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Health Services Research

European patients' views on the responsiveness of health systems and healthcare providers

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Background: Responsiveness to patients is now seen as a key characteristic of effective health systems. This study aimed to learn more about European people's views on the responsiveness of their country's health systems and healthcare providers. Methods: Telephone survey with random samples of the populations in Germany, Italy, Poland, Slovenia, Spain, Sweden, Switzerland and the UK using random digit dialling. **Results:** Responses were obtained from 8119 people aged 16 and over. Just over half the respondents said that doctors always listened carefully to them, gave them time for questions and provided clear explanations. Respondents from Switzerland and the UK reported consistently high rates of satisfaction with doctors' communication skills, while respondents from Poland were significantly less satisfied. Younger people were more critical than older people. Expectations of patient involvement in treatment decisions were high, particularly among younger people, with 74% indicating a desire to be actively involved. Most respondents felt they should have a choice of primary care doctor, specialist doctor and hospital, but less than half felt they had sufficient information to make an informed choice. There were significant variations between the countries in reported levels of involvement and in satisfaction with opportunities for choice. **Conclusions:** The results suggest that many European patients want a more autonomous role in health care decision-making. Policy-makers and clinicians should consider how to narrow the gap between public expectations and patients' experience.

Keywords: doctor–patient communication, choice, responsiveness, shared decision-making

Health systems throughout the world are searching for ways of making their services more responsive to patients and the public. The WHO has been encouraging this by including indicators of responsiveness in its World Health Reports.[1] Many European governments have recognized that the future of socialized health care services depends on their ability to keep abreast of changing needs and respond to these in an appropriate way in order to sustain public confidence. Regular surveys of the views and experiences of patients and the public are beginning to be seen as an indispensable addition to the panoply of performance indicators used for monitoring the effectiveness of health policy. We report here a survey of random population samples in eight European countries focusing on public views of the quality of doctor–patient communications and opportunities for involvement in choice of providers and treatments.

Patients seeking health care in European countries experience different degrees of freedom of choice. Most people can choose which primary care doctor to consult, albeit within certain constraints. In some countries (e.g. Switzerland) patients can go straight to a specialist doctor if they wish to, while in others (e.g. Italy) they must first secure a referral from a GP. The right to choose the timing and location of hospital treatment is well-established in some countries (e.g. Germany), whereas long waits and limited choice of location are the norm in others (e.g. UK). Policy makers in the UK and elsewhere are attempting to speed up access by making it easier for patients to travel to hospitals with spare capacity if they wish to.[2] Meanwhile, developments within the European Union are opening up new possibilities for patients willing to travel. Decisions by the European Court of Justice mean that patients now have the right to obtain treatment in another country when there are long waiting times in their own.[3] While few have exploited this right as yet, it seems likely that patients will increasingly expect to be offered a choice of provider and treatment location.

Good communications with doctors and other health professionals has long been seen as the bedrock of quality from the patient's perspective.[4] Patients appreciate doctors who are interested in what they have to say, who offer sufficient time for the patient's questions and who give clear explanations of treatments and management options. The expectation of direct patient involvement in choosing treatments or deciding how to manage their condition is becoming more common.[5] The extent to which patients expect to be actively involved in treatment decisions varies according to the prevailing medical culture. If it is paternalistic, both doctors and patients are likely to assume that decisions are the responsibility of the doctor only, whereas in a more egalitarian culture a partnership or shared decision-making approach may be preferred.

Methods

The survey was carried out in Germany, Italy, Poland, Slovenia, Spain, Sweden, Switzerland and the UK. People were asked to participate in a telephone interview to discuss their views on health care in their country and their attitudes to involvement and choice. The exact wording of the questions is shown in the tables that follow. The questionnaire was written in English and translated into German, Italian, Polish, Slovenian, Spanish, Swedish and French (in Switzerland both French and German versions were used).

The fieldwork, which was organised by NIPO, a Netherlands-based market research institute, using computer-assisted telephone interviewing (random digit dialing), took place in each of the eight countries in July 2002. Approximately 1000 interviews were carried out in each country with random samples of the adult population (aged 16 and over). Response rates (i.e. the number of calls made to obtain a completed

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interview) varied by country: Sweden 60% ($n = 1000$), Germany 45% ($n = 1026$); Switzerland 41% ($n = 1000$); Spain 40% ($n = 1000$); Poland 32% ($n = 1050$); Italy 18% ($n = 1021$); Slovenia 18% ($n = 1014$); UK 13% ($n = 1008$).

