

How do rural consumers contribute to quality assurance of health services?

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Abstract

Objective: To investigate the reasons for complaint or non-complaint by rural consumers of health services.

Design: Qualitative study using focus group discussion of hypothetical scenarios.

Setting: Selected rural communities in the Loddon-Mallee region of north-western Victoria.

Participants: Sixty volunteer participants in eight focus groups recruited through advertising.

Main outcome measure: Issues and themes concerning circumstances leading to, and factors inhibiting, complaints about a health service and awareness of complaints mechanisms.

Results: Compared with residents of larger towns, those of small communities were more likely to report they would complain to the local provider, whereas those in larger towns were more likely to mention Hospital Boards or the Commissioner. Deterrents to making complaints included the lack of services, scepticism about the role of complaints in bringing about change and an attitude that it was more appropriate to try to fix the problem than complain about it. Lack of awareness of appropriate complaint mechanisms which feed into quality assurance processes was also identified.

What is known about the topic?

Rural residents do not make as many complaints about health care services as metropolitan residents, although the reasons are not clear.

What does this paper add?

This study shows that rural consumers generally seem unaware of the complaint mechanisms that could provide feedback into the health service system's quality assurance processes and outlines the reasons why they may be reluctant to complain.

What are the implications for practitioners?

Health service providers and regulatory authorities should not interpret under-representation of complaints from rural communities as meaning greater consumer satisfaction with existing health care services. Better processes are required to ensure effective consumer participation in mechanisms designed to assure rural communities of quality health care services. These include approaches which inform rural residents of the options available to them for making complaints and how complaints are used in a quality assurance cycle.

Conclusions: Previously documented lower complaint rates from rural consumers can not be taken to mean greater satisfaction with health services.

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HEALTH CARE QUALITY assurance processes form an integral part of the Australian health care system, and consumer participation in quality definition, monitoring and feedback is a national priority within the health system^{1,2} Complaints about the health system (when responded to in ways which focus on quality improvement rather than allocation of blame) can be used to provide opportunities to improve the quality of health services for all consumers.^{1,3,4} If all consumers have equal access to opportunities to make com-

I Characteristics of communities where focus groups were held

Community	Population size	Distance from Melbourne (km)	Complaints rate*
1	< 1000	< 350	low
2	< 1000	> 350	medium
3	< 1000	< 350	high
4	< 1000	> 350	high
5	1000 – < 5000	< 350	low
6	1000 – < 5000	< 350	medium
7	> 10 000	< 350	low
8	> 10 000	> 350	low

*Complaints rate is the percentage of complaints per capita made to the Health Services Commission over a 13 year period, where low = < 0.5%; medium = 0.5 to 1%; high = > 1%.

plaints then it can be assumed that a lower complaint rate implies greater satisfaction with quality of health care and services. However, when lower numbers of complaints are a result of inadequate access to complaints mechanisms, unsatisfactory care may persist.

Complaints made by vulnerable or disadvantaged consumers are particularly significant, as these complainants are often those most in need of improved services. These groups include those living in rural and remote areas. Rural populations suffer health and medical workforce shortages, lower utilisation rates for medical services, and generally poorer health status compared with metropolitan residents.⁵⁻¹⁰ Access to primary care services is particularly important for residents of rural and remote communities facing problems of limited availability and choice of health services.¹¹⁻¹³ In the absence of adequate quality assurance mechanisms and equitable access to complaints management processes, the risk of sub-optimal care in rural communities persists.

In 2001, almost one million Victorians lived in communities with fewer than 10 000 residents and their surrounding rural hinterlands. An analysis of 23 000 records of enquiries made by

people throughout Victoria to the Health Services Commissioner (HSC) between 1988–2001 revealed a 25% under-representation of rural complaints,¹⁴⁻¹⁵ suggesting that rural residents may be less dissatisfied or less willing to express dissatisfaction with their health care services than metropolitan residents. The analysis also revealed differences in the issues of complaints by location, with rural residents making relatively more complaints about communication, rights and access issues, and fewer about treatment than metropolitan residents.

This study forms part of a larger investigation into the role of complaints in quality assurance related to the provision of health services in rural communities. This paper investigates possible reasons for the relatively low rates of rural complaints to the HSC — whether it represents greater satisfaction with health care services, greater reluctance to complain, or lack of access to complaints mechanisms through which to express concerns. The specific objectives of this research were:

- to identify the circumstances under which a complaint would or would not be made by rural health consumers;
- to identify what factors would inhibit or deter rural health consumers from making a complaint; and
- to identify rural health consumers' awareness of health services complaints mechanisms.

