

Knowing Patients

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Knowing patients: The customer survey and the changing margins of accounting in healthcare

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Abstract

This research investigates the changing “margins of accounting” (Miller, 1998) in the field of healthcare where, as in other fields, customer surveys have emerged as a means of accounting for customers and of holding professionals and organizations to account. Drawing upon methodological insights provided by genealogical studies of accounting and anthropological studies of “things,” this research addresses the activities and transformations that take place to move the survey from war to ward—from a means of learning about medical populations during and immediately after World War II to a means of accounting for the views of consumers and of holding providers accountable for their care. These movements are shown to entail the staging and stabilizing of “knowing patients” in both senses of the term: these are patients that are equipped and empowered as consumers with knowledge about quality and their care, and simultaneously stripped of their individualizing characteristics so as to be made knowable to organizations in terms that can be managed and improved. These findings speak to the limitations of accounting as it infiltrates fluid and personal spaces in order to represent people in modes other than financial and to reconstitute knowledge from below. Doing so is shown not just to limit the possibilities for customers to speak and to be heard, but to give rise to a particularly pernicious form of territorialization in which the subject and object of accounting knowledge become inextricably intertwined and indistinguishably blurred. This has implications for the promises and practices of accounting in a post-modern society and for the kinds of questions that researchers ask about its effects.

Keywords: survey, healthcare, accounting change, quality improvement

1.0 Introduction

The ascendancy of the customer as a highly malleable ideal through which to model and remake private and public sector organizations has been noted since the early 1980s. Since that time, the ideal of the customer has been sustained and embodied in programs of industrial efficiency (Peters, Waterman, & Jones, 1982), market orientation (DuGay & Salaman, 1992), public participation (Watkins & Arrington, 2007), quality improvement (Munro & Hatherly, 1993), “new economic citizenship” (Miller & O’Leary, 1994), and much else besides (Munro & Kernan, 1993).

As Vaivio (1999) and others have noted, “accounting has not escaped the customer’s growing influence” (p. 689). Indeed, he continues, “demands have been made for the production of a quantified knowledge” of the customer (Vaivio, 1999, p. 689). Much of this knowledge has been financial in nature; accounting has been extended through processes such as customer profitability analysis and customer lifetime value, which seek to quantify the customer and achieve customer-focused strategies (Bellis-Jones, 1989; Boyce, 2000; Foster, Gupta, & Sjoblom, 1996; Guilding & McManus, 2002; Helgesen, 2007). However, new economic citizenship has also required “accounting [to be] transformed” to represent the customer “in modes other than the financial” (Mouritsen, 1997, p. 6; Munro & Kernan, 1993). The rise of the customer has therefore entailed not just the extension of accounting but also a transformation at its margins—a “progressive leap beyond monetary measures” and the adaptation and adoption of new devices and techniques (Vaivio, 1999, p. 690).

This paper is about the addition of one such device, the customer or consumer survey, to the repertoire of accounting. This has been seen as essential to make organizations more responsive and accountable to the customer. In the private sector, customer satisfaction has been extended as an essential lead indicator of financial performance (Chen, Martin, & Merchant, 2014; Ittner & Larker, 1998; Reichheld, 2003). As such, customer survey measures have been incorporated into balanced scorecards, performance evaluations, and other management controls (Johnson, 1994; Meyer & Schwager, 2007; Rawson, Duncan, & Jones, 2013).¹ In the public sector, similarly, the capacity to know and be responsive to the customer has been central to the projects reinventing government (Osborne, 1993), and New

¹ Indicatively, Stone and Banks noted in 1997 that of The Times Global 500 companies, 78% regularly used surveys to measure customer-based performance.

Public Management (Fountain, 2001; Hood & Peters, 2004). Thus, the customer survey has been proposed as an important proxy for the customer's voice and organizational performance, and it has been incorporated into external accountability systems (e.g., rankings, report cards, and regulations) and internal controls (e.g., performance evaluation and management accounting and control) (Fuller & Smith, 1991; Kelly, 2005; Kirkpatrick & Martinez-Lucio, 1995; Pfeiffer & Coote, 1991; Wisniewski, 2001).

Much has been written about the significance and effects of adopting customer surveys for the purposes of accounting and accountability within organizations and “specific organizational sites” (Vaivio, 1999, p. 709). Within these sites, customer surveys have been shown to create new calculative spaces and visibilities, leading to new and often dysfunctional organizational dependencies, interactions, and orders (Mouritsen, 1997; Munro, 1995; Ogden, 1997). The literature, however, has largely overlooked the movement of the “margins of accounting” (Miller, 1998, p. 605) upon which such organizational activities are premised and that extend far beyond the organization as such (Power, 1998, 2015). It has also overlooked the way in which the survey and accounting are made to accommodate each other—the emergence, in the first instance, of the survey as something capable of accounting for the customer and holding people and organizations accountable.²

This research investigates a specific change to the margins of accounting: the intertwining of the Consumer Assessment of Health Providers and Services (CAHPS) survey and accounting and accountability in the field of healthcare in the US and other jurisdictions in recent years. Drawing from the methodological approaches used by genealogical studies of accounting (Miller and Napier, 1993) as well as anthropological studies of “things” (Appadurai, 1986), this research traces the emergence of this survey back to World War II. Between war and ward, this research identifies three historical stages in the lifecycle of the survey in which its form and functional activity varied, and in which, through its constitutive effects, the conditions for it to be intertwined with accounting and accountability emerged.

Through an investigation of these changing stages, this research highlights the consequences of the movement of the margins of accounting. On the one hand, it shows that the movement entails an ever more exacting staging of the patient as a *subject of knowledge*: a person

² This is perhaps an outcome of the status of customer accounting as “largely neglected by management accounting scholars” (Cäker & Strömsten, 2010, p. 151).

equipped with a view and a voice and capable of participating as a discerning consumer in his or her care (Gerteis et al., 1993). On the other hand, this study shows that the movement entails the staging of the patient as an ever more organizationally useful *object of knowledge*: a person formatted to accommodate organizational activity and to speak only in what Marsh describes as “organizationally-useful terms” (as cited in Miller & O’Leary, 1987, p. 261).

The emergence of the patient survey as a means of accounting and accountability is shown to involve the merging and blurring of the distinction between the subject and the object of accounting knowledge. Designed to ask about “experiences” and express quality, the survey and systems of accounting and accountability give rise to *knowing patients* in both senses of the term. These are patients that are empowered as the source of knowledge and equipped to speak as consumers about what they know. They are also and simultaneously patients that are stripped of many of their individualizing characteristics so as to be made knowable to organizations in terms that can be managed and improved. As a result of this movement in the margins of accounting, not only are the possibilities for patients to speak and to be heard limited, but more significantly, the distinction between the patients’ possibilities and the organizations’ demands become inextricably blurred.

This merging and blurring of the distinction between the patient or customer as someone that knows and that someone that is made knowable through accounting as it seeks to infiltrate fluid and local spaces, contributes to our understanding of the possibilities of accounting in a post-modern “risk society” (Beck, 1992; 2006). It shows the optimistic scenario, in which accounting is extended so as to remake knowledge “from below” (Funtowicz & Ravetz, 1990, p. 21; Beck, 2006; Jassanoff, 2003; see also Gray, 2002), to be “delayed or decayed” (Power, 1997) into the more pessimistic possibilities of an audit (Power, 1999) or evaluation (Dahler-Larsen, 2011) society. Empowering the patient through accounting is shown not entail a move beyond expertise, but rather its reification into soft and self-effacing forms. Accounting, as such, is shown to be involved in a new and particularly pernicious form of territorialization (Miller and Power, 2013); when attached to quality, accounting does not constitute objects in economic or financial terms (see, e.g., Covalleski, Dirsmith, & Michelman, 1993), but rather obfuscates the distinction between subject and object, between economic and non-economic, and between territorializing terms and the objects that are remade in their name.

This paper proceeds as follows. Section two introduces the empirical setting of the investigation. Section three describes the research method and approach. Section four empirically describes the processes by which the CAHPS survey came to redefine the margins of accounting and accountability in healthcare. Sections five and six reflect upon these processes, highlighting their relevance to accounting theory and practice.

2.0 Accounting for the customer in healthcare

The patient has always been a contested figure in healthcare. As historians note, the medical profession has continually battled itself, other professions, and even the patient to define and stabilize the nature of the patient's properties (Porter, 1999; Starr, 1982). Accounting has been shown to play an important role in the definition of the patient and his or her significance since the early 1980s, when the US and other jurisdictions began to implement a variety of programs to limit costs and achieve efficiency in healthcare (Bourn & Ezzamel, 1986; Chua & Preston, 1994; Kurunmäki, 1999; Llewellyn, 1998; Preston, 1992; for a more general description, see Hacking, 1986, 1999).

Since this time, accounting in healthcare has been shown to be central to a certain kind of territorialization (Miller & Power, 2013), namely the economization (Miller & Power, 2013) and financialization (Gleadle, Haslam, & Yin, 2014) of patients and their care (Abernethy, 1996; Covalleski et al., 1993; Chua, 1995). The construction of business units and market mechanisms and the calculation of standard costs of medical interventions and Diagnosis Related Groups (DRGs) have been shown to constitute patients as objects of economic calculation and intervention (Kurunmäki & Miller, 2006; Lapsley, 2001; Llewellyn & Northcott, 2005; Nyland & Pettersen, 2004). In doing so, they blur the line between cost and caring (Llewellyn, 1998; Samuel, Dirsmith, & McElroy, 2005), remake patients as customers and consumers (Bolton, 2002; Mold, 2010), and redefine their bodies in financial terms (Preston, Chua, & Neu, 1997; see also Coombs, 1987; Llewellyn, 1998; Preston, Cooper, & Coombs, 1992; Samuel et al., 2005).

While research has highlighted the role of accounting in the creation of the customer and her care as economic objects, less attention has been paid to the reciprocal demands upon accounting that the economized healthcare system and its customers have brought about. The emphasis on efficiency and cost has given rise to questions regarding the “quality of care”

(LeGrand, 1999; Malmlose, 2012) that is bought and sold and that previous reforms took “absolutely no account” of (Coombs, 1987, p. 402). Indeed, it is now argued that, along with cost, measures of quality are “a necessary condition if the health system is to be held properly to account” (Smith, 2009, p. 675; Foot, Ross, & Lyscum, 2011). These demands require new things of accounting; they call for accounting to attend to quality as the patients understand it, and to make it calculable, comparable and systematically reported (Smith, 2009). This entails the extension of accounting from its emphasis on cost into “fluid” local spaces (Vaivio, 2006) and the intimate and personal lives of patients of which a patient-centered notion of quality is a part (Armstrong et al., 2007).

Thus, to compliment DRGs and other measures of cost, a variety of new accountability structures and non-financial accounting measures and metrics have emerged in recent years (Conrad & Uslu, 2011; Smith, 2009). As Brennan (1998) explains,

[o]ver the course of the last 25 years, the field of health service research has bloomed, as have new techniques for measuring the quality of health care. Before 1970, quality existed simply in the eyes of the beholder. Since then, however, various tools have been devised to measure health status, satisfaction, and a series of outcomes. (p. 709)

Such measures include quality report cards, quality-adjusted life year measures, quality and outcomes frameworks, and nationally standardized consumer surveys (see Van Peursem, Pratt, & Lawrence, 1995). These devices operate at the margins of accounting yet remain largely overlooked within accounting literature.

This research investigates the CAHPS survey in the US, which was the first of hundreds of similar surveys to emerge since the 1990s as an important mechanism to account for quality and hold providers accountable.³ Such surveys are seen to offer a view of quality from the consumer’s perspective with the “same degree of accuracy as the majority of measures used in clinical medicine” (Chassin, Galvin, & National Roundtable on Health Care Quality, 1998, p. 11). Efforts to empower the consumer and hold healthcare systems, organizations, and professionals accountable to consumers have therefore entailed the embrace and extension of the survey for the purposes of accounting and accountability (Marshall et al., 2000). In the US, for instance, the CAHPS program expanded from a voluntary national reporting system

³ A 2008 OECD literature review counts 188 surveys of this kind (see also Delnoij, Asbroek, & Arah, 2006).

for health plans in 1996 into a significant measure of quality for all kinds of providers. Simultaneously, the survey was integrated into extensive public reporting initiatives such as HospitalCompare.gov and WhyNotTheBest.org. These allow for direct comparison between providers based on answers to the survey questions and composite scores (as shown in Figure 1) and illuminate geographical variations in performance documented by the survey findings (as shown in Figure 2). As in other jurisdictions, the surveys were also linked to regulation and accreditation of healthcare providers, and in 2015, were directly tied to approximately 3% of the reimbursements that providers receive from Medicare and Medicaid.