In the tables we show comparisons between the countries using weighted percentages and age-adjusted scores. Tables 1, 2 and 4 show age-adjusted mean scores on attitude scales. Responses to each of the four- and five-point attitude questions were scored and standardized for age using the direct method. These values were then summed to produce a weighted value. Differences between weighted and unweighted data were found to be minimal so only the weighted values are shown. In table 3 the percentages have been weighted to ensure that the results are nationally representative in terms of the age–sex distribution of the population in each country. For Germany, Italy, Switzerland and the UK regional weights were also applied.

Results

Doctor–patient communication

Respondents who had consulted a doctor within the previous 12 months (or other health professional if they hadn't seen a doctor) were asked to report on specific aspects of communication within the consultation. There were considerable differences between the countries in the proportion of respondents who said they had received health care in the previous 12 months: Germany 81%, Switzerland 70%, Poland 64%, Spain 63%, Slovenia 60%, UK 55%, Italy 51%, Sweden 50%. Among those who had made a consultation, 55% said their doctor always listened carefully to them, 54% said they always allowed time for questions and 57% said they always received clear explanations. Reports from Switzerland and the UK were consistently high across these measures, whereas reports from Poland were consistently low (table 1). There were only small differences between men and women so these are not shown here, but the age breakdowns show that older people tended to give more favourable ratings than younger people in response to each of the questions about communications. Despite the evidence that significant proportions of patients said that doctors didn't always achieve the highest standards of communication, overall satisfaction was still relatively high. A majority of respondents in Switzerland (87%), Sweden (83%), the UK (81%), Slovenia (77%), Spain (76%), Germany (72%) and Italy (69%) rated doctors' communication skills as 'good' or 'very good', but in Poland the proportion giving a positive rating was only 53%.

Involvement in treatment decisions

Interviewers in each of the countries asked people for their views on who should take the lead in making treatment decisions. Respondents were asked to select one of five

Table 1A Doctors' listening skills: *How often did the doctor listen carefully to you?*

Country	*n*[a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
Spain	623	3.56 (3.50–3.62)	3.45 (223)	3.64 (198)	3.57 (202)
Switzerland	695	3.49 (3.43–3.55)	3.47 (221)	3.47 (283)	3.38 (188)
UK	550	3.40 (3.33–3.47)	3.26 (302)	3.41 (194)	3.53 (191)
Slovenia	592	3.33 (3.26–3.40)	3.73 (225)	3.28 (206)	3.48 (161)
Germany	849	3.30 (3.25–3.35)	3.22 (237)	3.28 (302)	3.45 (310)
Italy	518	3.29 (3.21–3.37)	3.29 (155)	3.28 (179)	3.29 (184)
Sweden	483	3.29 (3.22–3.36)	3.14 (146)	3.36 (149)	3.38 (188)
Poland	666	3.12 (3.05–3.19)	3.07 (268)	3.09 (280)	3.12 (118)
Total	4976	3.35 (3.33–3.37)	3.27 (1636)	3.34 (1791)	3.44 (1549)

Scored as: 1 (never), 2 (sometimes), 3 (usually), 4 (always).
a: Excludes those who did not have any care, treatment or tests within previous 12 months.

Table 1B Time for questions: *How often did the doctor give you time to ask questions?*

Country	*n*[a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
Switzerland	686	3.43 (3.37–3.49)	3.38 (220)	3.46 (279)	3.53 (187)
UK	545	3.42 (3.35–3.49)	3.31 (160)	3.49 (194)	3.50 (191)
Italy	512	3.39 (3.31–3.47)	3.41 (152)	3.38 (178)	3.35 (182)
Slovenia	597	3.32 (3.25–3.39)	3.27 (226)	3.32 (207)	3.37 (164)
Germany	846	3.30 (3.24–3.36)	3.28 (236)	3.21 (300)	3.38 (310)
Spain	609	3.26 (3.18–3.34)	2.21 (217)	3.37 (196)	3.23 (196)
Sweden	472	3.19 (3.10–3.28)	3.01 (144)	3.33 (148)	3.29 (180)
Poland	659	2.86 (2.79–2.93)	2.81 (267)	2.81 (276)	2.94 (116)
Total	4926	3.27 (3.24–3.30)	3.20 (1622)	3.27 (1778)	3.35 (1526)

Scored as: 1 (never), 2 (sometimes), 3 (usually), 4 (always).
a: Excludes those who did not have any care, treatment or tests within previous 12 months.