Methods

Structured consumer focus groups were conducted in eight rural communities throughout the Loddon-Mallee region of north-western Victoria. To capture the diversity characterising rural communities, a sample of all communities in the region was selected on the basis of three main characteristics — population size, complaints rate, and distance from Melbourne (Box 1). A previous audit of the availability of local health services (measured in terms of the number of doctors, hospitals, emergency services and allied health specialists)¹⁶ showed a close relationship with population size, with

the smallest towns having fewest local health services.

Focus group participants were sought to ensure representation of rural groups most in need of, or using, health care services, such as young families, women and elderly people. Extensive advertising was undertaken in local media (both newspapers and radio), school newsletters, and through flyers displayed on community noticeboards and shop windows, to maximise the opportunities for recruiting representative rural consumers.

The focus groups were run for about 2 hours either in the morning or afternoon in each town. Notes were taken independently by two observers, and each session was audio-recorded for further analysis. The full range of responses and whether a consensus view was reached were noted.

To identify their level of satisfaction with services and the circumstances that would lead to a complaint, focus group participants were presented with several scenarios. These scenarios were developed by the HSC, based on actual

2 Scenarios presented to focus groups

Scenario 1 — Patient access to appropriate services

A woman took her child to the emergency department of her local hospital after her local general practitioner clinic was closed. The child had been vomiting and in pain for some hours that day. The nurse on duty examined the patient and recorded normal vital signs (blood pressure and temperature) and noted the patient was pale. She then called the local doctor on roster for that evening and discussed the patient with him. The GP advised the nurse to tell the patient to go home, take Panadol and attend the clinic when it opened in the morning. The mother and patient went home. During the night the pain increased and family members, not wanting to go back to the local hospital, took the child to a hospital more than 30 kilometres away. The patient was admitted for observation and the next day was operated on for appendicitis, after which she made a full recovery.

Scenario 2 — Provider communication with patients

A family had visited the same GP clinic for many years and had made special arrangements with the doctor they liked and trusted to pay their accounts over extended periods whenever circumstances required this. They had always paid the accounts in full whenever they could. When the doctor retired he was replaced by a younger doctor who wanted to make the accounts system more efficient. This doctor advised all the patients that accounts for anyone with a health care card would be bulk billed but everyone else would need to settle accounts promptly. The family arranged to see the doctor as they wanted to discuss their financial situation. In the meeting the doctor seemed very curt and dismissive and advised the family if they did not like the terms they were free to seek their medical care elsewhere. The next doctor is 30 kilometres away and the family does not have access to a car.

Scenario 3 — Patient treatment

A young woman had attended her local GP since she was a child and had developed a friendship as well as trust with the doctor and her family. She consulted her after she had severe back pain over several weeks that had not resolved. The doctor examined her briefly, decided she had strained her back playing sport and prescribed non steroidal anti-inflammatory medication. They concluded the consultation by discussing a local wedding they had both attended. The pain continued and the doctor reassured the woman but eventually agreed to send her to a specialist for an opinion. It was found she had crushed vertebrae that required surgery. The young woman believes that an earlier referral would have avoided weeks of pain and the delay may have exacerbated her condition.

Scenario 4 — Patient confidentiality issues

A young man was taken by his friend to the emergency department of his local hospital after an overdose of sleeping pills. The friend explained the situation to the nurse, who was also a family friend. Another neighbour was also in attendance at emergency because he had cut his hand and required sutures. The young man was admitted to hospital and recovered and was given a referral to a local psychiatric health service. He was very upset to discover the entire town seemed to be aware of the overdose and wondered whether the nurse had breached his privacy.

complaints made by consumers. Scenarios covered issues of treatment, communication, rights and access (Box 2), as these issues covered 85% of complaints from rural areas and showed the largest urban-rural differences.¹⁵ For each scenario, participants were asked to consider:

- How they would deal with the situation;
- Whether they would complain or not;
- To whom they would make the complaint; and
- What would encourage or inhibit making a complaint in the situation.

Qualitative thematic analysis was used to identify common patterns and variable relationships to provide insight into the reasons underpinning the type of response or action characterising rural health consumers' complaint behaviour.¹⁷⁻¹⁹ Two researchers reviewed all responses and identified common themes. The main themes emerged strongly from the records, were discussed and validated at team meetings of all the researchers, and there was no disagreement about them.

Ethics approval for this study was obtained from the Ethics Committee of Monash University. Written consent was provided by all participants.

Results

A total of 60 consumers volunteered for the eight focus groups. Thirteen males and 47 females participated, with 43 participants aged over 45 years. Group sizes ranged from 4 to 13.

Circumstances under which a complaint would or would not be made by rural health consumers

Each of the four scenarios generated a broad range of opinions and significantly divergent discussion.

- In Scenario 1, which dealt with patient access to appropriate services, participants who indicated they would complain focused their attention on the right of the patient to be treated by a doctor in an emergency situation as perceived by the patient, in contrast to non-complainants who recognised more the rights

of the doctor to "have a life" and who could not be expected to be on call 24 hours, 7 days a week.