[Figure 1: Comparative CAHPS data reported on HospitalCompare.gov]

[Figure 2: CAHPS data reported on WhyNotTheBest.org]

As with other external representations of performance, healthcare organizations and professionals have internalized these measures by integrating them into processes of management accounting and control (Power, 2007). As one report explains,

[t]he current requirements to publicly report scores on [CAHPS] ties the amount of reimbursement directly to levels of service performance. This reporting requirement has spurred a groundswell of activity around managing the perceptions of patients and ensuring a top service experience. (Beryl Institute, 2010, p. 1)

This activity is evident in a 2011 survey showing that 21% of hospitals rank “patient experience/satisfaction” as their number one priority for the next three years (falling between “quality/patient safety” and “cost reduction”) (Beryl Institute, 2011, p. 5). This prioritization has led to a variety of organizational changes, including the installation of internal patient survey systems to monitor performance on the survey questions of individual wards and professionals in real time, the linking of these scores to internal performance evaluation and reporting systems, and the creation of Chief Experience Officers (CXOs) to improve upon the scores (see, e.g., Wolf & Prince, 2014).

In summary, the CAHPS survey offers and is increasingly used as a means of performing accounting and achieving accountability in healthcare. Although the survey are contested by some organizations, they nonetheless provide representations of quality that can travel beyond the judgement of medical professionals and allow for systematic evaluation,

comparison, and intervention where none could exist previously (Brennan, 1998). Linked with public reporting and other initiatives, these representations contribute to the increasing barrage of public measures that calculate, rank, and rate performance in order to facilitate consumer representation and choice (Espeland & Sauder, 2007; Power, 1996). The survey also offers a new means of accountability as it is able “to reflect symbolically upon the practical interdependence of action” (Roberts, 1991, p. 335). Indeed, the survey is seen as a way to empower the consumer for the purposes of organizational and professional intervention and change, making it possible to implement the much-espoused “no decision about me without me” refrain (Delbanco et al., 2001).

3.0 Assembling the margins of accounting

The effects of these achievements, such as the creation of CXOs, are likely significant in their own right (see, e.g., Scott & Orlikowski, 2012). It is, however, the achievement itself—the movement of the “margins of accounting” (Miller, 1998)—that this research seeks to investigate and better understand. To do so, this research draws from and extends a long line of research that has sought to understand the consequences of accounting in terms of the assembly of the conditions of its emergence as much as its subsequent organizational effects (Burchell et al., 1985; Hopwood, 1990; Jeacle, 2003; Miller, 1991, 1998; Miller & Napier, 2006; Power, 2015). Such research has shown that accounting changes have “multiple conditions and sources of beginning” (Power, 2015, p. 43) and involve a wide set of “calculative practices” (Miller & Napier, 1993), including forms of ranking (Jeacle & Carter, 2011), rating (Scott & Orlikowski, 2012), and ordering (Pollock & D’Adderio, 2012), which come, often in gradations, to constitute accounting’s new beginnings.

In order to investigate the emergence of the multiple and dispersed conditions of accounting, this research takes inspiration from genealogical approaches to accounting history (Miller & O’Leary, 1987; Napier, 2001), as these approaches attend to the “outcomes of the past” rather than the “origins of the present” (Miller & Napier, 1993, p. 632). They investigate not the way in which current accounting practices are justified and sustained, but the assembly of the “conditions of possibility” for those accounting practices to first emerge (Miller, Hopper, & Laughlin, 1991, p. 394). In doing so, these studies highlight the importance of those changes that take place *before* and *beyond* an organization’s decision to adopt or adapt a customer survey, which are currently overlooked in accounting literature. They highlight the need to

address changes that take place at “multiple and dispersed sites” and involve a heterogeneous set of elements (Miller & Napier, 1993, p. 643) in order to prepare the world for accounting (Burchell et al., 1985)—those changes, in other words, that take place in accounting’s “shadows” (Power, 1996).

This genealogical approach is supplemented with the methodological ambitions of anthropological studies that investigate the “social life of things” (Appadurai, 1986; Miller, 2005). These studies attend to the ways in which devices, technologies, and other material things move between times and places and undergo transformations to their functional status, social significance, and physical characteristics along the way. They show that things have distinctive lifecycles or “biographies” (Kopytoff, 1986). Gifts, for instance, become commodities, found art objects, and then junk, only to emerge once again as heirlooms (Appadurai, 2006). Methodologically, the studies highlight, firstly, that “what is significant about the adoption of an alien technology is not the fact that it is adopted, but the way that it is culturally defined and put to use” (Kopytoff, 1986, p. 67). Secondly, the studies highlight that things create as well as respond to cultural demands. Things are not only adopted and put to use but also travel down “trails of symbolic attachments” (Engström & Blackler, 2005, p. 309), and during each stage in its life, a thing allows the next stage to emerge; for instance, a thing’s construction as a commodity feeds into the conditions for it to be remade as art.

These are important contributions to genealogical studies within accounting, which have almost exclusively addressed the assembly of conditions of a singular accounting “event” (Napier, 1993, p. 461), such as the emergence of value-added accounting in the UK (Burchell et al., 1985) or the development of costing techniques during and just after World War I (Loft, 1986). These studies imply that things act or “make operable” various ideas and ideals (Miller & Napier, 1993, p. 641), but that they do so only once and primarily as recipients of those ideas and ideals. In contrast, anthropological literature reminds us that things have rich social lives that help to assemble the conditions of the present as well as make them operable. Drawing upon these fields of study, therefore, this research investigates the assembly of the margins of accounting not as one event, but as one stage in the lifecycle of the survey as it moves from war to ward.

4.0 The movement of the customer survey from war to ward

Surveys come in many forms and are called upon to do a wide variety of things (Halsey, 2004; Marsh, 1982). This research is not interested in surveys in general, but in the specific thread in the development of surveys that ultimately led to the emergence of the CAHPS survey and the remaking of the margins of accounting. In order to address this particular historical thread, this research performs a bibliographic analysis of the 236 books and articles listed in the bibliography on the CAHPS development project's website. This bibliography includes seminal books, grants and contracts, and other reports and journal articles, including special issues of journals that documented different aspects of the development of the survey during the three stages of the contract. It aims to provide public information about the scientific foundation for development of the survey and the many detailed choices that it entailed. As Latour (1987) highlights, bibliographies of this kind provide a detailed history or sedimentation of historical fact-making. They illuminate constellations of debates and objects that have been mobilized and remobilized to constitute scientific facts and settle debates through time (Latour & Woolgar, 2013).

With this in mind, the citations in the CAHPS bibliography were traced backwards through three periods, or generations, and a factor analysis for each generation's citations was undertaken, leading to the identification of 7 to 8 clusters of citations in each. These clusters, labeled in Figure 3 according to their most central (or commonly cited) citations, helped to identify changes in the debates surrounding the survey throughout time. The papers in each cluster were read and analyzed to identify key authors, institutions, forms of expertise, preoccupations, ambitions, and other such themes. These themes were then broadly investigated. Where, for example, cognitive psychology was identified because the author was a cognitive psychologist or it was directly mentioned in the text, a general investigation of the development of cognitive psychology was performed.

[Figure 3: Bibliographic analysis of the CAHPS bibliography]

Explicating and analyzing this timeline allows us to identify three distinctive yet deeply interconnected stages in the lifecycle of the survey and the surrounding elements that produced the conditions necessary for the margins of accounting to change. These stages and the movements between them are recounted in the following sub-sections.

4.1 Morbidity and attitude surveys and the emergence of patients' view, 1945–1980

Prior to 1945, the use of surveys to undertake widespread investigations of health and illness had a long and significant history (Marsh, 1982). However, many of the conditions required for the emergence of the CAHPS survey as a central tool for accounting and accountability can be traced back to activities taking place during and directly after World War II. This section shows how the survey activities performed during this time led to the construction of morbidity and attitude surveys as a means of knowing about patients and constituting the existence of their views about health, illness, and care. Capable of staging stable objects, the survey became capable of problematization and critique during this time, if not yet accounting and accountability (see Miller and O'Leary, 1994).

The screening, selection, and rehabilitation activities performed by psychiatric units in the military during World War II transformed the development and use of surveys in the post-war years (Box & Thomas, 1944; Pols & Oak, 2007). These activities involved a variety of technological developments, such as new sampling techniques (Thunhurst & Macfarlane, 1992), but more significantly, they highlighted new possibilities about what illness was and where it was located. Surveys of soldiers and populations performed during the war illuminated not only that many health issues went undiagnosed but also that there were situational and environmental factors outside the existing bio-medical model that were potentially central to health and care (Carlson & Klerman, 1990; Jones et al., 2006).

This led to a far-reaching paradigm shift in psychology and epidemiology in the post-war years (Carlson & Klerman, 1990). Previous psychiatric etiology had been concerned with the individual factors that predisposed people to mental ill-health, and clinical epidemiology was primarily concerned with the somatic “degeneration” of individuals. In contrast, the etiology of the post-war “golden era of social epidemiology” (Klerman, 1986, p. 162) focused increasingly on the “social institutions and historical forces” that might affect “the variations and prevalence of distress and disability” (Susser, 1985, p. 150).

This post-war paradigm shift went hand in hand with the extension of a variety of large-scale surveys to discover the “social and institutional” factors that were tentatively seen to affect health during the war (e.g., Duncan-Jones & Henderson, 1978; Henderson et al., 1979;

Hollingshead & Redlich, 1958; Mechanic & Volkart, 1960; Srole et al., 1962). As the extract from the Midtown Manhattan survey in Figure 4 illustrates, the morbidity surveys asked patients a bewildering array of questions, ranging from childhood fears to drinking patterns. However, coupled with diagnostic tools, they established a whole new methodology for knowing the patient. As Carlson and Klerman (1990) explain,

[t]he new methodology emanating from this paradigm was the development of structured interviews to obtain standardized information about the patient's past history and current social functioning symptomatic status. In parallel, sets of operational criteria and diagnostic algorithms were codified and used in assigning an individual patient to one or another diagnostic category. (p. 30)

This new methodology established the survey as a device capable of constituting medical facts. The morbidity survey asked people about themselves and in doing so identified all sorts of socio-psychological characteristics, such as "dissatisfactions," "lifestyles," and "stresses" (Freidson, 1961). As Armstrong et al. (2007) note, "patients who reported themselves as being highly anxious could be described as having anxiety disorder and those reporting depression could be labeled as having (clinical) depression" (pp. 572–573).

[Figure 4: Extract from Midtown Manhattan study interview schedule (Srole et al., 1962, p. 389)]

The survey came to have a similarly constitutive role in medical sociology around the same time. During the war, sociologists based in the Department of Defense such as Merton, Lazarsfeld, and Likert had undertaken hundreds of "attitude surveys" (Lazarsfeld, 1949, p. 370) and conducted over half a million interviews with soldiers in order to access the social and subjective world upon which attitudes and morale were thought to depend. Immediately after the war, the authors used this data to produce a volume titled *The American Soldier* (Merton et al., 1946), which argued that surveys could allow for the systematic measurement of the social world. The volume was enthusiastically received and ushered in a movement similar to that seen in psychiatry and epidemiology (Converse, 2009). According to Lerner, it resulted in the creation of a "new social science" that would use the modern method of "rigorous testing of explicit hypotheses on largely quantified data accumulated by structured observation in empirical situations approximating [...] the model of controlled experiments" (Platt, 1996, p. 60;). Moreover, the enterprising authors of the work established large and high-profile academic research centers with close ties to both the government and industry,

thus “giving hegemony to the new model survey, and to the departments where its leaders were now located” (Platt, 1996, p. 50).

This new social science gave rise to social indicator research, opinion polling, and consumer research (Osborne & Rose, 1999; Rose, 1996). It also resulted in the widespread use of surveys in medical sociology. Koos’ (1954) survey of “what people think and why they behave as they do in regards to health” (p. 38) marked the beginning of the proliferation of such surveys (Armstrong, 1984; e.g., Freidson, 1960, 1961; Hannay, 1979; Zola, 1966). Using a combination of structured and open-ended questions, these studies asked about and constituted a whole host of new patient characteristics, such as “perceptions,” “hopes,” and “fears” (see Armstrong, 2002).

The patient survey emerged as a device capable of producing facts about the patient that could rival or even replace the historically established medical ones. Indicatively, the divergence between “objective” medical facts and “subjective” survey responses was seen as a “major area of difficulty” (Wadsworth, Butterfield, & Roger, 1971, p. 93) for the survey project up to the mid-1970s (Leblow, 1974). By the early 1980s, however, the assumption that patients’ opinions had to be validated by medical facts was itself seen to be unfounded. In fact, the survey’s ability to produce information that did not correspond with the “objective reality” of medicine was argued to not be a limitation, but its “unique strength” (Ware et al., 1983, p. 247). The survey, therefore, emerged as a way to stage the patient as a new and increasingly stable object.

