

Research Article

# Health Systems' Performance with Respect to Responsiveness in Suryapet, Telangana

Jyothi Kurapati<sup>1</sup>, Bal Nagorao Rakshase<sup>2</sup>

<sup>1</sup>PhD Scholar, School of Medical Science, University of Hyderabad, Telangana, India.

<sup>2</sup>Associate Professor, School of Health System Studies, Tata Institute of Social Sciences, Mumbai, India.

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## I N F O

### Corresponding Author:

Jyothi Kurapati, School of Medical Science,  
University of Hyderabad, Telangana, India.

### E-mail Id:

[kjyothiuh@gmail.com](mailto:kjyothiuh@gmail.com)

### Orcid Id:

<https://orcid.org/0000-0002-6257-6713>

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## A B S T R A C T

**Introduction:** The responsiveness of the health system denotes its goal of responding to the legitimate expectations of the serving population. The study uses WHO's responsiveness domains as the main variables. It was undertaken to determine how well the health system was responding to the needs of people living in the Suryapet district of Telangana. The objective of the study was to assess the responsiveness and its domains in a health system in the state of Telangana.

**Method:** This objective has been fulfilled by enquiring the patients using quantitative approach. 150 interview schedules were conducted. The study used convenience sampling to assemble data from healthcare consumers.

**Results:** In the domain of dignity, the percentage of people who agreed that they were receiving dignity during the treatment was around 87.3%. The domain of autonomy had 79.3% of the respondents. For the domain of confidentiality, 100% of the participants thought that their health information was maintained confidentially. The domain of communication had 65%; the domain of prompt attention showed that 68% of the participants were dissatisfied with the promptness of attention in public health settings. 71% of the respondents were dissatisfied with the quality of basic amenities in public health settings, and 89% of the participants were satisfied that they were allowed to choose the healthcare provider.

**Conclusion:** Results indicated that the health system performance falls short in responding to the needs of a large population. The health system was not responding up to the mark to the legitimate expectations of people.

**Keywords:** Responsiveness, Health System, Healthcare, Expectations of Patients, Non-medical Aspects

## Introduction

The ability of national health systems to respond is a fundamental goal. Health systems that are responsive anticipate and adapt to current and future health requirements, leading to improved health outcomes. The lack of standardised frameworks beyond the normative criteria of responsive care may explain why responsiveness is the least explored of all the health system objectives. The health systems are relied upon to meet their main and various social goals, including understanding rights and reacting to patients' desires. These have gained specific prominence in recent decades.

Health systems worldwide are looking for methods to make their services more accessible to patients and the general public. One of the fundamental aims of health systems is responsiveness, which is crucial to policymakers, administrators, and the people they care for.<sup>1</sup> According to the World Health Organization's (WHO) framework for health system performance assessment, health, responsiveness, and fairness of finance are three aims of the health system.<sup>2</sup> Responsiveness within the context of a system can be attained when institutions are built to be aware of and respond appropriately to the expectations of individuals. The ability of the health system to respond to consumers' legitimate expectations for non-medical aspects of the health system is referred to as responsiveness. The "legitimate" is described as conforming to recognised principles or established protocols and standards.<sup>3</sup>

Satisfaction is linked to responsiveness. Furthermore, patient satisfaction with non-medical components of care is frequently linked to greater treatment adherence, quicker seeking of care, as well as gaining a better understanding and memory of medical knowledge.<sup>4</sup> As a result, responsiveness can be summarised as having two major components: (a) respect for people, which includes dignity, confidentiality, and autonomy of individuals and their families to make health-related decisions; and (b) client orientation, which includes prompt attention, access to social support networks during care, quality of basic amenities, and provider choice.<sup>2</sup>

Responsiveness is just not a metric for how well a health system reacts to the demands of patients, as evidenced by health outcomes. It is a metric that assesses how well a system works in non-health areas, such as fulfilling or failing to meet a population's expectations for preventive, care, and non-personal services.<sup>5</sup> Responsiveness can be regarded from two perspectives: first, the consumer of the healthcare system, with more responsiveness seen as a means of gaining customers. Second, responsiveness has to do with safeguarding patients' rights to adequate and timely care.<sup>6</sup>