- In Scenario 2, which dealt with provider communication with patients, opinion diverged between the would-be complainants who felt the doctor should have been more compassionate "in needing to differentiate between a business and community health needs" and those who would not complain because they felt the "doctor was well within his rights to run a business".
- In Scenario 3, which dealt with patient treatment, the discussion focused on who was at fault — on the one hand some considered the "doctor should be more professional", while others felt the "patient needed to stress the seriousness of the problem". Ensuing discussion resulted in broad agreement of the need to establish and maintain "a balance between professional and personal relationships" so that the relationship does not get in the way of diagnosis or treatment.
- Scenario 4, which dealt with patient confidentiality issues, somewhat surprisingly generated least discussion or controversy. The general consensus was that people in small rural communities generally "accept that everyone knows everyone else's business", with some suggesting that in knowing about mental health issues small communities were more compassionate. This was surprising given the stigma often associated with treatment of mental illness.²⁰

Of the four scenarios, those dealing with access to and communication with health service providers were most likely to generate complaints. A consumer was particularly likely to complain about situations regarding patient access to appropriate health services. Participants expressed concern that they "only go to the hospital if they have a serious problem, and therefore would expect to be seen by a doctor". (These results are very consistent with findings from previous studies of consumer preferences for health services conducted in three NSW rural communities.)²¹⁻²² Because consumers are very

aware of pressures on the health services in rural communities, they only use them when necessary. Hence, any trip to the hospital would be considered an emergency situation. In the case of the scenario depicting provider communication with patients, the issue of concern was the doctor's manner in implementing changes to payment practices rather than any qualms about the need for changes *per se*.

The analysis sought to identify the existence of any relationship between the likelihood of generating complaints and the population size of communities, their geographical location and the communities' complaint rates over the 13-year analysis period.

Population size

Comparing the selected towns according to population size generated interesting results. Small towns having fewest local health services were generally more forgiving and understanding of their local health services, with residents reporting that they only attend a health service when a genuine problem arises. Any complaints that did arise were generally raised with the local provider involved. Residents of larger towns were more aware of complaints mechanisms beyond the local health service providers, including Hospital Boards and the Office of the Health Services Commissioner.

Geographical location of the community

The distance from Melbourne was less relevant to consumers than the location of the nearest alternative major hospital. In relation to the way they would respond to the problems resulting from scenarios 1 and 2, many consumers opted to drive to another town and see another doctor or go to the nearest major hospital (usually at least 1 hour's drive away) commenting the "child would end up there anyway". Elderly participants, however, faced more of a dilemma in dealing with these situations, expressing concerns that with "minimal access to transport, going elsewhere was not an option". These patients would have no choice but to go back to the same doctor and sort out any differences.

Complaint rate

There was no obvious difference in people's responses to the scenarios between towns with different complaint rates.

Factors likely to inhibit or deter consumers from making a complaint

The focus groups generated considerable insight into the factors that promote or inhibit the propensity to make a formal complaint. Complaint "triggers" and "inhibitors" fell largely within five broad categories:

- First, many of the issues targeted by participants for complaint were "macro" issues relating to resource allocation and the need for more local health services, rather than "micro" issues relating to individual problems that arise at the local level. In short, residents felt a need to complain about "lack of services rather than faulty services".
- Secondly, residents were conscious of the stigma attached to making formal complaints, with many feeling that a complaint would "jeopardise health services", that "the doctor may leave town", or they "should be thankful to have a doctor". Moreover, residents acknowledged there was also a risk to future health service providers coming to any town if it was seen as a "whinging community".
- Thirdly, many consumers commented, "What would be the use of complaining?" and "Who listens?", indicating a feeling of relative impotence to bring about changes and improvements through use of any complaints mechanisms. This may be a pragmatic recognition of the fact that many problems stem from workforce shortages that cannot be easily addressed by individual complaints, but may also suggest the role of effective complaints in quality assurance cycles is not well appreciated.
- Associated with the above, the discussion provided considerable evidence of some level of acceptance of, or resignation to, a lower level of health service — "when you live in a small rural community, you expect minimal

services” or “that’s what you get in the bush”. People perceived their health service as “adequate” and were “thankful to have it”.

- Finally, in responding to health issues likely to trigger complaints, it was apparent that rural communities generally, and particularly the smaller ones, first take a very positive action-oriented approach to issues related to their health services — “don’t complain, try to fix it”. The prevailing ethos was either to draw on the leadership skills of key community stakeholders to make representation on behalf of the community or to organise fundraising activities to support local health services. Some concern was expressed in smaller communities about the threat to the community leadership and impact of demographic change as existing community leaders age and fewer younger members were available to take on leadership roles or display the same commitment to issues as their older counterparts.