As a stable object, the patient began to be capable of problematization and critique. Indeed, while the traditional biomedical model upon which Western medicine had been based understood disease and the patient to be wholly contained within the physical tissue (Porter, 1999), the survey insisted that the patient extended well beyond the physical (Kennedy, 1971; McLachlan, Godber, & Nuffield Provincial Hospital Trust, 1976; Menninger, 1975). Drawing upon survey findings, therefore, researchers said that the patient was comprised of all kinds of non-somatic elements. For instance, the patient was said to look

for a great deal more than mere survival, or relief of pain ... He wants, in general, to function usefully in his family, in his job, and in his community; he wants to be free from anxiety; and, he wants to have a relationship with his physician which satisfies his particular needs. (Sidel, 1966, p. 764)

These differences culminated in the articulation of the “paradox of health”: the proposition that *more* intervention could actually cause patients to feel *less* well (McKoeun, 1979).

Thus, during the 1980s, the survey and its object began to become intertwined with the articulation not just of what *is*, but what *ought to be* (Miller & O’Leary, 1984, 1994; Miller & Power, 2015). It was but a small step from the articulation of the paradox of health to the proposition that “counting the dead is not enough” (Cartwright, 1981), and to the argument that “the successful application of medical knowledge depends on what patients think and feel about doctors, nurses, and hospitals” (Cartwright, 1964, p. 3). The patient that the survey revealed was therefore shown to be capable of demanding that things might be changed, managed, and improved.

4.2 Customer satisfaction and the quality of care, 1980–1990

From the 1980s onward, in this gap between biomedical knowledge and that emanating from survey activities, the satisfaction survey emerged at the center of discourse and debate. This section shows how the development and extension of the satisfaction survey as a measure of quality transformed the patient from the object of survey knowledge to its ostensive subject. In doing so, it became intertwined with accountability; the satisfaction survey emerged as both the voice of the patient and a measure of quality and thus as a means of holding providers accountable for their care.

The satisfaction survey became the major focus of attention during the 1980s for a variety of overlapping reasons that resulted from the post-war survey activities. From a traditional biomedical perspective, satisfaction had been shown to be “a potentially important factor in health care in that it may influence whether or not a patient seeks medical help, whether the patient complies with a therapeutic regimen and whether the patient maintains a continuing relationship with a physician” (Larsen & Rootman, 1976, p. 29; see Cartwright, 1983, pp. 87–92). This highlighted satisfaction’s medical importance, even for those still skeptical of the patients’ view. As a result, clinicians wrote in 1981:

Patient satisfaction has long been of interest to health professionals, although the emphasis has changed somewhat. For example, 10 years ago the issue centred around whether to consider patient perceptions; today the discussion centres on

how much weight to give the patients' perceptions and how to measure those perceptions. (Stamps & Finkelstein, p. 1108)

The expression of satisfaction was also increasingly seen as a consumer right. One outcome of the post-war survey activities and the stabilization of the patient's view was the emergence of a "consumer movement in healthcare" in the 1980s (Miller & Rose, 2008, p. 76; Porter, 1999; see Schwarzkopf, 2009 on related fields). The movement sought to counter and replace medical professionals' authority and hegemony through the activation of the patient a consumer of care (Cartwright, 1983; Henderson & Peterson, 2002). Satisfaction surveys were seen to play an important role in achieving these goals. As Cartwright (1983) summarized,

[t]he most fundamental contribution made by surveys in the health field is that most of them are concerned with the needs, experiences, and attitudes of patients in a service which might otherwise be dominated by professional paternalism. In a very real sense, surveys are part of a democratic process: they are essentially sample referendums. (p. 198)

Indeed, authors likened surveying patient satisfaction to "casting a vote in the elections," enabling "patients to vent their feelings and [giving them] the sense that they participate in their care" (Vuori, 1991, p. 185; see also Berliner and Salmon, 1980).

These two movements interacted, moreover, with aspirations to measure and assure the quality of care, which emerged in the mid-1980s alongside a variety of efforts by the government and others to determine, compare, and constrain healthcare costs (see, e.g., Chua, 1995; Samuel et al., 2005). Efforts to constrain costs resulted in questions about the quality of the products and services that were bought and sold (Malmrose, 2013). Quality had hitherto been defined as something that only the attending physician could judge, but close inspection revealed large unexplained variations in professional definitions and standards of care (Porter, 1999; Scott et al., 2000; Timmermans & Berg, 2003). Therefore, it was increasingly argued that a new and "usable definition of quality" was required (Lohr, 1985, p. 2). This referred to a definition that could extend beyond professional judgment and could be standardized, calculated, compared, and therefore bought and sold.

Avedis Donabedian's structure-process-outcome model of quality provided such a definition. Against the claim that only the physician could judge quality, Donabedian (1988) stated that "the concept of quality can be rather precisely defined, and [...] it is amenable to

measurement accurate enough to be used as a basis for the effort to monitor or ‘assure’ it” (p. xxxii). He outlined a model in which professional judgment would be replaced with the systematic measurement of relations between structures, processes, and outcomes of care and in which customer satisfaction occupied a central position. Donabedian (1992) insisted not only that satisfaction was an outcome as significant as morbidity and mortality but also that it was something that only the customer could reliably judge.

Donabedian’s model emerged as “one of the very few points of consensus” in debates about quality from the 1990s onward (Leguido-Quigley, 2008, p. 10). With this point of consensus came the codification of the view that customer satisfaction was a “necessary outcome of any transaction irrespective of the efficacy of that transaction” (Linder-Pelz, 1982, p. 577; see also Cleary & McNeil, 1988; Davies & Ware, 1988; Guzman et al., 1988). This status of customer satisfaction was reified through government efforts to measure and assure the quality of care. Intensive government intervention began when Congress asked the Office of Technology Assessment (OTA) in 1988 to “assess whether valid information could be developed and disseminated to the public to assist their choices of physicians and hospitals,” and it continued in 1990 when Congress charged the Institute of Medicine (IOM) with the task to “design a strategy for quality review and assurance in Medicare” (Lohr, 1990, p. R13). In addition, the National Committee for Quality Assurance (NCQA) was launched in 1990 in order to establish a national consensus on the definition, measurement, and assurance of quality. These efforts made explicit that patient satisfaction was a central measure of healthcare outcomes and that, as such, systematic surveying of patient satisfaction would be a “central part” of efforts to achieve quality assurance (McMillan, 1987, p. 54).

Through these activities, the satisfaction survey emerged as capable of more than problematization and critique. As envisioned by the IOM and NCQA, the survey was a tool for management and organizational change due to its ability to act as the voice of the patient and measure the quality of care. It was a means to “transform healthcare from a sellers’ market to a consumers’ market where satisfaction is in part of the definition of quality” (Vuori, 1991, p. 183; see also IOM, 1999). The satisfaction survey thus became entangled with accountability: it was thought to be capable of helping patients express demands and ensuring that they were taken into account by healthcare providers.

The pursuit of accountability through the survey entailed a subtle shift in its object. Post-war morbidity and attitude surveys had sought to determine the characteristics of the “average patient” (Leblow, 1974, p. 335). The satisfaction survey, by contrast, was concerned with information about the individual providers. Indicative of this shift, satisfaction measures came to be interpreted differently. Global measures of satisfaction, such as that from a 1983 survey shown in Figure 5, were once derided for illuminating the inconsistencies of the patients’ view (see Higgins, 1965), but now they were seen to provide important information about variations in the delivery of care (Cleary & McNeil, 1988). As such, the patient’s relation to the survey changed; the patient was staged as the object of the survey and also increasingly as its subject, as the survey became a means to know about patients as much as know about providers of care.

[Figure 5: Global satisfaction measure (Ware et al., 1983, p. 250)]

The development of a satisfaction survey capable of accountability, however, presented new challenges. It had been shown that a “satisfaction rating is both a measure of care and a measure of the patient who provides the rating” (Ware et al., 1983, p. 248) and that “satisfaction may be more affected by patient factors than by organizational characteristics” (Pascoe, 1983, p. 200). This meant that, as Ware (1977) had noted years earlier, that

[w]ithout a better understanding of what causes patients to be more or less satisfied with the care they receive [...] it is not clear whether the medical care system should be held accountable for all the variability in satisfaction scores. (pp. 24–25; see similar arguments in Cleary & McNeil, 1988)

In order to empower the patient as a customer capable of speaking about quality, therefore, it became important to separate the satisfaction attributable to the customer (socio-demographic characteristics, mood, form of payment, expectations, psychological state, and much else) from the satisfaction attributable to the provider of care (what the provider did or did not do and how they did it). In other words, as the survey became enrolled in ever more exacting activities to count, calculate, and hold providers accountable, much of the patient whose perspective it purported to represent and that was illuminated in the post-war years had to be removed.

4.3 From satisfaction to experiences with care, 1990–2010

If the satisfaction survey highlighted the problem of separating the patient from the provider, the consumer experience survey, which emerged between 1990 and 2010, provided a solution. This section shows that as the aims for quality measurement and assurance gave way to those for improvement and intervention, the experience survey emerged as a means of accounting for quality and establishing accountability between the healthcare consumer and the provider of care. This movement is shown to involve not just the staging of the patient as both the subject and object of the survey but also, more significantly, the blurring of the relation and difference between the two.

By the early 1990s, debates about quality had moved from questions of *whether* it could be measured and assured to propositions about *how* improvements could be achieved (Berwick, Godfrey, & Rossner, 1990; Shortell, Bennett, & Byck, 1998). Central among these propositions was the argument first advanced by Donald Berwick (1989) for “continuous quality improvement as an ideal in healthcare” (p. 53). His call for the adoption and adaptation of “modern industrial quality science” into healthcare (Laffel & Blumenthal, 1993, p. 285) quickly gained widespread support from accreditation agencies, purchasers, and leaders in the medical profession, particularly following a series of high profile reports of quality and safety failures (Blumenthal & Kilo, 1998; Chassin et al., 1998; IOM, 1999b; Shortell et al., 1998). This led to the emergence of a “quality improvement movement in healthcare” (Øvretveit, 2000, p. 74): an international movement to import industrial improvement principles to healthcare in order to continuously improve the quality of care.

Based in industrial science, the quality improvement movement proposed new ambitions for the patient. It envisioned the patient not just as someone with a vote or a voice but also as a consumer that products and services could be made for and adapted to (see Milstein et al., 2000). The “science of quality measurement” (Romano & Mutter, 2004, p. 131) was therefore said to require information about the consumer that was actionable, and about specific processes that providers could seek to improve (Marshall et al., 2000). As Meterko, Nelson, and Rubin (1990) explained,

[d]uring the last decade organization-wide quality improvement efforts in both service and manufacturing sectors in the United States have embraced customer evaluations of goods and services to monitor quality. American organizations are finally adopting the quality improvement theories of Deming and Juran responsible for post-war Japanese industrial success. *A key component of these*

theories is that suppliers of a good or service must receive feedback from customers in order to identify deficiencies and guide the design of improvements [emphasis added]. (p. S3)

The need for actionable feedback problematized existing satisfaction surveys, particularly those relying on global measures. Because they provided little information about precisely what providers could do to improve, they were said to “limit the value of many patient surveys, and inhibit their use in total quality improvement efforts” (Nelson & Niederberger, 1990, p. 409).

A growing number of experiments using public reporting as a means to achieve quality improvements, beginning with the public reporting of standardized hospital mortality data by the Health Care Financing Administration from 1986 to 1993, also problematized the satisfaction survey (Cleary, 1998, Marshall et al., 2000).⁴ A growing “science of quality improvement” (Ørvetveit & Gustafson, 2002, p. 270) showed such surveys to be unable to clearly differentiate between providers of care (satisfaction ratings tended to vary only by a few points) or provide information to consumers that they found relevant for decision-making (Romano & Mutter, 2004; Vuori, 1991).

Therefore, new surveys were needed that could clearly differentiate between providers and give them the feedback necessary to improve. These aspirations led a number of authors closely aligned with the cognitive psychologist John Ware and medical sociologist Paul Cleary to advance the “promising but rarely employed strategy” (Cleary & McNeil, 1988, p. 26) of determining a number of “distinct quality-related attributes that can be measured and interpreted separately” (OTA, 1988, p. 246). They showed what such a process entailed in a trial undertaken in 1983. It involved a literature review to determine the specific objects and behaviors that mattered to patients. These were then grouped into distinct topics (such as access, finance, resources, and continuity of care, as shown in Figure 6) and cognitively tested in interviews to ensure they were understood separately by patient-consumers. Finally, these topics were developed into the specific kind of questions about experiences with care illustrated in Figure 7.