Health system responsiveness is defined by the World Health Organization (WHO) as "a health system's ability to respond appropriately to the universally legitimate expectations of individuals, whether they are perceived as consumers or patients".<sup>7</sup> It is a result that can be achieved when organisations and institutions are designed to be aware of and responsive to individual expectations.<sup>8</sup> The complete healthcare experience encompasses the use of the healthcare service in and of itself and the physical surroundings.<sup>9</sup> The conceptual framework for measuring responsiveness is used in hospitals and other healthcare institutions for its service excellence. The term "health system responsiveness" refers to a non-medical aspect of service involving protecting a patient's legitimate needs and expectations as guaranteed by human rights, including patient rights.<sup>10</sup> These domains are as follows: dignity, prompt attention, autonomy, communication, choice of healthcare provider, confidentiality, access to social support for inpatients, and quality of basic amenities for inpatient and outpatient care.<sup>6,11</sup>

Dignity is respectful treatment by medical personnel. The right to ask questions and share information during consultations and treatment and privacy during examination and treatment are all examples of dignity.<sup>12</sup> Individual autonomy refers to a person's right to be informed about their condition and possible alternative therapies, to discuss treatment, and to give informed consent to testing and treatment.<sup>13,14</sup> Confidentiality refers to conducting consultations with patients in a way that respects their privacy and protects the confidentiality of information given by the patient, particularly information about an individual's illness unless such information is required to be shared with a healthcare provider or explicit consent has been obtained.<sup>15</sup> Clarity of information, attentive listening to the patient's inquiries, and explanations to be understood are all examples of communication.<sup>16</sup> Patients should be guaranteed to prompt attention in an emergency, and they should also be allowed to care within a reasonable time for non-emergency health concerns or surgery. Therefore waiting lists should not be excessively extensive.<sup>17</sup> Healthy environment, consists of frequent cleaning and maintenance processes for medical buildings, sufficient furniture, adequate air, clean water, toilets and linen, and healthy cuisine.<sup>18</sup> Having access to social support while in the hospital should allow for regular visits from families and friends, as well as religious practices that do not interfere with the hospital's operations or hurt the feelings of other patients.<sup>19</sup> The ability to choose a doctor and an institution that can provide healthcare are referred to as the choice of care provider.<sup>20</sup>

From the stand point of patients, responsiveness research is comparable to patient satisfaction research. However, they differ in their approaches: the latter focuses on improving

the efficacy of medical treatment, while the first is primarily concerned with treatment ethics.

The specific aim of the study was to assess the performance of the health systems concerning responsiveness in Telangana. Specifically, it answered two critical questions: do the WHO responsiveness and its domains reflect the expectations of health service users, and which responsiveness domains are the most important to people.

## Materials and Methods

Based on the objectives and research questions, a quantitative methodology was adopted. The present study also uses the interpretive approach for exploring and assessing the performance of the health systems with respect to responsiveness. It was conducted in Suryapet government health facilities. It consists of two area hospitals or sub-district hospitals, three community health centres, 24 PHCs, and 195 sub-centres serving a large population. This study focused on the healthcare experiences of patients and their relatives. The data collection duration was from May to September 2018.

## Research Tools

The current study used the interview schedule to fulfil the research's aim and objectives and to obtain responses from healthcare consumers regarding the performance of the health system with respect to responsiveness. It contained eight themes and 20 questions.

## Sampling and Sampling Size

The study used convenience sampling to assemble data from healthcare consumers. A total of 150 interview schedules were conducted with the inpatients of the healthcare systems.

## Inclusion Criteria

Persons who were willing to participate in the study and provided written consent were included in the study. It was ensured that the included respondents must have utilised in-patient healthcare services in respective public health centres for not less than 3 days.

## Data Analysis

The data collected were analysed using SPSS Version 22. Descriptive statistics like mean, median, frequency, and percentages were used to understand the responsiveness and their domains. For the graphical interpretation, Microsoft Excel was used for better understanding and quality of the graphs. The reliability test was done using Cronbach's alpha to understand the quantitative data set and its reliability.