Table 1C Doctors' explanations: *How often did the doctor explain things in a way you could understand?*

Country	*n*[a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
Switzerland	696	3.58 (3.52–3.64)	3.54 (220)	3.58 (286)	3.60 (190)
UK	551	3.49 (3.42–3.56)	3.51 (161)	3.44 (195)	3.62 (195)
Spain	619	3.45 (3.38–3.52)	3.41 (223)	3.51 (197)	3.41 (199)
Sweden	481	3.45 (3.38–3.52)	3.30 (145)	3.51 (151)	3.55 (185)
Germany	847	3.37 (3.32–3.42)	3.36 (237)	3.37 (300)	3.40 (310)
Italy	514	3.37 (3.29–3.45)	3.41 (154)	3.44 (177)	3.35 (183)
Slovenia	598	3.23 (3.16–3.30)	3.18 (225)	3.13 (208)	3.44 (165)
Poland	662	2.98 (2.91–3.05)	2.92 (265)	2.91 (279)	3.02 (118)
Total	4968	3.36 (3.34–3.38)	3.31 (1630)	3.34 (1793)	3.44 (1545)

Scored as: 1 (never), 2 (sometimes), 3 (usually), 4 (always).
a: Excludes those who did not have any care, treatment or tests within previous 12 months.

Table 1D Overall rating of communications: *Overall how would you rate how well health care providers communicated with you?*

Country	*n*[a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
Switzerland	705	4.27 (4.22–4.32)	4.15 (222)	4.25 (290)	4.44 (193)
UK	550	4.21 (4.13–4.29)	4.10 (162)	4.21 (195)	4.33 (193)
Sweden	488	4.13 (4.05–4.21)	3.94 (145)	4.25 (151)	3.26 (192)
Slovenia	603	4.04 (3.97–4.11)	3.97 (227)	3.94 (210)	4.27 (166)
Spain	616	3.97 (3.90–4.04)	3.83 (223)	4.01 (195)	4.12 (198)
Germany	849	3.88 (3.83–3.93)	3.84 (238)	3.90 (302)	3.91 (309)
Italy	515	3.70 (3.62–3.78)	3.78 (154)	3.59 (181)	3.76 (180)
Poland	662	3.55 (3.49–3.61)	3.49 (267)	3.50 (277)	3.62 (118)
Total	4988	3.97 (3.95–3.99)	3.87 (1638)	3.94 (1801)	4.09 (1549)

Scored as: 1 (very bad), 2 (bad), 3 (moderate), 4 (good), 5 (very good).
a: Excludes those who did not have any care, treatment or tests within previous 12 months.

responses: the patient alone, the patient after consultation with the doctor, the doctor and patient together, the doctor after discussion with the patient or the doctor alone.[6] Overall, 5% saw themselves (the patient) as the sole decision-maker and a further 18% said the patient should make the decision after consulting the doctor, giving a total of 23% who saw the patient as having the primary role. In contrast 10% said the doctor alone should decide and 16% said the doctor should make the dcision after discussion with the patient, giving a total of 26% who preferred to assign the role of main decision-maker to the doctor. The shared decision-making model, in which doctor and patient are jointly responsible for making treatment decisions, was the most popular, with 51% of the total sample opting for it. Older people were more likely to view the doctor as the primary decision-maker: 31% of those aged 55 and over said the doctor should decide, compared to 24% of those aged under 35.

There were notable variations between the countries (table 2A). While 91% of Swiss respondents and 87% of those in Germany felt the patient should have a role in treatment decisions, either sharing responsibility for decision-making with the doctor or being the primary decision-maker, the proportion of Polish patients who felt the same way was only 59% and in Spain it was only 44%. In these two countries a much higher proportion of patients felt the doctor rather than the patient should be the primary decision-maker. However, the trend for younger people to want a more patient-centred approach than older people was consistent in all the countries.