⁴ These included the Cleveland Health Quality Program, California Cooperative Health Care Reporting Initiative, healthgrades.com, and dartmothatlas.com.

These questions were not altogether different from those asked before (indeed, as Item 1 in Figure 7 shows, the surveys still included one global measure of satisfaction), yet they were distinctive in that they substituted the problematic space of “satisfaction” with the space of “experiences,” which were seemingly more personal, actionable, and amenable to management. Indeed, the questions sought to ask about discrete and identifiable people and things, such as doctors and expenses (Item 33) or places and their level of convenience (Item 12).

[Figure 6: Dimensions of satisfaction (Ware et al., 1983, p. 256)]

[Figure 7: Satisfaction items (Ware et al., 1983, p. 252)]

Unlike “satisfaction,” “experiences” provided the conditions for separating the consumer from the provider and allowing the survey to be extended for the purposes of accounting and accountability as never before. By retaining Likert-type response scales ranging from “completely agree” to “completely disagree,” the questions required patient-consumers to formulate views and express perceptions. As such, they were seen to be capable of expressing their voices and intimate wishes as consumers. Since they were based on experiences, these were views and voices about things within the healthcare organization that could be attended to, managed, and improved. As formulated, for instance by Pine and Gilmore (1998), an experience was said to occur when the consumer was placed in a particular organizational setting that could be managed, engineered and improved. As the groupings in Figure 6 illustrate, experiences involve events with parts that can be isolated and related to specific professionals (“family doctors,” “specialists”, etc.) and to actions they were seen to undertake (“explain,” “consider,” etc.).⁵ As such, they united and blurred the relation between patient and provider, giving the patient a view and voice about specific things that organizations could understand, manage, and improve.

⁵ The identification of distinctive and largely verifiable experiences also provided better conditions for the development of case-mix adjustment techniques because, for many items, experiments could be designed to separate differences in response patterns that reflected systematic biases rather than actual differences in the quality of care (Rosenheck, Wilson, & Meterko, 1997; Zaslavsky et al., 2001).

Ware and Cleary's strategy provided the template for large-scale survey activities performed in the US and elsewhere between 1990 and 2000 (Gold & Woodridge, 1995). Large-scale patient experience surveys were developed by Ware and colleagues (Meterko et al., 1990; Cleary et al., 1991). They were argued to demonstrate the ability of the survey to "detect significant differences among [...] respondents receiving care at different places or times or under known different conditions" (Meterko et al., 1990, p. S9), and as such to be "extremely useful for quality improvement and assessment efforts" that had displaced the measurement and assurance efforts at the center of public attention (Cleary et al., 1991, p. 261). High-profile projects, such as the Commonwealth-Picker hospital survey, which was the forerunner to the CAHPS survey (Gereteis et al., 1993), the Primary Care Assessment Survey in Massachusetts (Safran et al., 1998, p. 728), and others (Rogers & Smith, 1999) explicitly replicated this survey approach.

These survey activities in turn contributed to concerns about quality. Following a two-year national round table initiated by the Institute of Medicine in 1998, it was stated that there were "serious and extensive" problems with quality as the patient perceived it and that "a major effort to rethink and reengineer how we deliver health care services and how we assess and try to improve the quality of care" was required (Chassin et al., 1998, p. 11). The resulting efforts entailed the extension of the survey for the express purpose of accounting and accountability as never before. From the late 1990s, large-scale and often government-led activities were undertaken to systematically collect, formally standardize, and publicly report the quality of healthcare providers and professions using the experience survey alongside biomedical measures (Timmermans & Berg, 2010). The survey was first extended nationally for the purpose of accounting in 1995 when the National Care Quality Association (NCQA) assessed the performance of health plans based on their Healthcare Effectiveness Data and Information Set (HEDIS), which included an "experience with care" domain based on experience survey returns (Safran et al., 1998). The HEDIS measures, although "very controversial" (Epstein, 1995), were audited by a third party and upheld as key measures of health plan performance. The findings were made available through the online reporting tool called Quality Compass, and the NCQA worked closely with the US News and World Report

to rank health plans based on the data (Schneider & Leiberman, 2001).⁶ The survey thereby began to calculate and represent performance; alongside other measures, it allowed rankings, ratings, and formal comparisons to patient choices where once judgments prevailed.

By 1998, there were so many overlapping and sometimes contradicting measurement systems, report cards, rankings, and ratings that the Performance Measurement Coordination Council and the National Quality Forum were launched to standardize measures (Skolnick, 1998). These initiatives highlighted the need for national and even international standardization of quality measurement and surveys of customers (Safran et al., 1998). The Healthcare Research and Quality Act of 1999 tasked the Agency for Healthcare Research and Quality (AHRQ) with achieving these goals. As part of this scope of work, it launched the CAHPS I project to “develop and test questionnaires that collect information on consumers’ experiences and assess health plans and services,” led by those survey developers such as Paul Cleary and Susan Edgman-Levitan who had previously developed the Commonwealth-Picker survey.

The result of this first round of work was the CAHPS survey instrument (extracts of which are shown in Figure 8) to publicly measure health plan performance. Designed specifically to support the aims of quality improvement and reporting for the consumer (McGee et al., 1999), it contained 18 items asking “‘how often’ or whether patients experienced a critical aspect of hospital care, rather than whether they were ‘satisfied’ with the care” (HCAHPS 2012, p. 2). Created in this way, and endorsed by the National Quality Forum, the survey provided “a leading mechanism for generating scientifically sound measures of consumer perspectives on health care access and quality” (Lake et al., 2005, p. xi; see also Crofton, Lubalin and Darby, 1999; Scanlon et al., 2002). As such, it was deemed essential for all kinds of accounting and accountability activities, “including marketing and planning, government regulation and private accreditation, enhanced purchaser decision-making, increased accountability of providers, and provider quality improvement activities” (Lake et al., 2005, p. xi). One review concurred, stating the following:

CAHPS surveys are used by health care decision makers to help them make informed choices of health care providers. For example, the CAHPS Health Plan

⁶ Parallel efforts were pursued by local, regional, and national providers and payers, resulting in a proliferation of different experience surveys and accounting systems (Marshall et al., 2000).

Survey is used by a wide variety of organizations, including the National Committee for Quality Assurance, Centers for Medicare and Medicaid Services, state Medicaid programs, Department of Defense, purchasing coalitions, and health plans for a wide variety of purposes, including *informing consumers, accrediting health plans, assuring accountability, monitoring performance, and identifying quality improvement targets* [emphasis added]. (Darby, Hays, & Kletke, 2005, p. 1973).

[Figure 8: Extracts from the CAHPS health plan survey instrument (from www.cahps.arhq.gov)]

The benefits of CAHPS remained largely a potential as most consumers, it was highlighted, remained unaware of their role (Lake et al., 2005). Yet, the “allure of the market based on ‘consumer choice’” offered by the survey proved nearly irresistible (Schneider & Leiberman, 2001, p. 96), and it was extended nationally and internationally as a primary means of accounting for quality. In the USA, survey was expanded to cover all kinds of healthcare organizations and was linked to accreditation processes, public reporting initiatives, and ultimately to reimbursement rates throughout the 2000s. Promoted at a series of international conferences led by the IHI and Picker, the CAHPS survey also became the template for national survey programs in hundreds of jurisdictions throughout the world (see OECD, 2008 for an overview).

Such surveys were said not just to represent the social-psychological patient of the post-war years but also to empower the patient with a voice, view, and the ability to choose, demand, and intervene. They provided representations of the patients’ “individuality,” “the fullness of the context in which illness occurs,” and “their emotional needs”—a rich view of the patient as a person that the biomedical model and a financialized healthcare system were said to have left behind (Gereteis et al., 1993, p. 20). They were also said to be powerful tools of organizational change; for organizational comparisons and interventions, they were “fair,” “relevant,” and could overcome any “unintended effects” (Price et al., 2014, p. 253).

5.0 Knowing consumers

This paper has described the process by which the customer survey in healthcare came, through a long process of accumulation conditions, to be intertwined with accounting and accountability in recent years. This process is recounted in three inseparable but distinctive stages in the still-unfolding lifecycle of the survey illustrated schematically in Figure 9 based on the similar but changing elements that constituted the survey: from the top clockwise, the central aspiration upon which they were based, the dominant form of expertise upon which they were designed, the name and form that they took, and the notion of the patient that they framed.

[Figure 9: Three stages in the lifecycle of the customer survey]

In the first stage of the lifecycle of the survey, which took place between 1945 and 1980, *morbidity and attitude surveys* emerged as a method capable of expressing a view or voice of the patient that could rival and even replace the historically prevailing biomedical one. During this period, survey activity staged the social-psychological patient as an object of medicine. It showed patients to have perceptions, hopes, wishes, and fears that were stable and solid, and that might even be as real as the historically prevailing biomedical bodies that doctors had been trained to provoke and attend to. Through its capacity to construct patients as stable objects, the survey became intertwined with problematization and critique (Miller, 1998); it accumulated managerial and accounting aspirations as it documented a deep and incommensurable divide between the social-psychological patient's world and definition of quality and that provided by traditional medical expertise.

In the second stage of the lifecycle of the survey, which took place between 1980 and 1990, the *customer satisfaction survey* was developed and extended as a means of giving those social-psychological patients a view and a voice not precisely about themselves, but about healthcare quality and providers of care. This made the survey capable not just of knowing about patients but also of making patients capable of knowing; it provided a view of quality through the patients' eyes. Thus, it was designed, at least in principle, as a mechanism for ensuring accountability: through the survey, it was said that the performance and quality of providers could become dependent upon what their patients thought, felt, and perceived.

In the third stage, which took place between 1990 and 2010, the goals regarding quality measurement and assurance gave way to those of improvement and intervention and the

nationally standardized *experience survey* emerged. Organized around “experiences,” which are objective and verifiable yet expressions of the patient’s inner world, the survey became capable of separating the consumer from the provider and of supporting the patient as both accounting’s subject and object. In doing so, it came to provide the seemingly unadulterated expression of the patient and at the same time measures of performance and objectives of managerial action. It provided a number that could be used for comparisons, rankings and ratings, calculations, and far-reaching programs for accounting and accountability (see, e.g., Figures 1 and 2).

It was thus through a long process of accumulation rather than a single event during which the conditions necessary for accounting change emerged (c.f. Burchell et al., 1985; Loft, 1986; Napier, 2006). Over time, and through its constitutive effects, the survey accumulated different accounting capabilities, such as the ability to problematize, seek to manage, seek to improve, know, account, compare, calculate, and hold accountable. In contrast to a long line of genealogical studies suggesting that devices operate only once and typically serve as the recipient of ideas, this research illuminates the centrality of devices in the ongoing extension of accounting’s margins. Such devices are shown not just to give expression to the will to accounting and accountability but instead to provoke and provide some of their diffuse sites and sources of beginning (Power, 2015). Therefore, each stage in the lifecycle of a thing as it accumulates the ability to count, calculate, account, and hold accountable identifies what is necessary for a new and particular kind of accounting to emerge. This research shows accounting’s embrace of the customer survey, in particular, to involve two parallel and increasingly intertwined movements.

On the one hand, this research shows the development and extension of the survey for purposes of accounting and accountability to entail the ever more precise articulation of the patient as a *knowing subject*. Through each stage in the development of the survey and as its relationship with accounting became ever closer, the patient was empowered with ever more resources and capabilities. The patient was first equipped to speak up about herself in terms that could problematize and compete with the historically dominant biomedical terms. Reframed as a discerning customer, she was next empowered to speak not just about herself but about providers of care and enabled to demand that her voice was taken into account. Finally, she was given the view and voice of a consumer who was capable not only of voting

and of choosing but also of penetrating organizational life and distinguishing and defining the terms upon which competition could be based and choices could be made.

On the other hand, this research shows the development and extension of the survey for purposes of accounting and accountability to involve the ever more precise staging of the patient as an *object of knowledge*. Through each stage in the lifecycle of the survey and as its relationship to accounting became ever more intertwined, the patient was formatted and framed in order to be probed, provoked, and even mined, first as the object of social-psychological knowledge, next as the object of management and intervention to determine quality of the providers of care, and finally as a way to know about the organizational tasks through which quality improvement could be achieved. To empower the patient, in other words, she had to be increasingly remade in what Miller and O’Leary (1987), paraphrasing Marsh, describe as “organizationally useful terms” (p. 261).