## Ethical Considerations

The study fulfilled all ethical aspects. Ethical clearance

was taken from the Tata Institute of Social Sciences, Mumbai. Key aspects of ethics were considered and participants received adequate information on the study, both verbally and through the participant's information sheet. It was ensured that the participants were effectively knowledgeable about the study. Participants were given sufficient time to decide on their contribution to the study. They were given the informed consent form and were asked to sign consent after reading and understanding if they were ready to participate in the study.

## Results

### Dignity

The percentage of people who agreed that they were treated with dignity was around 87.3%, meaning that most of the patients believed that they were treated with dignity. 8.7% of people's responses seemed to neither agree nor disagree, and 2.7% of respondents disagreed with being treated with dignity (Table 1). The mean value for dignity was 3.1, median was 3.0, and standard deviation was 0.62. When the reliability test was used for dignity domain and its questions, the reliability was most significant as it showed 0.739.

### Autonomy

**Table 1. Frequency and Percentage Distribution of Participant's Responses regarding Dignity during Treatment**

Responses	Frequency	Percentage
Strongly disagree	1	0.7
Disagree	4	2.7
Agree	131	87.3
Strongly agree	1	0.7
Neither agree nor disagree	13	8.7
Total	150	100.0

For the domain of autonomy, 79.3% of the respondents agreed that they had autonomy during the treatment. 19.3% of the patients neither agreed nor disagreed with having received autonomy during treatment and 1.3% of respondents disagreed with having received autonomy during treatment. The mean for the variable autonomy was set at 3.3, median was 3.0, and mode was also 3.0.

### Confidentiality

Eighty per cent of the respondents strongly agreed, and 20% agreed that their health information was maintained confidentially. That means 100% of the people believed that their health information was safe. The central tendency for the variable confidentiality was that the mean was around

3.8, the median was set at 4.0, the mode was 4.0, and the standard deviation was around 0.40.

### Communication

Forty-four per cent of the respondents strongly agreed, and 21.3% agreed that health personnel communicated well with them. 33.3% of respondents disagreed with good health personnel communication, and 0.7% of the respondents strongly disagreed and neither agreed nor disagreed with good healthcare staff communication. Overall, the highest number of people believed that health personnel communicated well with them. The mean for the variable communication was 3.1, median was 3.0, mode was 4, and the standard deviation was set at 0.9 (Table 2).

### Prompt Attention

Sixty-six per cent of the participants disagreed, and 2%

**Table 2. Frequency and Percentage Distribution of Participant's Responses regarding Personnel Communication**

Response	Frequency	Percentage
Strongly disagree	1	0.7
Disagree	50	33.3
Agree	32	21.3
Strongly agree	66	44.0
Neither agree nor disagree	1	0.7
Total	150	100.0

strongly disagreed with receiving prompt attention in public health settings. Sixteen per cent of the respondents agreed, 15.3% strongly agreed to having received prompt attention in public health settings, and 0.7% of participants could not decide. Overall, results showed that most respondents believed that they were not given prompt attention (Table 3).

### Access to Social Support Networks

**Table 3. Frequency and Percentage Distribution of Prompt Attention to Patients**

Response	Frequency	Percentage
Strongly disagree	3	2.0
Disagree	99	66.0
Agree	24	16.0
Strongly agree	23	15.3
Neither agree nor disagree	1	0.7
Total	150	100.0

Eighty-two per cent of the respondents strongly agreed that they had access to social support networks during healthcare. 16.7% of participants neither agreed nor disagreed with accessing social support networks during healthcare. 1.3% of the participants disagreed with accessing social support networks during healthcare. Most respondents believed that they had access to social support networks during healthcare. The mean values for this variable were set at 2.4, the median was 2.0, mode was 2.0, and standard deviation was 0.7.

### Quality of Basic Amenities

53.3% of the respondents disagreed, and 18% strongly disagreed with the quality of basic amenities in public health settings. 21.4% of respondents agreed, and 7.3% of the participants strongly agreed with it. Finally, the overall results showed that the people were unsatisfied with the quality of basic amenities in public health settings (Table 4).