Even in Poland and Spain the preference among patients for a passive role in treatment decision-making was by no means universal. Table 2B shows the extent to which patients felt they had been involved as much as they wanted in decisions about their care. Satisfaction with their level of involvement was greatest in the UK and Switzerland where 71 and 63%, respectively, said the doctor always involved them as much as they wanted. The proportion responding positively was somewhat lower in the other countries: Sweden 56%, Italy 56%, Slovenia 46%, Germany 42%, Spain 40%, and in Poland only 19% indicated that their doctor always involved them sufficiently. Interestingly, more people in Spain (29%), Poland (16%) and Slovenia (13%) said doctors never involved them in decisions about their care, whereas the proportion reporting no involvement in the other countries was $<10\%$.

Choice of provider

The overwhelming majority of respondents felt patients ought to have a free choice of primary care doctor, specialist doctor or hospital (table 3). This was true in all the study countries except Sweden where the majority wanted a free choice of GP, but only 31% felt they should have a free choice of specialist doctors and only 54% wanted a free choice of hospital.

Table 2A Expectation of involvement in treatment decisions: *In general, when you need medical treatment and more than one treatment is available, who do you think should make the decision about which treatment is best for you?*

Country	*n* [a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
Germany	1020	3.23 (3.18–3.28)	3.31 (296)	3.25 (372)	3.08 (352)
Switzerland	993	3.21 (3.16–3.26)	3.29 (334)	3.28 (417)	3.00 (242)
Sweden	982	3.02 (2.96–3.08)	3.05 (265)	3.16 (310)	2.76 (407)
Slovenia	1011	2.98 (2.93–3.03)	3.05 (384)	3.02 (385)	2.81 (242)
Italy	1010	2.96 (2.90–3.02)	3.04 (375)	3.02 (355)	2.74 (280)
UK	1002	2.96 (2.90–3.02)	3.14 (332)	2.98 (366)	2.72 (304)
Poland	1024	2.80 (2.74–2.86)	2.86 (473)	2.76 (416)	2.70 (135)
Spain	960	2.25 (2.18–2.32)	2.45 (404)	2.22 (304)	2.03 (252)
Total	8002	2.92 (2.90–2.94)	3.00 (2836)	2.98 (2925)	2.75 (2214)

Scored as: 1 (doctor should decide), 2 (doctor should make decision after consulting patient), 3 (doctor and patient should decide together), 4 (patient should decide after consulting doctor), 5 (patient should decide).

Table 2B Reported involvement in treatment decisions: *How often did the doctor involve you as much as you wanted to be in deciding about your care, treatment or tests?*

Country	*n*[a]	Mean score (95% CIs)	Age range [mean score (*n*)]		
			up to 35	36–55	56 and over
UK	416	3.47 (3.38–3.56)	3.43 (122)	3.50 (141)	3.84 (153)
Switzerland	408	3.40 (3.31–3.49)	3.37 (121)	3.42 (167)	3.42 (120)
Sweden	395	3.31 (3.22–3.40)	3.20 (113)	3.41 (125)	3.32 (157)
Italy	433	3.25 (3.16–3.34)	3.44 (128)	3.21 (138)	3.20 (167)
Germany	578	3.18 (3.11–3.25)	3.06 (154)	3.20 (210)	3.32 (214)
Slovenia	360	3.01 (2.90–3.12)	2.92 (118)	3.07 (135)	3.08 (107)
Spain	492	2.69 (2.58–2.80)	2.61 (178)	2.65 (164)	2.82 (150)
Poland	445	2.56 (2.47–2.65)	2.50 (157)	2.69 (199)	2.42 (89)
Total	3527	3.11 (3.08–3.14)	3.02 (1091)	3.12 (1279)	3.18 (1157)

Scored as: 1 (never), 2 (sometimes), 3 (usually), 4 (always).
a: Excludes those who did not have any care, treatment or tests within previous 12 months.