It has long been known that accounting is involved in processes of economic and financial territorialization and the creation of a particular kind of consumer (Graham, 2010; Jeacle, 2003; Miller & O’Leary, 1987; Miller & Power, 2013). Within healthcare, the development of new accounting devices, such as standard costs and budgets, have been shown to embrace and remake the patient as a financialized object: someone, for instance, with “resource consuming organs” (Samuel et al., 2005, p. 272) capable of acting and being acted upon rationally in terms of efficiency, cost reduction, and eliminating waste (Covaleski et al., 1993). This research builds upon and extends this literature by highlighting the distinctive kind of consumer that accounting helps to assemble when economy-related goals are complemented by those related to quality. In the case studied here, accounting was not extended expressly for economy-related purposes, although it was justified on the basis that effective markets required a “usable definition of quality” (Lohr, 1985, p. 2). Rather, it was extended so as to complement and make up for the financial, to add more dimensions to financialized customers, and to add more qualities to the economy of care.

The extension of accounting beyond the financial and to embrace quality entailed the simultaneous empowerment and subjugation of the patient: the staging of *knowing consumers* in both meanings of the term. She is a person that, through accounting, is equipped as all-knowing and capable of demanding things of organizations and professionals—she can require “doctors”, “specialists”, and others to “explain” and “consider” (see Figure 8). At the

same time, she is stripped of many of her characteristics and dimensions in order to be known in terms that organizations can address and improve upon—she no longer has “expectations”, “troubles”, or worries (see, e.g., Figure, 4). Through the notion of “experiences,” in other words, the goals and possibilities of expression and participation are inextricably intermingled with those of intervention, management, and, especially, quality improvement.

These experiences may or may not correspond directly with the reality of the patient’s experiences, views, and perceptions, or, for that matter, with organizational processes and activities. The significant point that this research highlights, however, is that as accounting and the survey converge, and as the accounting is extended, it becomes increasingly difficult to know what is being achieved. It is possible to say that through these movements a compromise was reached between the twin goals to empower the patients and improve the quality of care, but it is more precise to say that through accounting the objectives to know patients and improve quality became inextricably blurred. Indeed, in order to express quality, as opposed to economy, accounting required not a *view on* the patient but the *view of* the patient, as if without perspective or remainder. The extension of accounting for the purposes of quality, therefore, entailed the emergence of a particularly pernicious form of territorialization: not a financialized subject, but the blurring of the distinction between the subject and the object of accounting knowledge, the calculating center and the calculated periphery, and the knowing and the known.

6.0 Conclusions

This outcome of efforts to account for the customer suggests that there are certain limitations for accounting in the reflexive stage of modernity outlined by Beck (1992) and others (Derber, Schwartz, & Magass, 1990, p. 210). A variety of authors, such as Jasanoff (2003) and Beck (1992, 2006), as well as many advocates of social and environmental accounting (e.g., Gray, 2002), have optimistically suggested that, confronted with the inherent limitations of modernity and traditional forms of expertise, accounting might be adapted and extended so as to enable new forms of participation and deliberation and create new forms of knowledge “from below” (Funtowicz & Ravetz, 1990, p. 21). In this particular case, these goals were partially realized. Indeed, the addition of the survey to the repertoire of accounting was advanced explicitly as a means of “de-professionalization” (Marshall, 1999, p. 691) and countering medical paternalism (Levy & Howard, 1982). It was a process, as the developers

of the Commonwealth-Picker and later CAHPS surveys explain, of empowering patients to speak by removing the professional view:

Our conscious effort throughout this project [...] has been to set aside those *professional* frames of reference in order to cast a clearer light on the *patient's* perspective. Our aim is to find out what patients want, need and experience in healthcare, not what professionals (however well-motivated) believe they need or get. We invite the reader, at least for the time being, to do the same. (Gerteis et al., 1993, p. xviii)

As an indication of patient empowerment through accounting, the survey methodologists suggest that the patient is able to speak, without their involvement at all: “we stake no exclusive claim to the territory explored in these pages, nor do we pretend to be pioneers” (Gerteis et al., 1993, p. xxi).

This research, however, shows these optimistic scenarios of participation and empowerment to be “delayed or decayed” (Power, 1997) into the more pessimistic practicalities of an “audit” or “evaluation” society (Dahler-Larsen, 2011; Power, 1999) in which efforts to increase participation and counter medical paternalism do not lead to the remaking of knowledge from below, but to the reification of new “soft” forms of expertise in the patient or customer’s name. This research shows that the emergence of the expertise of “measurement scientists” and “quality improvement specialists” in response to a critique of professional medicine and economics experts brings back “managerial ideals about rationality, procedures, oversight and predictability [...] with a new force” (Dahler-Larsen, 2011, p. 174). Contrary to the claim that the construction of the contemporary survey involved setting professional frames aside, this research showed that it involved constituting a kind of subject-less expertise. Tying together accounting and the survey, soft and self-effacing forms of expertise allowed the patient to be simultaneously empowered and organizationally contained.

This research has drawn attention to the long shadows of accounting, as they extend beyond the organization and specific organizational sites. However, it also draws attention to, and has implications for, the practice of accounting for customers within those organizations and organizations sites. Existing research suggests that the organizational practice of customer accounting is difficult and often dysfunctional because it requires accounting to deal with

something that is fluid and local (Boyce, 2000; Mouritsen, 1997; Ogden, 1997). Vaivio (1999) even argues that customer accounting represents the limits of what accounting is capable of achieving:

Extending ever deeper into the organization's operational dimension, the new non-financial measures will probably meet the limits of what can be expected from the increasing quantification of organizational life and prevailing management practices. Systematic quantification, even when focused on non-financial measures, tends to aggregate and standardize within the spaces where it is being injected. Quantification pays little attention to the complexity of detail. But the resistance that surfaced [...] suggests that in the domain of operational management detail maintains critical significance. (p. 710)

In summary, existing research suggests that customer accounting fails when confronted with the richness and complexity of the intimate spaces represented by quality and the non-financial.

This research suggests, in contrast, that accounting might not fail in the face of such intimacy, but stand in for it. Some organizational sites may indeed be dominated by debates and conflicts about the details and imperfections of representations of quality and the customer (see, e.g., Mouritsen, 1997). This research highlights, however, that there are nonetheless large-scale programs to construct and stabilize these representations as objects of management in and of themselves. These programs, which seek to manage and improve fluid and human spaces such as quality that are seen to be timeless and essential, do not accurately represent their objects for, as with the economy, there are no underlying and invariable objects to which they might or might not correspond. Rather, they establish the metrological equipment necessary to make their objects real. This means that they can and perhaps increasingly do succeed, not through representational faithfulness, but by becoming organizationally useful and, to managers, "the one number you need to grow" (Reichheld, 2003, p. 46).

As accounting is extended into those more intimate spaces, therefore, this research calls for studies that do not assume that such spaces already exist and can be revealed through means other than accounting. It calls for studies instead that take seriously the propositions of management gurus and quality improvement specialists that measurement really is unproblematic (aside from questions of statistical significance) and that management really is

simple (aside from questions about which particular number to grow). When such research is undertaken, as it has been here, new kinds of questions about management and accounting practice emerge, such as the following: What do managers do when they really can focus on just one number? What is lost when a clear, precise, and statistically significant number is gained? How do customers communicate to professionals and organizations once everything that is organizationally useful about them is already known through accounting?

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References

- Abernethy, M. A. (1996). Physicians and resource management: The role of accounting and non-accounting controls. *Financial Accountability & Management*, 12(2), 141–156.
- Appadurai, A. (Ed.). (1986). *The social life of things: Commodities in cultural perspective*. Cambridge University Press: Cambridge MA.
- Appadurai, A. (2006). The thing itself. *Public Culture*, 18(1), 15–22.
- Armstrong, D. (1984). The patient's view. *Social Science and Medicine*, 18(9), 737–744.
- Armstrong, D. (2002) *A new history of identity: A sociology of medical knowledge*. Basingstoke and New York: Palgrave.
- Armstrong, D., Lilford, R., Ogden, J., & Wessely, S. (2007). Health-related quality of life and the transformation of symptoms. *Sociology of Health and Illness*, 29(4), 570–583.
- Beck, U. (1992). *Risk society*. London: Sage
- Beck, U. (2006). Living in the world risk society. *Economy and Society*, 35(3), 329–45.
- Bellis-Jones, R. (1989). Customer profitability analysis. *Management Accounting*, 67(2), 26–28.
- Berliner, H. S., & Salmon, J. W. (1980). The holistic alternative to scientific medicine: History and analysis. *International Journal of Health Services*, 10(1), 133–147.
- Berwick, D. M. (1989). Continuous improvement as an ideal in health care. *New England Journal of Medicine*, 320(1), 53–56.
- Berwick, D. M. (2008). The science of improvement. *Journal of the American Medical Association*, 299(10), 1182–1184.
- Berwick, D. M., Godfrey, A. B., & Roessner, J. (1990). *Curing health care: New strategies for quality improvement*. San Francisco: Jossey-Bass.
- Beryl Institute (2010). *Zeroing in on patient experience: Views and voices from the front line*. Bedford, TX: Beryl Institute.
- Beryl Institute (2011). *A report on the Beryl Institute benchmarking study: The state of patient experience in American hospitals*. Bedford, TX: Beryl Institute.
- Blumenthal, D., & Kilo, C. M. (1998). A report card on continuous quality improvement. *Milbank Quarterly*, 76(4), 625–648.
- Bolton, S. C. (2002). Consumer as king in the NHS. *International Journal of Public Sector Management*, 15(2), 129–139.
- Bourn, M., & Ezzamel, M. (1986). Costing and budgeting in the National Health Service. *Financial Accountability & Management*, 2(1), 53–71.
- Box, K., & Thomas, G. (1944). The wartime social survey. *Journal of the Royal Statistical Society*, 107(3/4), 151–189.
- Boyce, G. (2000). Valuing customers and loyalty: The rhetoric of customer focus versus the reality of alienation and exclusion of (devalued) customers. *Critical Perspectives on Accounting*, 11, 649–689.

- Brennan, T. A. (1998). The role of regulation in quality improvement. *Milbank Quarterly*, 76(4), 709–731.
- Burchell, S., Clubb, C., & Hopwood, A. G. (1985). Accounting in its social context: Towards a history of value added in the United Kingdom. *Accounting, Organizations and Society*, 10(4), 381–413.
- Cäker, M., & Strömsten, T. (2010). Customer accounting when relationships and networks matter. In H. Hakansson, K. Kraus, & J. Lind (Eds.), *Accounting in networks* (pp. 151–183). New York: Routledge.
- Carlson, M., & Klerman, G. L. (1990). Paradigm shifts in USA psychiatric epidemiology since World War II. *Social psychiatry and psychiatric epidemiology*, 25(1), 27–32.
- Cartwright, A. (1964). *Human relations and hospital care*. London: Routledge & Kegan Paul.
- Cartwright, A. (1981). Counting the dead is not enough. *The Lancet*, 318(8241), 308.
- Cartwright, A. (1983). *Health surveys in practice and potential; A critical review of their scope and methods*. London: Hollen Street Press Limited.
- Chassin M. R., Galvin. R. W., & National Roundtable on Health Care Quality (1998). The urgent need to improve health care quality: Institute of Medicine national roundtable on health care quality. *The Journal of the American Medical Association*, 280(11), 1000–1005.
- Chen, C. X., Martin, M., & Merchant, K. A. (2014). The effect of measurement timing on the information content of customer satisfaction measures. *Management Accounting Research*, 25(3), 187–205.
- Chua, W. F. (1995). Experts, networks and inscriptions in the fabrication of accounting images: a story of the representation of three public hospitals. *Accounting, Organizations and Society*, 20(2), 111–145.
- Chua, W. F., & Degeling, P. (1993). Interrogating an accounting-based intervention on three axes: Instrumental, moral and aesthetic. *Accounting, Organizations and Society*, 18(4), 291–318.
- Chua, W., & Preston, A. (1994). Worrying about accounting in health care. *Accounting, Auditing & Accountability Journal*, 7(3), 4–17.
- Cleary, P. D., Edgman-Levitan, S., Roberts, M., Moloney, T.W., McMullen, W., & Walker, J. D. (1991). Patients evaluate their hospital care: A national survey. *Health Affairs*, 10, 254–267.
- Cleary, P. D. (1998). Satisfaction may not suffice!: A commentary on “a patient's perspective.” *International Journal of Technology Assessment in Health Care*, 14(01), 35–37.
- Cleary, P. D., & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25(1): 25–36.
- Conrad, L., & Uslu, P. G. (2011). Investigation of the impact of “payment by results” on performance measurement and management in NHS trusts. *Management Accounting Research*, 22(1), 46–55.
- Converse, J. M. (2009). *Survey research in the United States: Roots and emergence, 1890-1960*. Transaction Publishers: New Brunswick USA and London UK.

