability & Management*. Vol. 22, No. 2.
- Øvretveit, J. (2001) Quality evaluation and indicator comparison in health care. *International Journal of Health Planning and Management*. Vol. 16, Issue 3.
- Patients' Rights Laws in Europe <http://aitel.hist.no/~walterk/wkeim/patients.htm> (accessed 03.09.08)
- Peabody, J. W. & Liu, A. (2007) A cross-national comparison of the quality of clinical care using vignettes. *Health Policy and Planning*. Vol. 22, No. 5.
- Pedersen, K. M. (2002) The World Health Report 2000: dialog of the deaf? *Health Economics*. Vol. 11, No. 2.
- Pierson, P. (2004) Positive feedback and path dependence. In P. Pierson. *Politics in time. History, institutions, and social analysis*. Princeton: Princeton University Press.
- Press Release. The Netherlands Top in Healthcare. 2005.
<http://www.healthpowerhouse.com/media/GeneralPR.pdf> (accessed 03.09.08)
- Policy Department Economic and Scientific Policy. The Impact of the European Court of Justice Case Law on National Systems for Cross-Border Health Service Provision. Briefing Note. (2006)
http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_briefingnote_en.pdf (accessed 03.09.08)
- Positive Estonia http://www.erel.ee/index.php/page_id/646 (accessed 03.09.08)
- Rich, R. F. & Merrick, K. R. (2006). Cross border health care in the European Union: challenges and opportunities. *The Journal of contemporary health law and policy*. Vol. 23, Issue 1.
- Richards, T. (1999) Patients' priorities. Need to be assessed properly and taken into account. *British Medical Journal*. Vol. 318, No. 7179.
- Richardson, J., Wildman, J., Robertson, I.K. (2003) A critique of the World Health Organisation' evaluation of health system performance. *Health Economics*. Vol. 12, Issue 5.
- Robinson, J. C. (2001) The End of Managed Health Care. *Special Communication*. Vol. 285, No. 20.
- Schickle, D. (1997) Public preferences for health care; prioritization in the United Kingdom. *Bioethics*. Vol. 11, No. 334.
- Scharpf, F. W. (2002) The European Social Model: Coping with the Challenges of Diversity. *Journal of Common Market Studies*. Vol. 40, No. 4.
- Schlesinger, M. (2002). A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession. *Milbank Quarterly*. Vol. 80, No. 2.

Selecting indicators for patient safety at the health systems level in OECD countries” (2004) OECD Health Technical Papers No. 18 <http://www.oecd.org/dataoecd/53/26/33878001.pdf> (accessed 03.09.08)

Starr, P. (1982) *The Social Transformation of American Medicine*. New York.

Step toe, A. & Wardle, J. (2001) Health behavior, risk awareness and emotional well-being in students from Eastern Europe and Western Europe. *Social Science and Medicine*. Vol. 53, No. 12.

Stone, D. (2005) The False Promise of Consumer Choice. In *Consumer Choice. Social Welfare & Health Policy*. (Ed. by R.F. Rich & C.T. Erb). *Policy Studies Review Annual*. Vol. 14. Transaction Publishers. New Brunswick (USA) and London (UK).

Stuyft, V. & Unger, J.P. (2000) Improving the performance of health systems: the World Health Report as go-between for scientific evidence and ideological discourse. *Tropical Medicine and International Health*. Vol. 5, No. 10.

Terry, M. (2005) Health Care Consumerism: Engaging the Real Buyers – Employees. *Benefits Quarterly*. Vol. 21, Issue 2.

Tharakan, P. K.M. (2003) European Social Model under Pressure. *The World Economy*. Vol. 26, Issue 10.

The Development of Structures for Citizen and Patient Participation in the Decision Making Process Affecting Health Care (2000) Adopted by the Committee of Ministers on 24 February 2000 at the 699th meeting of the Ministers' Deputies <https://wcd.coe.int/ViewDoc.jsp?id=340437&Site=COE&BackColorInternet=DBDCF2&BackColorIntranet=FDC864&BackColorLogged=FDC864> (accessed 03.09.08)

The Euro Health Consumer Index (2006) Health Consumer Powerhouse <http://www.healthpowerhouse.com/media/RaportEHCI2006en.pdf> (accessed 03.09.08)

The Euro Health Consumer Index (2007) Health Consumer Powerhouse http://www.healthpowerhouse.com/media/Rapport_EHCI_2007.pdf (accessed 03.09.08)

The recommendation paper (2007) Health Consumer Powerhouse http://www.healthpowerhouse.com/files/HCP_recommendations.pdf (accessed 03.09.08)

The World Health Report 2000 - Health systems: improving performance (2000) http://www.who.int/whr/2000/en/whr00_en.pdf (accessed 03.09.08)

Tracking Health Care Quality. Health Care Quality Indicators Project. http://www.oecd.org/documentprint/0,3455,en_2649_37407_37088930_1_1_1_37407,00.html (accessed 03.09.08)

Veenhoven, R. (2002) Why Social Policy Needs Subjective Indicators? *Social Indicators Research*. Vol. 58, No. 1-3.

Wailoo, K., Jost T. S., Schlesinger, M. (2004) Professional Sovereignty in a Changing Health Care System: Reflections on Paul Starr's *The Social Transformation of American Medicine*. *Journal of Health Politics, Policy and Law*, Vol. 29, No. 4–5.

WHO Programme on Health Statistics

<http://www.who.int/healthinfo/statistics/programme/en/index.html> (accessed 03.09.08)

Williams, A. (2001) Science or Marketing at WHO? A Commentary on “World Health 2000”. *Health Economics*. Vol. 10, Issue 2.