### Choice of Care Provider

**Table 4. Frequency and Percentage Distribution of Quality of Basic Amenities during Treatment**

Response	Frequency	Percentage
Strongly disagree	27	18.0
Disagree	80	53.3
Agree	32	21.4
Strongly agree	11	7.3
Total	150	100.0

71.3% of the participants strongly agreed, and 18.7% of the respondents agreed that they were allowed to choose the healthcare provider. 5.3% of the respondents disagreed, 0.7% strongly disagreed that they were allowed to choose the healthcare provider, and 4.0% of the participants could not decide. Most participants believed that they were allowed to choose the healthcare provider in a public healthcare setting. The central tendency values were set at 3.7 for mean, 4.0 for median, 4.0 for mode, and the standard deviation was around 0.65.

The study results showed patients' preferences in all the responsiveness domains, 89.3% of the respondents' 1st choice was prompt attention. 88.7% of respondents' 2nd choice was clear communication. 86% of respondents' 3rd choice was the dignity of the patient during treatment. 78.7% of the participants' 4th choice was the choice of care provider. 76.7% of people gave their 5th choice to the quality of basic amenities. 76.7% of the participants' 6th choice was access to social support during the treatment. 69.3% of the participants' 7th choice was confidentiality of

the health information. 66.7% of respondents' 8th or last choice was autonomy of the patient during the treatment.

## Discussion

The results of this research specify that the health system was not responding up to the mark to the legitimate expectations of a large population.

Some characteristics of the population of interest have made the health system less sensitive to their needs. This study showed that familial dependence is a barrier to patient dignity, starting from the home and family, and ranging to social and health systems. This is consistent with the results of a research study which showed that in developed countries patients were considered incompetent persons who needed help, which caused feelings of sympathy.<sup>21</sup> This study also specified that the absence of education and employment led to a further down grading of patients. Familial dependency also constituted an obstacle to confidentiality since family members would escort the patient to the hospital and be present during the examination, history taking, and communication of the physician's advice. Like wise, family members' attendance also represented a barrier to openness and clear communication between the patient and the provider. This problem was severe in cases of women attended by their sisters or in-laws while they consulted gynaecologists. It has been visible that this is common in Asian cultures, where the family is considered to have an absolute right to patient health.<sup>22</sup>

Familial dependency was also an obstacle to the patient's autonomous decision-making process. In the case of male patients, this study showed that the family did everything possible to opt for the best treatment to make the patient independent and productive. On the other hand, it was found that women were underprivileged when gynaecologists stated that most patients were treated according to the family's convenience, without any involvement of the patient. This has been made known to be factual in at least half of the families in Nepal, India, and Bangladesh, where women's views have not been taken into account in their treatment.<sup>23</sup> Familial dependency and absence of knowledge also played a significant role in the choice of healthcare provider. In the lack of proper information on the qualifications and experience of doctors in the area, patients and their family members select doctors mainly based on rumours. However, both in the case of health decisions and in the choice of providers, the participants firmly believed that the role of the family was helpful and appreciated. Doctors thought that the middle-class family imposed their choices on the patient.

## Limitations

This study was conducted in the Suryapet district of

Telangana. It cannot be generalised to the entire state of Telangana.

## Conclusion

This study was directed primarily to conclude how the health system, that is government hospitals located at Suryapet, met the requirements of the population it serves. The study aimed to assess the performance of the health systems with respect to responsiveness in Suryapet district. Data collection tools were designed for the study and procedures were led to assess the significance of different responsiveness domains for healthcare consumers and what their precise experiences were in these domains. The outcomes of this research specify that the health system was not responding up to the mark to the legitimate expectations of a large population. The experiences of the participants and the barriers that obstruct the responsiveness of the health system can be better understood. The results of this study indicate a great need for dedicated healthcare facilities for patients. It is recommended that to upgrade the existing hospitals dedicated to caring may be at least at the district level, where they deliver general and specialised medical services. This study also indicated the insufficiency of public transport for the villages. It is recommended that individual hospitals provide a working ambulance to take and leave patients on specific routes. This can be considered a joint development project by government hospitals, to ensure the allocation of funds by the Planning Commission.

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**Conflict of Interest:** The authors declare that they have no conflict of interest.

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