- Coombs, R. W. (1987). Accounting for the control of doctors: Management information systems in hospitals. *Accounting, Organizations and Society*, 12(4), 389–404.
- Covaleski, M. A., Dirsmith, M. W., & Michelman, J. E. (1993). An institutional theory perspective on the DRG framework, case-mix accounting systems and health-care organizations. *Accounting, Organizations and Society*, 18(1), 65–80.
- Crofton, C., Lubalin, J. S., Darby, C. (1999) Foreword on the consumer assessment of health plans study. *Medical Care*, 37(3), MS1–MS9.
- Dahler-Larsen, P. (2011). *The evaluation society*. Stanford University Press: Palo Alto CA.
- Darby, C., Hays, R. D., & Kletke, P. (2005). Development and evaluation of the CAHPS® Hospital Survey. *Health Services Research*, 40(6p2), 1973–1976.
- Davies, A. R., & Ware, J. E. (1988). Involving consumers in quality of care assessment. *Health Affairs*, 7(1), 33–48.
- Delbanco, T., Berwick, D. M., Boufford, J. I., Ollenschläger, G., Plamping, D., & Rockefeller, R. G. (2001). Healthcare in a land called PeoplePower: Nothing about me without me. *Health Expectations*, 4(3), 144–150.
- Delnoij, D. M., Ten Asbroek, G., & Arah O. A. (2006). Made in the USA: The import of American Consumer Assessment of Health Plan Surveys (CAHPS) into the Dutch social insurance system. *European Journal of Public Health*, 16(6), 652–659.
- Derber, C., Magrass, Y. R., & Schwartz, W. A. (1990). *Power in the highest degree: Professionals and the rise of a new mandarin order*. Oxford University Press: Oxford.
- Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260(12), 1743–1748.
- Donabedian, A. (1992). The Lichfield Lecture. Quality assurance in health care: Consumers' role. *Quality in Health Care*, 1(4), 247–251.
- DuGay, P., & Salaman, G. (1992) The cult[ure] of the customer. *Journal of Management Studies*, 29, 615–634.
- Duncan-Jones, P., & Henderson, S. (1978). The use of a two-phase design in a prevalence survey. *Social Psychiatry*, 13, 231–237.
- Engström, Y., & Blackler, F. (2005) On the life of the object. *Organization Studies*, 12(3), 307–330.
- Epstein, A. (1995). Performance reports on quality—prototypes, problems, and prospects. *New England Journal of Medicine*, 333(1), 57–61.
- Espeland, W., & Sauder, M. (2007). Rankings and reactivity: How public measures recreate social worlds. *American Journal of Sociology*, 113(1), 1–40.
- Foot, C., Ross, S., & Lyscom, T. (2011). *How do quality accounts measure up? Findings from the first year*. London: The Kings Fund.
- Foster, G., Gupta, M., & Sjoblom L. (1996). Customer profitability analysis: Challenges and new directions. *Cost Management*, Spring, 5–17.
- Fountain, J. E. (2001). Paradoxes of public sector customer service. *Governance*, 14(1), 55–73.
- Freidson, E. (1960). Client control and medical practice. *American Journal of Sociology*, 374–382.

- Freidson, E. (1961). The organization of medical practice and patient behavior. *American Journal of Public Health and the Nation's Health*, 51(1), 43–52.
- Fuller, L., & Smith, V. (1991). Consumers' reports: Management by customers in a changing economy. *Work, Employment & Society*, 5(1), 1–16.
- Funtowicz, S. O., & Ravetz, J. R. (1990). Global environmental issues and the emergence of second order science, Report EUR 12803 EN. Luxembourg: Commission of the European Communities.
- Gerteis, M., Edgman-Levitan, S., Daley, J., & Delbanco, T. L. (1993). *Through the patient's eyes: Understanding and promoting patient-centered care*. San Francisco: Jossey-Bass.
- Gleadle, P., Haslam, C., & Yin, Y. P. (2014). Critical accounts and perspectives on financialization. *Critical Perspectives on Accounting*, 25(1), 1–4.
- Gold, M., & Wooldridge, J. (1995). Surveying consumer satisfaction to assess managed-care quality: Current practices. *Health Care Financing Review*, 16(4), 155–173.
- Graham, C. (2010). Accounting and the construction of the retired person. *Accounting, Organizations and Society*, 35(1), 23–46.
- Gray, R. (2002). The social accounting project and *Accounting, Organizations and Society*: Privileging engagement, imaginings, new accountings and pragmatism over critique? *Accounting, Organizations and Society*, 27(7), 687–708.
- Guilding, C., & McManus, L. (2002). The incidence, perceived merit and antecedents of customer accounting: An exploratory note. *Accounting, Organizations and Society*, 27(1), 45–59.
- Guzman, P. M., Sliepcevich, E. M., Lacey, E. P., Vitello, E. M., Matten, M. R., Woehlke, P. L., & Wright, W. R. (1988). Tapping patient satisfaction: A strategy for quality assessment. *Patient Education and Counseling*, 12(3), 225–233.
- Hacking, I. (1986). Making up people. In T. Heller, M. Sosna, and D. Wellbery (Eds.), *Reconstructing individualism* (pp. 222–236). Stanford University Press: Stanford CA.
- Hacking, I. (1999). *The social construction of what?* Harvard University Press: Cambridge MA.
- Halsey, A. H. (2004). *A history of sociology in Britain: Science, literature and society*. Oxford University Press.
- Hannay, D. R. (1979). *The symptom iceberg: A study of community health*. London: Routledge & Kegan Paul: Oxford.
- HCAHPS (2012). *HCAHPS Fact Sheet. May 2012*. Retrieved January 9, 2013, from <http://www.hcahpsonline.org/files/HCAHPS%20Fact%20Sheet%20May%202012.pdf>
- Helgesen, Ø. (2007). Customer accounting and customer profitability analysis for the order handling industry—A managerial accounting approach. *Industrial Marketing Management*, 36(6), 757–769.
- Henderson, S., & Petersen, A. R. (2002). *Consuming health: The commodification of health care*. Psychology Press.
- Henderson, S., Duncan-Jones, P., Byrne, D.G., Scott, R., & Adcock, S. (1979). Psychiatric disorder in Canberra. A standardized study of prevalence. *Acta Psychiatrica Scandinavica*, 60(4), 355–374.

- Higgins, P. (1965). Human relations and hospital care, book review. *Medical Care*, 3(2), 128.
- Hollingshead A., & Redlich F. (1958). *Social class and mental illness*. New York: Wiley.
- Hood, C., & Peters, G. (2004). The middle aging of new public management: Into the age of paradox? *Journal of Public Administration Research and Theory*, 14(3), 267–282.
- Hopwood, A. G. (1987). The archeology of accounting systems. *Accounting, Organizations and Society*, 12(3), 207–234.
- Hopwood, A. G. (1990). Accounting and organisation change. *Accounting, Auditing & Accountability Journal*, 3(1).
- Institute of Medicine. (1999). *Measuring the quality of health care*. Washington, DC: The National Academies Press.
- Institute of Medicine. (1999b). *To err is human: Building a safer healthcare system*. Washington, DC: National Academies Press.
- Ittner, C. D., & Larcker, D. F. (1998). Are nonfinancial measures leading indicators of financial performance? An analysis of customer satisfaction. *Journal of Accounting Research*, 36(supplement): 1–35.
- Jasanoff, S. (2003). Technologies of humility: Citizen participation in governing science. *Minerva*, 41(3), 223–244.
- Jeacle, I. (2003). Accounting and the construction of the standard body. *Accounting, Organizations and Society*, 28(4), 357–377.
- Jeacle, I., & Carter, C. (2011). In TripAdvisor we trust: Rankings, calculative regimes and abstract systems. *Accounting, Organizations and Society*, 36(4), 293–309.
- Jobe, J., & Mingay, D. (1991). Cognition and survey measurement: History and overview. *Applied Cognitive Psychology*, 5, 175–192.
- Johnson, H. T. (1994). Relevance regained: Total quality management and the role of management accounting. *Critical Perspectives on Accounting*, 5(3), 259–267.
- Jones, E., Woolven, R., Durodie, B., & Wessely, S. (2006). Public panic and morale: Second World War civilian response re-examined in the light of the current anti-terrorist campaign. *Journal of Risk Research*, 9(1), 57–73.
- Kelly, J. M. (2005). The dilemma of the unsatisfied customer in a market model of public administration. *Public Administration Review*, 65(1), 76–84.
- Kennedy, E. M. (1971). Measurement of quality in medical care. *New England Journal of Medicine*, 285(24), 1381.
- Kirkpatrick, I., & Martinez-Lucio, M. (1995). *The politics of quality in the public sector: The management of change*. London and New York: Routledge.
- Klerman, G. (1986). The National Institute of Mental Health–Epidemiologic Catchment Area (NIMH–ECA) program. *Social Psychiatry*, 21(4), 159–166.
- Koos, E. L. (1954). *The health of Regionville, what the people thought and did about it*. New York: Columbia University Press.
- Kurunmäki, L. (1999). Professional vs financial capital in the field of health care—struggles for the redistribution of power and control. *Accounting, Organizations and Society*, 24(2), 95–124.

- Kurunmäki, L., & Miller, P. (2006). Modernising government: The calculating self, hybridisation and performance measurement. *Financial Accountability & Management*, 22(1), 87–106.
- Laffel, G., & Blumenthal, D. (1993). The case for using industrial quality management science in health care organizations. In A. Al-Assaf & J. Schmele (Eds.), *The textbook of total quality in healthcare* (pp. 40–51). Boca Raton: CRC Press.
- Lake, T., Kvam, C., & Gold, M. (2005). *Literature review: Using quality information for health care decisions and quality improvement* (final report to the Department of Health and Human Services). Cambridge, MA: Mathematica Policy Research Inc.
- Lapsley, I. (2001). Accounting, modernity and health care policy. *Financial Accountability and Management*, 17(4), 331–350.
- Larsen, D. E., & Rootman, I. (1976). Physician role performance and patient satisfaction. *Social Science and Medicine*. 10(1), 29–32.
- Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Harvard University Press: Cambridge MA.
- Latour, B., & Woolgar, S. (2013). *Laboratory life: The construction of scientific facts*. Princeton University Press: Princeton NJ.
- Lazarsfeld, P. (1949). The American soldier—An expository review. *Public Opinion Quarterly*, 13(3), 377–404.
- Leblow, J. (1974). Consumer assessments of the quality of medical care. *Medical Care*, 12(4), 328–337.
- Legido-Quigley, H. (2008). *Assuring the quality of health care in the European Union: A case for action* (No. 12). World Health Organization: Geneva.
- LeGrand, J. (1999). Competition, cooperation, or control? Tales from the British National Health Service. *Health Affairs*, 18(3), 27–39.
- Levy, S. M., & Howard, J. (1982). Patient-centric technologies. T. Boll and R. Rozensky (Eds.) *Handbook of clinical health psychology* (pp. 561–585). Springer.
- Linder-Pelz, S. (1982). Toward a theory of patient satisfaction. *Social Science & Medicine*, 16(5), 577–582.
- Llewellyn, S. (1998). Boundary work: Costing and caring in the social services. *Accounting, Organizations and Society*, 23(1), 23–47.
- Llewellyn, S., & Northcott, D. (2005). The average hospital. *Accounting, Organizations and Society*, 30(6), 555–583.
- Locker, D., & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. *Social Science and Medicine. Part A: Medical Psychology and Medical Sociology*, 12, 283–292.
- Loft, A. (1986). Towards a critical understanding of accounting: The case of cost accounting in the UK, 1914–1925. *Accounting, Organizations and Society*, 11(2), 137–169.
- Lohr, K. N (1985). *Peer review organizations; quality assurance in Medicare*. RAND Corporation. Retrieved June, 2013, from <http://www.rand.org/content/dam/rand/pubs/papers/2008/P7125.pdf>