Wilbulpolprasert, S. & Tangcharoensathien, V. (2001) Health system performance – what’s next? *Bulletin of the World Health Organization*. Vol. 79, No. 6.

Wiseman, V., Mooney, G., Berry, G., Tang, K.C. (2004) Involving the general public in priority setting: experiences from Australia. *Social Science & Medicine*, Vol. 58, Issue 7.

Appendix 1. Difference between Preferences of the Public and Professionals/Managers

Services or treatments	Public (n = 355)	General practitioners (n = 66)	Consultants (n = 116)
Treatments for children with life-threatening illness (leukaemia)	1	5	2
Special care and pain relief for people who are dying (hospice care)	2	4	4
Medical research for new treatments	3	11	8
High-technology surgery and procedures which treat life-threatening conditions (heart or liver transplants)	4	12	12
Preventive services (screening, immunisation)	5	6	7
Surgery to help people with disabilities to carry out everyday tasks (hip replacements)	6	8	5
Therapy to help people with disabilities carry out everyday tasks (speech therapy, physiotherapy, occupational therapy)	7	7	10
Services for people with mental illness (psychiatric wards, community psychiatric nurses)	8	2	1
Intensive care for premature babies who weigh less than one-and-a-half pounds and are unlikely to survive	9	13	15
Long-stay care (hospital and nursing home for elderly people)	10	3	6
Community services or care at home (district nurses)	11	-	3
Health education services (campaigns encouraging healthy lifestyles)	12	10	11
Family planning services (contraception)	13	9	9
Treatments for infertility (test tube babies)	14	14	14
Complementary or alternative medicine (acupuncture, homeopathy, herbalism)	15	15	16
Cosmetic surgery (tattoo removal, removal of disfiguring lumps and bumps)	16	15	15

City and Hackney Health Authority Survey – mean priority ranks (1 = highest priority) (Shickle, 1997, p. 282)

Category	% of general public	% of doctors	% of managers
Treatment that saves people's lives but often means they are unable to lead a normal life	31	16	21
Treatment that greatly improves people's ability to lead a normal life, although the illness itself is not life-threatening	57	62	62
Don't know	13	22	17

King's Fund Survey – 'If you had to choose between the two types of treatment shown here, which would you prioritize?' (Shickle, 1997, p. 281)

Services or treatments	General public	Doctors	Managers
Childhood immunisation	1	1	1
Screening for breast cancer	2	7	5
Care offered by GPs	3	2	2=
Intensive care for premature babies	4	8	8
Heart transplants	5	9=	9
Support for carers of elderly people	6	3=	4
Hip replacement for elderly people	7	5	6
Education to prevent young people smoking	8	3=	2=
Treatment for schizophrenia	9	6	7
Cancer treatment for smokers	10	9=	10

King's Fund Survey – 'If you were responsible for prioritizing health services, how would you prioritize the things on the list below, in rank order 1 to 10?' (Shickle, 1997, p. 281)

Appendix 2. Patients' priorities. International perspective

Main rank	What would make it a GP problem?	Denmark	Sweden	Finland	UK	Norway	Germany	Ireland	The Netherlands	Spain	Portugal	DK	Sweden	Finland	UK	EU
1	Dominic would like a GP should be available to provide care for their own patients.	21	20	13	11	11	13	13	11	11	11	11	11	11	11	11
2	A GP should be able to provide care for their own patients.	20	19	18	17	16	15	14	13	12	11	11	11	11	11	11
3	A GP should be able to provide care for their own patients.	19	18	17	16	15	14	13	12	11	10	10	10	10	10	10
4	A GP should be able to provide care for their own patients.	18	17	16	15	14	13	12	11	10	9	9	9	9	9	9
5	A GP should be able to provide care for their own patients.	17	16	15	14	13	12	11	10	9	8	8	8	8	8	8
6	A GP should be able to provide care for their own patients.	16	15	14	13	12	11	10	9	8	7	7	7	7	7	7
7	A GP should be able to provide care for their own patients.	15	14	13	12	11	10	9	8	7	6	6	6	6	6	6
8	A GP should be able to provide care for their own patients.	14	13	12	11	10	9	8	7	6	5	5	5	5	5	5
9	A GP should be able to provide care for their own patients.	13	12	11	10	9	8	7	6	5	4	4	4	4	4	4
10	A GP should be able to provide care for their own patients.	12	11	10	9	8	7	6	5	4	3	3	3	3	3	3
11	A GP should be able to provide care for their own patients.	11	10	9	8	7	6	5	4	3	2	2	2	2	2	2
12	A GP should be able to provide care for their own patients.	10	9	8	7	6	5	4	3	2	1	1	1	1	1	1
13	A GP should be able to provide care for their own patients.	9	8	7	6	5	4	3	2	1	0	0	0	0	0	0
14	A GP should be able to provide care for their own patients.	8	7	6	5	4	3	2	1	0	0	0	0	0	0	0
15	A GP should be able to provide care for their own patients.	7	6	5	4	3	2	1	0	0	0	0	0	0	0	0
16	A GP should be able to provide care for their own patients.	6	5	4	3	2	1	0	0	0	0	0	0	0	0	0
17	A GP should be able to provide care for their own patients.	5	4	3	2	1	0	0	0	0	0	0	0	0	0	0
18	A GP should be able to provide care for their own patients.	4	3	2	1	0	0	0	0	0	0	0	0	0	0	0
19	A GP should be able to provide care for their own patients.	3	2	1	0	0	0	0	0	0	0	0	0	0	0	0

Description of patients' priority percentages 'very/most important' and rank numbers (n=3540) (Grol et al., 1999, p. 8-9)