People were asked if they felt they had sufficient information to make informed choices about the best provider for them. Overall, less than half of the respondents felt able to make an informed choice of primary care doctor, and the proportion was even less for specialist doctors and hospitals. Younger people tended to be more critical than older people of the availability of information to support provider choices. For example, 55% of those aged 55 and over said they had sufficient information to choose the best primary care doctor for them, as against only 39% of those aged under 35. There were also variations between the countries. More than half the respondents in Italy were confident that they had sufficient information to choose, whereas the proportion in Spain expressing similar confidence was less than a third. It was noteworthy that in Germany and Switzerland, where free choice of specialist is currently the norm, less than half the respondents felt they had sufficient information to make an informed choice.

Respondents were asked to rate the extent to which patients in their country had opportunities to make choices about their health care. The differences between the countries were striking. The majority of respondents in Spain (73%) and Switzerland (70%) said they were satisfied with the opportunities for choice in their country, whereas the proportion fell to less than half in Sweden (45%), Germany (43%) and Italy (38%), and less than a third in Slovenia (30%), the UK (30%) and Poland (15%).

Table 4 shows the age-adjusted mean scores on a scale measuring perceived opportunities for choice in each of the countries.

Discussion

Telephone surveys are a reasonably efficient way of eliciting the views of members of the public in different countries, but it is important to be aware of the limitations of this method. First, response rates are often quite low and are dependent on the quality of the original list of phone numbers from which the random selections are drawn, the extent of telephone coverage, the time of day the calls are made, and the willingness of those approached in this way to respond to questions. Response rates varied considerably between our study countries, but the resulting samples were reasonably representative in terms of age–sex distribution, with the exception of Poland where the sample was deficient in the number of respondents from the over 65 age-group. Age standardization was therefore used to adjust for this problem. Linguistic problems must also be considered. Translation of the questionnaires was carried out

Table 3 Choice of health care provider

	Proportion (%) of respondents answering 'yes' to indicated question							
	Germany $n = 1026$	**Italy** $n = 1021$	**Poland** $n = 1050$	**Slovenia** $n = 1014$	**Spain** $n = 1000$	**Sweden** $n = 1000$	**Switzerland** $n = 1000$	**UK** $n = 1008$
A. Demand for choice of provider. *In general, if you need to [consult a primary care doctor/consult a specialist doctor/go to hospital] do you think you should have a free choice?*								
Primary care doctors	98	86	98	98	89	86	93	87
Specialist doctors	97	83	95	87	86	31	84	79
Hospitals	94	85	94	86	78	54	85	80
B. Information to support choice of provider. *Do you feel you have sufficient information about [primary care doctors/specialist doctors/hospitals] to choose the best one for you?*								
Primary care doctors	52	53	43	45	30	31	52	40
Specialist doctors	42	53	32	25	23	23	41	28
Hospitals	42	54	35	30	32	36	52	35

Table 4 Rating of opportunities for choice: *Overall, how would you rate the opportunities for patients in this country to make choices about their health care?*

Country	n [a]	**Mean score (95% CIs)**	**Age range [mean score (*n*)]**		
			up to 35	**36–55**	**56 and over**
Spain	930	3.93 (3.87–3.99)	3.92 (401)	3.92 (293)	3.97 (236)
Switzerland	983	3.86 (3.81–3.91)	3.71 (331)	3.86 (415)	4.02 (237)
Germany	1010	3.35 (3.30–3.40)	3.44 (295)	3.23 (369)	3.53 (346)
Italy	977	3.28 (3.22–3.34)	3.30 (367)	3.12 (340)	3.43 (270)
Sweden	923	3.19 (2.13–3.25)	3.23 (258)	3.08 (296)	3.25 (369)
Slovenia	987	3.05 (3.00–3.10)	3.02 (376)	2.98 (381)	3.20 (230)
UK	972	3.05 (2.99–3.11)	3.04 (322)	2.90 (360)	3.25 (290)
Poland	1014	2.67 (2.62–2.72)	2.68 (463)	2.65 (415)	2.79 (136)
Total	7796	3.29 (3.27–3.31)	3.26 (2813)	3.21 (2869)	3.45 (2114)

Scored as: 1 (very bad), 2 (bad), 3 (moderate), 4 (good), 5 (very good)

carefully and the questions were relatively straightforward, but complete linguistic equivalence is hard to achieve and it is possible that slight differences in meaning may explain observed differences between the countries, at least to some extent.