- Lohr, K. N. (1990). *Medicare: A strategy for quality assurance* (Vol. 1). Washington, DC: National Academies Press.
- Malmlose, M. (2012). *The role of management accounting in new public management reforms: Implications in a socio-political health care context* (PhD Thesis, Aarhus University). Aarhus, Denmark.
- Marsh, C. (1982). *The survey method: The contribution of surveys to sociological exploration*. London: George, Allen and Unwin.
- Marshall, M., Shekelle, P. G., Leatherman, S., & Brook, R. H. (2000). Public release of performance data. What do we expect to gain? A review of the evidence. *Journal of the American Medical Association*, 283, 1866–1874.
- McGee, J., Kanouse, D. E., Sofaer, S., Hargraves, J. L., Hoy, E., & Kleimann, S. (1999). Making survey results easy to report to consumers: How reporting needs guided survey design in CAHPS™. *Medical Care*, 37(3), MS32–MS40.
- McKeown, T. (1979) *The role of medicine: Dream, mirage or nemesis?* Oxford: Basil Blackwell.
- McLachlan, G., Godber, G. E., & Nuffield Provincial Hospital Trust. (1976). *A question of quality?: Roads to assurance in medical care*. London: Nuffield Hospital Trust.
- McMillan J. R. (1987). Measuring consumer satisfaction to improve quality of care. *Health Progress*, 6876-80
- Mechanic, D., & Volkart, E. H. (1960). Illness behavior and medical diagnoses. *Journal of Health and Human Behavior*, 86–94.
- Menninger, W. W. (1975). Caring as part of health care quality. *Journal of the American Medical Association*, 234(8), 836–837.
- Merton, R.K., Fiske, M., & Curtis, A. (1946). *Mass persuasion: The social psychology of a war bond drive*. Harper and University of Michigan Press.
- Meterko, M., Nelson, E., & Rubin, H. (1990). Patient judgments of hospital quality: Report of a pilot study. *Medical Care*, 28(9), S1–S56.
- Meyer, C., & Schwager, A. (2007). Understanding customer experience. *Harvard Business Review*. 85(2):116-26.
- Miller, D. (Ed.) (2005). *Materiality*. Durham and London: Duke University Press.
- Miller, P. (1991). Accounting innovation beyond the enterprise: Problematizing investment decisions and programming economic growth in the UK in the 1960s. *Accounting, Organizations and Society*, 16(8), 733–762.
- Miller, P. (1998). The margins of accounting. *European Accounting Review*, 7(4), 605–621.
- Miller, P., & Napier, C. (1993). Genealogies of calculation. *Accounting, Organizations and Society*, 18(7), 631–647.
- Miller, P., & O’Leary, T. (1987). Accounting and the construction of the governable person. *Accounting, Organizations and Society*, 12(3), 235–265.
- Miller, P., & O’Leary, T. (1994). Accounting, “economic citizenship” and the spatial reordering of manufacture. *Accounting, Organizations and Society*, 19(1), 15–43.

- Miller, P., & Power, M. (2013). Accounting, organizing, and economizing: Connecting accounting research and organization theory. *Academy of Management Annals*, 7(1), 557–605.
- Miller, P., & Rose, N. (2008). *Governing the present: Administering economic, social and personal life*. Polity: London.
- Miller, P., Hopper, T., & Laughlin, R. (1991). The new accounting history: An introduction. *Accounting, Organizations and Society*, 16(5), 395–403.
- Milstein, A., Galvin, R., Delbanco, S., Salber, P., & Buck, C. (2000). Improving the safety of health care: The leapfrog initiative. *Effective Clinical Practice*, 6, 313–316.
- Mold, A. (2010). Patient groups and the construction of the patient-consumer in Britain: An historical overview. *Journal of Social Policy*, 39(4), 505–521.
- Mouritsen, J. (1997). Marginalizing the customer: Customer orientation, quality and accounting performance. *Scandinavian Journal of Management*, 13(1), 5–18.
- Munro, R. (1995). Governing the new province of quality: Autonomy, accounting and the dissemination of accountability. In A. Wilkinson & H. Willmott (Eds.), *Making quality critical: New perspectives of organisational change* (pp. 127-155). London: Routledge.
- Munro, R., & Kernan, D. (1993). *Governing the new province of quality: From presentation of economic reality to re-presenting the customer*. Presentation at the 11th International SCOS Conference on Organizational Symbolism, Organizations, and Symbols of Transformation, Barcelona, Spain. EADA-Collbato.
- Munro, R., & Hatherly, D. (1993). Accountability and the new commercial agenda. *Critical Perspectives on Accounting*, 4(4), 369–395.
- Napier, C. J. (2001). Accounting history and accounting progress. *Accounting History*, 6(2), 7–31.
- Napier, C. J. (2006). Accounts of change: 30 years of historical accounting research. *Accounting, Organizations and Society*, 31(4), 445–507.
- Nelson, C. W., & Niederberger, J. (1990). Patient satisfaction surveys: An opportunity for total quality improvement. *Journal of Healthcare Management*, 35(3), 409.
- Nyland, K., & Pettersen, I. J. (2004). The control gap: The role of budgets, accounting information and (non-) decisions in hospital settings. *Financial Accountability & Management*, 20(1), 77–102.
- Office of Technology Assessment (OTA). (1988). *The quality of medical care: Information for consumers*. US Congress, OTA: Washington DC.
- Ogden, S. G. (1997). Accounting for organizational performance: The construction of the customer in the privatized water industry. *Accounting, Organizations and Society*, 22(6), 529–556.
- Organization of Economic Cooperation and Development (OECD). (2008). *National and cross-national surveys of patient experience: A structured review*. Retrieved December 2013, from <http://www.oecd.org/health/health-systems/39493930.pdf>
- Osborne, D. (1993). Reinventing government. *Public Productivity & Management Review*, 16(4): 349–356.
- Osborne, T., & Rose, N. (1999). Do the social sciences create phenomena?: The example of public opinion research. *British Journal of Sociology*, 50(3), 367–396.

- Øvretveit, J. (2000). Total quality management in European healthcare. *International Journal of Health Care Quality Assurance*, 13(2), 74–80.
- Øvretveit, J., & Gustafson, D. (2002). Evaluation of quality improvement programmes. *Quality and Safety in Health Care*, 11(3), 270–275.
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: A literature review and analysis. *Evaluation and Program Planning*, 6(3), 185–210.
- Peters, T. J., Waterman, R. H., & Jones, I. (1982). In search of excellence: Lessons from America's best-run companies. Harper Collins: New York.
- Pfeffer, N., & Coote, A. (1991). *Is quality good for you?: A critical review of quality assurance in welfare services* (No. 5). Institute for Public Policy Research: London.
- Pine, B. J., & Gilmore, J. H. (1998). Welcome to the experience economy. *Harvard Business Review*, 76, 97–105.
- Platt, J. (1996). *A history of sociological research methods in America*. New York: Cambridge University Press.
- Pollock, N., & D'Adderio, L. (2012). Give me a two-by-two matrix and I will create the market: Rankings, graphic visualisations and sociomateriality. *Accounting, Organizations and Society*, 37(8), 565–586.
- Pols, H., & Oak, S. (2007). War and military mental health: The US psychiatric response in the 20th century. *American Journal of Public Health*, 97(12), 2132–2142.
- Porter, R. (1999). *The greatest benefit to mankind: A medical history of humanity from antiquity to the present*. London: Fontana Press.
- Power, M. (1996). Making things auditable. *Accounting, Organizations and Society*, 21(2–3), 284–315.
- Power, M. (1997). From risk society to audit society. *Soziale systeme*, 3(1), 3–21.
- Power, M. (1999). *The audit society: Rituals of verification*. Oxford University Press: Oxford.
- Power, M. (2007). *Organized uncertainty. Designing a world of risk management*. Oxford University Press: Oxford.
- Power, M. (2015). How accounting begins: Object formation and the accretion of infrastructure. *Accounting, Organizations and Society*, 47: 43–55.
- Preston, A. M. (1992). The birth of clinical accounting: A study of the emergence and transformations of discourses on costs and practices of accounting in US hospitals. *Accounting, Organizations and Society*, 17(1), 63–100.
- Preston, A. M., Chua, W. F., & Neu, D. (1997). The diagnosis-related group-prospective payment system and the problem of the government of rationing health care to the elderly. *Accounting, Organizations and Society*, 22(2), 147–164.
- Preston, A. M., Cooper, D. J., & Coombs, R. W. (1992). Fabricating budgets: A study of the production of management budgeting in the National Health Service. *Accounting, Organizations and Society*, 17(6), 561–593.
- Price, R. A., Elliott, M. N., Cleary, P. D., Zaslavsky, A. M., & Hays, R. D. (2014). Should health care providers be accountable for patients' care experiences? *Journal of General Internal Medicine*, 30(2), 253–256.

- Rawson, A., Duncan, E., & Jones, C. (2013). The truth about customer experience. *Harvard Business Review*, 91(9), 90–98.
- Reichheld, F. F. (2003). The one number you need to grow. *Harvard Business Review*, 81(12), 46–55.
- Roberts, J. (1991). The possibilities of accountability. *Accounting, Organizations and Society*, 16(4), 355–368.
- Robson, K. (1991). On the arenas of accounting change: The process of translation. *Accounting, Organizations and Society*, 16(5), 547–570.
- Rogers, G., & Smith, D. P. (1999). Methodology matters. Reporting comparative results from hospital patient surveys. *International Journal for Quality in Health Care*, 11(3), 251–259.
- Romano, P. S., & Mutter, R. (2004). The evolving science of quality measurement for hospitals: Implications for studies of competition and consolidation. *International Journal of Health Care Finance and Economics*, 4(2), 131–157.
- Rose, N. (1996). *Inventing our selves: Psychology, power and personhood*. New York: Cambridge University Press.
- Rosenheck, R., Wilson, N., & Meterko, M. (1997). Influence of patient and hospital factors on consumer satisfaction with inpatient mental health treatment. *Psychiatric Services*, 12, 1553–1561.
- Safran, D. G., Kosinski, M., Tarlov, A. R., Rogers, W. H., Taira, D. A., Lieberman, N., & Ware, J. E. (1998). The Primary Care Assessment Survey: Tests of data quality and measurement performance. *Medical Care*, 36(5), 728–739.
- Samuel, S., Dirsmith, M. W., & McElroy, B. (2005). Monetized medicine: From the physical to the fiscal. *Accounting, Organizations and Society*, 30(3), 249–278.
- Scanlon D. P., Chernew, M. E., McLaughlin, C. G., & Solon, G. (2002). The impact of health plan report cards on managed care enrolment. *Journal of Health Economics*, 21, 19–41.
- Schneider, E. C., & Lieberman, T. (2001). Publicly disclosed information about the quality of health care: Response of the US public. *Quality in Health Care*, 10(2), 96–103.
- Schwarzkopf, S. (2009). The “consumer jury”: Historical origins and social consequences of a marketing myth. *CHARM*.
- Scott, R., Reuf, M., Mendel, P., & Caronna, C. (2000). *Institutional change and healthcare organizations: From professional dominance to managed care*. Chicago: University of Chicago Press.
- Scott, S. V., & Orlikowski, W. J. (2012). Reconfiguring relations of accountability: Materialization of social media in the travel sector. *Accounting, Organizations and Society*, 37(1), 26–40.
- Shortell, S. M., Bennett, C. L., & Byck, G. R. (1998). Assessing the impact of continuous quality improvement on clinical practice: What it will take to accelerate progress. *Milbank Quarterly*, 76(4), 593–624.
- Sidel, V. W. (1966). Evaluation of the quality of medical practice. *Journal of the American Medical Association*, 198(7), 763.

- Skolnick, A. A. (1998). JCAHO, NCQA, and AMAP establish council to coordinate health care performance measurement. *Journal of the American Medical Association*, 279(22), 1769–1770.
- Smith, P. C. (2009). *Performance measurement for health system improvement: Experiences, challenges and prospects*. Cambridge University Press: Cambridge, MA.
- Srole, L., Langner, T. F., Michael, S. T., Kirkpatrick, P., Opler, M. K., & Rennie, T. A. C. (1962). *Mental health in the metropolis: The Midtown Manhattan Study* (Vol. 1). New York: McGraw Hill.
- Stamps, P. L., & Finkelstein, J. B. (1981). Statistical analysis of an attitude scale to measure patient satisfaction with medical care. *Medical Care*, 19(11), 1108–1135.
- Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.
- Stone, C. L., & Banks, J. M. (1997). The use of customer- and employee-based performance measures in top 500 companies. *The TQM Magazine*, 9(2), 152–158.
- Susser, M. (1985). Epidemiology in the United States after World War II: The evolution of technique. *Epidemiology Reviews*, 7, 147–177.
- Tanur, J. (1992). *Questions about questions: Inquiries into the cognitive bases of surveys*. New York: Russell Sage Foundation.
- Thunhurst, C., & MacFarlane, A. (1992). Monitoring the health of urban populations: What statistics do we need? *Journal of the Royal Statistical Society. Series A (Statistics in Society)*, 317–352.
- Timmermans, S., & Berg, M. (2003). *The gold standard: The challenge of evidence-based medicine and standardization in health care*. Philadelphia: Temple University Press.
- Vaivio, J. (1999). Examining “the quantified customer”. *Accounting, Organizations and Society*, 24(8), 689–715.
- Vaivio, J. (2006). The accounting of “the meeting”: Examining calculability within a “fluid” local space. *Accounting, Organizations and Society*, 31(8), 735–762.
- Van Peurse, K. A., Prat, M. J., & Lawrence, S. R. (1995). Health management performance: A review of measures and indicators. *Accounting, Auditing & Accountability Journal*, 8(5), 34–70.
- Vuori, H. (1991). Patient satisfaction—Does it matter? *International Journal for Quality in Health Care*, 3(3), 183–189.
- Wadsworth, M. E. J., Butterfield, W. J. H., & Roger, B. (1971). *Health and sickness: The choice of treatment: Perception of illness and use of services in an urban community*. Tavistock Publications: London.
- Ware, J. E., Davies-Avery, A., & Stewart, A. L. (1977). *The measurement and meaning of patient satisfaction: A review of the literature*. Rand Corporation: Santa Monica CA.
- Ware, J. E., Snyder, M. K., Wright, W. R., & Davies, A. R. (1983). Defining and measuring patient satisfaction with medical care. *Evaluation and Program Planning*, 6(3), 247–263.
- Watkins, A. L., & Arrington, C. E. (2007). Accounting, new public management and American politics: Theoretical insights into the National Performance Review. *Critical Perspectives on Accounting*, 18(1), 33–58.