Rural health consumers’ awareness of health services complaints mechanisms

Many participants identified a “need to complain to maintain services”, but clearly lacked any knowledge of complaints mechanisms or to whom they might complain beyond speaking with local individuals or providers. In particular, in the smaller towns, consumers were unaware of the complaint mechanisms that could provide feedback into the health service system. Individual problems were generally addressed through conversations with friends and family, with a view that merely talking about the problem was enough to make the complainant “feel better”.

Where issues of concern warranted a complaint, these were mostly directed to the local health service provider or individuals in key positions in the community, such as local members of parliament or hospital executives. In many cases these complaints were related to lack of local services or resources. It was apparent that many consumers lacked knowledge of the health and community services available in the

smaller and medium sized towns (albeit often on a periodic or visiting basis) or about support and assistance available to access health care including transport, accommodation and financial assistance.

Discussion and implications

Improved knowledge of the reasons for complaint helps explain the extent to which rural consumers use complaints mechanisms to redress outstanding problems and improve service quality. It is clear from the findings of this and other studies that lack of complaints does not necessarily imply satisfaction with the quality of health care services. In the absence of appropriate use of quality assurance processes such as complaints mechanisms, the danger is that rural health service problems persist or are only revealed too late (as in the recent situation experienced by a consumer in Queensland which led to a Commission of Enquiry into safety and quality at Bundaberg Base Hospital).²³

This study has some limitations. Firstly, the number of focus group participants was less than we would have liked, skewed toward older residents and females. These limited numbers reflect the difficulty of engaging rural stakeholders in such research. Even with variable scheduling of focus groups and reimbursement of costs, most eligible participants are engaged in very busy, often unpredictable daily schedules. From the researchers’ perspective, the high costs of conducting focus groups across an extensive rural region, logistical difficulties in coordinating meetings and accessing appropriate venues requires significant planning. Secondly, limiting the scenarios to four meant that not all local problems likely to generate a complaint were necessarily captured, as one-on-one post-group discussion revealed. Nonetheless, given time constraints for participants and the danger of scenario fatigue, the choice of issues provided an excellent nidus for relevant participant discussion. Thirdly, despite scenario selection based on typical complaints received by the HSC, structured guidance was constantly required to ensure consumer dis-

cussion did not focus solely on shared feelings about the lack of available health services and difficulties confronting rural communities in health workforce recruitment and retention.

These limitations notwithstanding, the results from this study highlight several key policy implications. First, it is apparent that some broad educational process is required in rural areas to increase awareness of how the quality assurance process (of which complaints mechanisms are a part) can be used to bring about improved health care services. The task is to make consumers' participation in quality assurance more effective. Reluctance to complain because of a "what's-the-point" attitude, or ignorance of how to complain, perpetuates the risk of maintaining lower quality health services outside of metropolitan and regional centres. Given the numbers of Australians living in and around small rural communities and their poor health status, health authorities can only bring about improved health outcomes if they are aware of this reluctance to complain as an impediment to improvements in health care.

Second, in the absence of quality local health care, the "solution" often adopted by rural consumers is to bypass local services to attend those at larger, more distant centres. This behaviour may exacerbate the problems of excessive waiting times, closed books or overworked health staff at these alternative centres, with the risk that this increased pressure and workload may aggravate existing problems of workforce recruitment and retention. At the same time it affects the viability of the local service.

Third, health authorities must recognise that dealing with overarching macro-level issues (such as service availability and accessibility) are major determinants of the micro issues that are reflected in health complaints, such as those made to the HSC. Merely investigating a complaint into an overworked, harassed but committed health professional without addressing the reasons behind their excessive workload and resultant stress may not bring about sustained improvements in service quality.

Fourth, several of the issues that were prominent in the consumer discussion reflect the need for a whole-of-government approach to health in rural areas. The importance of inter-sectoral issues (such as transport, support accommodation, childcare and financial assistance) cannot be overemphasised, with alternative transport policies a particular concern for ensuring adequate access to health care services, especially for a significantly ageing rural population.

Fifth, acceptance of a sense of rural "resignation" with the current health services situation has inherent dangers. Health authorities and rural communities both face a real risk that rural health status and the quest to improve rural health outcomes, particularly in relation to those chronic diseases targeted as national priorities, will fail and may even worsen unless every attempt is made to monitor and improve the quality of health services available to rural residents.

The findings reported in this study have clear implications for health service providers, regulatory authorities, and consumer participation in the processes and mechanisms designed to assure rural communities of quality health care services. What is apparent is that under-representation of complaints from rural communities should not be interpreted as consumer satisfaction with existing health care services or that current arrangements for delivering health care to residents of the region, particularly availability and access arrangements, are satisfactory. The quest to bring about improved rural health outcomes requires a more effective consumer participation and evaluation process.

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Competing interests

The authors declare that they have no competing interests.

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