Propositions related to the thesis

Measururing client-centred health care using the universal World Health Organization concept of "health system responsiveness"

1. The domains of responsiveness are similarly understood by different populations as distinct and complementary aspects of quality of care.
2. Being treated with human dignity, having clear communication and experiencing timely access to needed health care, are the most highly valued domains of responsiveness, regardless of culture, economic and development context of the country, or personal factors like educational attainment, age, sex, health status or health service utilization.
3. Personal characteristics of a client have universally consistent impacts on the use of a response scale; in particular these are: educational attainment, own health status, and own experiences of quality of care. A vignette-based procedure to adjust for these impacts is advocated to improve within-country comparisons of health care responsiveness.
4. The responsiveness of a health system affects health care utilization and the clinical outcomes obtained. Better care yields better health by multiple pathways, with more efficiency another likely result.
5. The responsiveness measure is suitable for adaptation to specific health sub-systems, and allows for comparative analysis on any level of population aggregation.
6. The right to health in international law in General Comment 14 (The Right to the Highest Attainable Standard of Health[1]), includes the notion that all human beings should be treated equally, without discrimination, by legal and other social institutions. Therefore State actors have the obligation to protect, promote and fulfil the respectful treatment of users in health systems, and consequently have concomitant obligations for its systematic assessment.
7. Unequal performance is a persistent feature of health systems globally. The dominant explanation i.e., resource variation across countries, can be challenged by the observation that 'personal' responsiveness domains show inequalities similar to more resource-dependent 'setting' domains, whereas the former can presumably be reduced at lower cost.
8. Current health sector developments involve digitalization of all information processes, reducing patient contact time, promoting telemedicine and furthering active digital participation of the client in her/his medical dossier. The implications of these developments for health system responsiveness are occasionally acknowledged, sometimes measured, but seldom part of a routine quality cycle.
9. It is a logical and empirical fallacy to consider that health resources alone can address the underperformance of health systems, or that health sectors can be reformed to improve performance in isolation from changes in connected social institutions.
10. The WHO Commission on Social Determinants of Health Final Report[2] suggests that population health is considerably improved by social systems with institutions that strive for population empowerment and more equitable resource distribution. The most powerful health system reforms may thus arise from combining better financial protection with better responsiveness.
11. The more important qualities of human existence are, the more they escape measurement. (This saves the clergy.) The successful quantification of even a small part of these qualities emphasizes rather than undermines the value of the remainder and of the whole.

Nicole B. Valentine
Rotterdam, December 14th 2018

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[1] http://www.refworld.org/pdfid/4538838d0.pdf (accessed 11 June 2018)

[2] Commission on Social Determinants of Health. Final report. Closing the gap in a generation. Health equity through action on the social determinants of health. Geneva: World Health Organization; 2008. Accessed on 12 June on: http://www.who.int/social_determinants/thecommission/finalreport/en/