Satisfaction ratings reflect three variables: the personal preferences of the patient, the patient's expectations and the realities of the care received. Expectations are influenced by many factors including the prevailing culture, the media, commercial pressures, age, socio-economic status and health status, and by previous experience of interaction with health professionals. Disentangling the effects of expectations, experience and satisfaction is difficult. Nevertheless, our results suggest there is a gap between the expectations of people in these European countries in respect of the desire for a more autonomous role in health care decisions and their actual experience.

Satisfaction with doctor–patient communications was quite high, especially among older people, but there is clearly room for improvement either in clinicians' skills or in the time available for consultations. Patients' expectations of involvement in decisions about their care differed significantly between the countries, with people in Spain and Poland exhibiting a much greater preference for a paternalistic style than those in Switzerland and Germany, while those in Sweden, Slovenia, Italy and the UK formed a middle group. Nevertheless, dissatisfaction with opportunities for involvement in treatment decisions was also highest in Spain and Poland, suggesting that significant numbers of people in these countries are frustrated with the paternalistic approach, notwithstanding the prevailing culture.

The overwhelming majority of respondents wanted to be able to choose their health care providers, yet most felt they did not have sufficient information to make an informed choice. The demand for choice of provider was exceptionally high everywhere except Sweden. It is not entirely clear why the results from Sweden were so different. Swedish people tend to go to hospitals administered by their local county council rather than further afield, and perhaps people are content with this restriction. However, completely free choice of specialist or hospital is fairly uncommon in the other countries too. Most Europeans are unaccustomed to having a free choice, yet many seem to want it, despite the fact that they do not feel confident about their ability to make an informed choice.

Global satisfaction ratings are especially hard to interpret and the results shown in table 4 are an example of this. On the face of it, it seems strange that the Spanish respondents gave the most positive ratings to opportunities for choice in health care since their responses to the questions about how well informed they feel and their reports of lack of involvement in treatment decisions are suggestive of restricted choice. Perhaps Spanish

people do actually have greater opportunities to influence referral decisions than those in the other countries, or perhaps they have low expectations of choice and are relatively content with what is available. In Switzerland expectations of choice and involvement are high and people are relatively satisfied with their health care system in this regard. Results from the UK present a more mixed picture. Respondents were relatively content with their level of involvement in treatment decisions, but quite dissatisfied with opportunities for choice in general.

People in Poland were noticeably more dissatisfied in relation to all the measures of responsiveness in this study. This was true within age groups as well as in the total figures, so sampling problems seem unlikely to account for this difference. Possible problems with the translation cannot be entirely ruled out, but the same pattern was seen in all questions and each of the response categories, suggestive of true underlying differences. Corroborative evidence is provided by WHO's *World Health Report 2000* which ranked Poland below the other seven countries in their responsiveness table.[1] Like other aspects of public policy in Poland, the health system has undergone fairly fundamental change since the political upheavals of the late 1980s and a new health insurance scheme was introduced in 1999. Our findings suggest that health care in Poland has some way to go to reach the standards of responsiveness achieved in the other countries in the survey.

Public demand for a more autonomous role for patients in health care decision-making was markedly related to age, with younger people being less satisfied than those in the older age groups. This might suggest that people accept a more passive role as they get older, perhaps because they have more experience of the health care system or because they place greater value on continuity of care from familiar physicians, or it might signify a more general cultural change. Cross-sectional surveys such as this cannot resolve this issue, but if greater expectation of involvement and choice and a more critical reaction to paternalistic styles are characteristic of future generations of health care users, then providers will have to adapt or dissatisfaction will increase further.

Policy-makers and clinicians should consider how to narrow the gap between expectations and reality. If Europeans are not satisfied with speed of access or the quality of care available in their own country, it is possible that they will increasingly seek to exercise their rights to treatment in other EU countries. They will need information about the quality of care provided in each health care facility if they are to make informed choices.

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Key points

- Random population surveys were carried out to investigate European people's views on health system responsiveness and the quality of doctor-patient communications.
- There is considerable room for improvement in professional communication skills.
- A majority of respondents wanted a more autonomous role, including choice of healthcare provider and active involvement in treatment decisions. Policy-makers and clinicians should consider how to narrow the gap between public expectations and patients' experience.

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