- Wisniewski, M. (2001). Using SERVQUAL to assess customer satisfaction with public sector services. *Managing Service Quality*, 11(6), 380–388.
- Wolf, J.A., & Prince, D. (2014) The chief experiences officer - An emerging role. Bedford, TX: The Beryl Institute.
- Zaslavsky, A. M., Zaborski, L., Ding, J., Shaul, M., Cioffi, & Cleary, P. D. (2001). Adjusting performance measures to ensure equitable plan comparisons. *Health Care Financing Review*, 22(3), 109–126.
- Zola, I. K. (1966). Culture and symptoms—an analysis of patients’ presenting complaints. *American Sociological Review*, 615–630.

Figure 1:

	View Graphs View More Details	SADDLEBACK MEMORIAL MEDICAL CENTER 24451 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653 (949) 837-4500 Add to my Favorites Map and Directions	MISSION HOSPITAL REGIONAL MED CENTER 27700 MEDICAL CENTER RD MISSION VIEJO, CA 92691 (949) 364-1400 Add to my Favorites Map and Directions	ORANGE COAST MEMORIAL MEDICAL CENTER 9920 TALBERT AVENUE FOUNTAIN VALLEY, CA 92708 (714) 378-7406 Add to my Favorites Map and Directions
Patients who reported that their nurses "Always" communicated well.		72%	76%	73%
Patients who reported that their doctors "Always" communicated well.		76%	79%	77%
Patients who reported that they "Always" received help as soon as they wanted.		56%	56%	61%
Patients who reported that their pain was "Always" well controlled.		69%	72%	68%
Patients who reported that staff "Always" explained about medicines before giving it to them.		55%	59%	58%
Patients who reported that their room and bathroom were "Always" clean.		69%	73%	71%
Patients who reported that the area around their room was "Always" quiet at night.		42%	50%	49%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.		81%	79%	79%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).		65%	75%	69%
Patients who reported YES, they would definitely recommend the hospital.		70%	80%	74%

Figure 2:

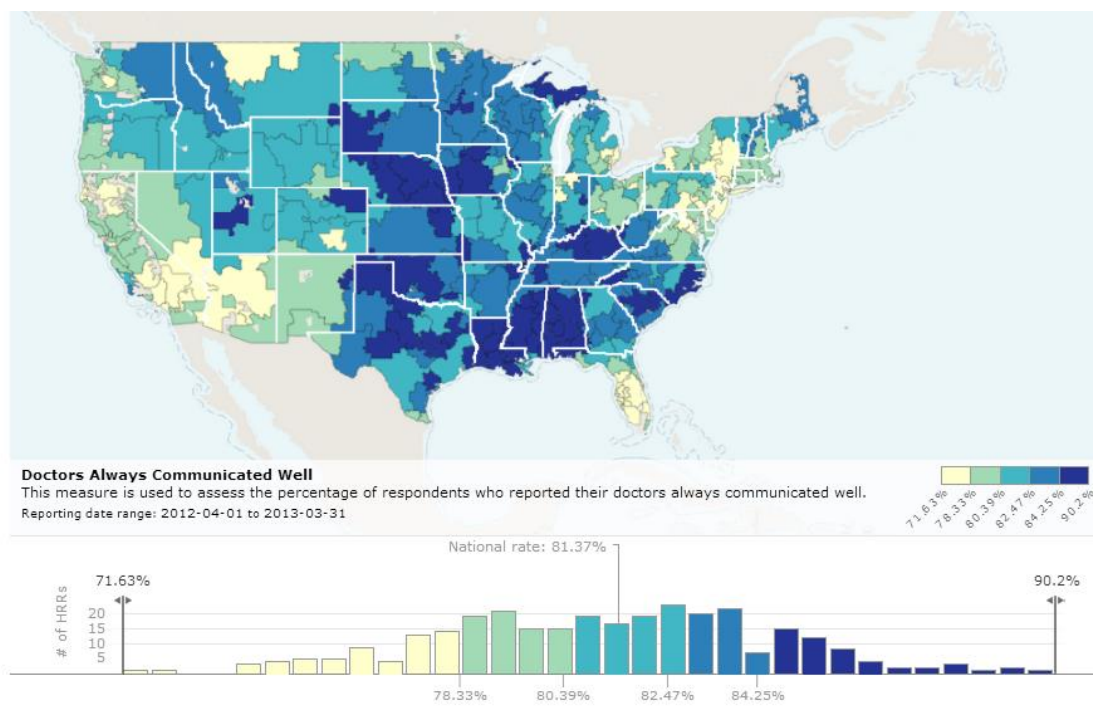


Figure 3:

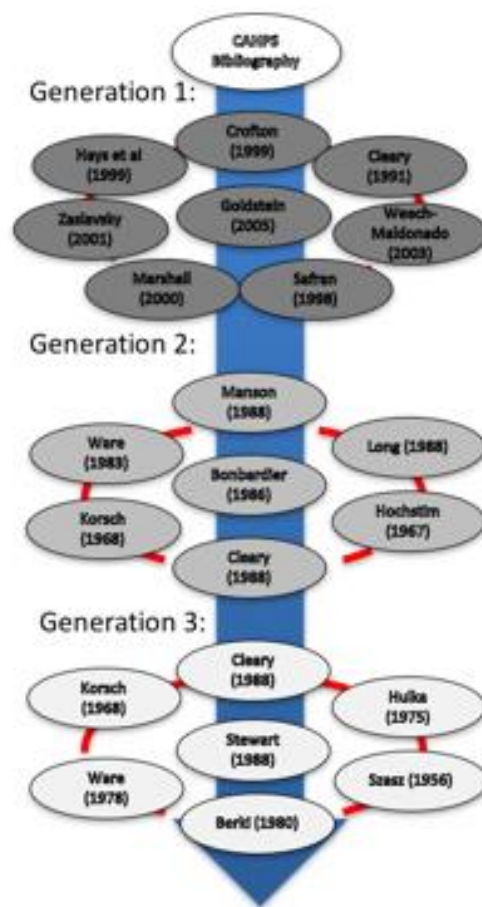


Figure 4:

R25-3. Childhood health poor
 R25-8. Birth defects _____
 R26-5. Childhood trouble—sleep
 R26-9. Childhood trouble—stammer or stutter
 R27-1. Childhood trouble—upset stomach fairly often
 Childhood Fears of
 R27 Strangers 6. Little 7. Much
 R28 Thunder 2. Little 3. Much
 R28 Being left alone 8. Little 9. Much
 R29 High Places 2. Little 3. Much
 R29 Animals 8. Little 9. Much
 R30 Being laughed at 2. Little 3. Much
 R31 Being bawled out 2. Little 3. Much
 R45-2. Is worrying type
 B11-1. Dated opposite sex more often than others did 2. About same 3. Less often
 B14-7. Liked school very much 8. All right 9. Disliked 0. Hated
 G5-1. One should do everything perfectly
 G5-5. One drink is one too many
 G5-9. Never show feelings to others
 G6-1. Never change mind
 G6-5. Always be on guard with people
 G7-1. Often, old ways are best ways
 G7-5. Prefer to go out by myself
 G7-9. Feel somewhat apart even among friends

Figure 5:

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I'm very satisfied with the medical care I receive	1	2	3	4	5

Figure 6:

VALIDATED ITEM GROUPINGS FOR PSQ SUBSCALES

Dimension/Item Grouping	Item Number
Access to care (nonfinancial)	
1. Emergency care	19, 37, 48
2. Convenience of services	12, 43
3. Access	18, 31
Financial aspects	
4. Cost of care	14, 24, 49, 63
5. Payment mechanisms	4, 20, 36, 56
6. Insurance coverage	9, 21, 38
Availability of resources	
7. Family doctors	53, 67
8. Specialists	7, 32
9. Hospitals	42, 61
Continuity of care	
10. Family	8, 65
11. Self	5, 23
Technical Quality	
12. Quality/competence	3, 6, 17, 25, 30, 34, 50, 51, 60
13. Prudence-Risks	47, 54
14. Doctor's facilities	10, 40
Interpersonal manner	
15. Explanations	28, 62, 66
16. Consideration	22, 26, 29, 39, 55
17. Prudence-Expenses	33, 68
Overall satisfaction	
18. General satisfaction	1, 16, 45, 58

Note. Source: Adapted from Figure 21 in Ware, Snyder, and Wright (1976a), p. 196.

Figure 7:

ITEMS IN FORM II OF THE PSQ

Item Number	Item Content
1*	I'm very satisfied with the medical care I receive.
2	Doctors let their patients tell them everything that the patient thinks is important
3*	Doctors ask what foods patients eat and explain why certain foods are best.
4*	I think you can get medical care easily even if you don't have money with you.
5*	I hardly ever see the same doctor when I go for medical care.
6*	Doctors are very careful to check everything when examining their patients.
7	We need more doctors in this area who specialize.
8*	If more than one family member needs medical care, we have to go to different doctors.
9*	Medical insurance coverage should pay for more expenses than it does.
10*	I think my doctor's office has everything needed to provide complete medical care.
11	Doctors never keep their patients waiting, even for a minute.
12*	Places where you can get medical care are very conveniently located.
13	Doctors act like they are doing their patients a favor by treating them.
14*	The amount charged for medical care services is reasonable.
15	Doctors always tell their patients what to expect during treatment.
16*	Most people receive medical care that could be better.
17	Most people are not encouraged to get a yearly exam when they go for medical care.
18*	If I have a medical question, I can reach someone for help without any problem.
19*	In an emergency, it's very hard to get medical care quickly.
20	I can arrange for payment of medical bills later if I'm short of money now.
21*	I am happy with the coverage provided by medical insurance plans.
22*	Doctors always treat their patients with respect.
23*	I see the same doctor just about every time I go for medical care.
24	The amount charged for lab tests and x-rays is extremely high.
25*	Doctors don't advise patients about ways to avoid illness or injury.
26*	Doctors never recommend surgery (an operation) unless there is no other way to solve the problem.
27	Doctors hurt many more people than they help.
28*	Doctors hardly ever explain the patient's medical problems to him.
29*	Doctors always do their best to keep the patient from worrying.
30*	Doctors aren't as thorough as they should be.
31*	It's hard to get an appointment for medical care right away.
32*	There are enough doctors in this area who specialize.
33*	Doctors always avoid unnecessary patient expenses.
34*	Most people are encouraged to get a yearly exam when they go for medical care.
35*	Office hours when you can get medical care are good for most people.
36*	Without proof that you can pay, it's almost impossible to get admitted to the hospital.
37	People have to wait too long for emergency care.

Figure 8:

Your Health Care in the Last 6 Months

4. In the last 6 months, when you **needed care right away**, how often did you get care as soon as you thought you needed?

- 1 ☐ Never
 2 ☐ Sometimes
 3 ☐ Usually
 4 ☐ Always

6. In the last 6 months, **not** counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

Your Personal Doctor

11. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

12. In the last 6 months, how often did your personal doctor listen carefully to you?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

13. In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

14. In the last 6 months, how often did your personal doctor spend enough time with you?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

Your Health Plan

23. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

24. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- ¹ ☐ Never
² ☐ Sometimes
³ ☐ Usually
⁴ ☐ Always

Figure 9:

