

“There’s no point in complaining, nothing changes”: rural disaffection with complaints as an improvement method

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Abstract

Objective: To validate earlier findings that lack of access to health services is the most likely issue of complaint by rural consumers, and that lack of knowledge about how to make effective complaints and scepticism that responses to complaints bring about service improvement account for the under-representation of complaints from rural consumers.

Design: Unaddressed reply-paid mail survey to 100% of households in small communities, and 50%, 20% or 10% in progressively larger communities.

Setting: Eight communities in the Loddon-Mallee region of Victoria.

Participants: 983 householders most responsible for the health care of household members, responding to a mailed questionnaire.

Main outcome measures: Issues of complaints actually made; issues of unsatisfactory situations when a complaint was not made; reasons for not complaining; to whom complaints are made; and plans for dealing with any future complaint.

Results: Earlier findings were confirmed. Lack of access to health services was the most important issue, indicated by 54.8% of those who had made a complaint, and 72% of those who wanted to but did not. The most common reason given for not complaining was that it was futile to do so. Lack of knowledge of how to make effective complaints which might contribute to the quality assurance cycle was evident.

Conclusions: Rural consumers’ disaffection with health complaints as a means to quality improvement poses a significant barrier to consumer engagement in quality assurance processes. Provider practices may need to change to regain community confidence in quality improvement processes.

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What is known about the topic?

Formal complaints are one way that consumers can contribute to quality improvement. Rural residents make fewer complaints to the Health Services Commissioner than metropolitan residents, and access is the most common cause of complaints for rural residents.

What does this paper add?

The most common reason why rural residents don’t make formal complaints when they are dissatisfied with their care is that they believe it is futile to do so. Over half of those who had complained reported that their complaint produced no change.

What are the implications?

The question of whether and how complaining makes a difference needs to be addressed by health care providers, as rural consumers are sceptical. ♦

CONSUMER VIEWS ABOUT the quality of health services provide a valuable source of information to those concerned with accountability and quality assurance in service provision.^{1,2} When such views are expressed as complaints which are responded to in ways which focus on quality improvement rather than allocation of blame, opportunities may arise to improve the quality of health services for all consumers.^{3,4}

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In Australia, many practices and provider agencies have internal complaints-handling procedures, operating voluntarily or mandated under funding arrangements. Additionally, each state and territory has an independent commissioner responsible for the investigation of complaints against providers of health and medical services. All have some responsibility to consider ways in which information obtained from complaint investigations may be used to improve the quality of health services for all consumers.

Complaints made by consumers from vulnerable or disadvantaged circumstances are particularly significant as these complainants are often those most in need of services. In rural Victoria, despite the population's poorer health status⁵⁻⁸ and an undersupply of health and medical workers,⁹ rural residents are less likely than metropolitan residents to make complaints to the Health Services Commissioner (HSC).¹⁰

This article reports the findings of a household survey across eight rural communities investigating consumers' experiences with actual and potential complaints in relation to health services. This study forms part of a larger investigation into the role of complaints in quality assurance of health services in rural communities. In particular, this survey sought to test empirically explanations for the rural-urban complaint differential published previously. Lack of access to health services and the consequent reduced opportunities to utilise health care have been identified as a probable partial explanation of this difference, along with a lack of consumer knowledge about the complaints process.^{11,12} The survey also sought to validate the findings from a series of focus groups conducted in the Loddon-Mallee region of Victoria in which participants identified lack of access to health services as the area most likely to generate complaints from rural consumers. In addition, lack of awareness of available complaint mechanisms, along with scepticism about the role of complaints in bringing about change, were the reasons consumers would not make complaints in unsatisfactory situations.¹³

Methodology

Survey method

The study surveyed residents from eight rural and remote communities from the Loddon-Mallee region of north-west Victoria. To provide sufficient opportunity for a range of views and experiences to emerge, about 1000 responses were sought, in equal numbers from small, medium and large towns, from the adult most responsible for ensuring household health care needs were met — usually females over the age of 25.¹⁴⁻¹⁶

The survey was designed to canvass the range of experiences of consumers interacting with the health system, in a way which protected their privacy. Several methodologies were considered, including computer-aided telephone and face-to-face interviewing and a personally addressed mail survey with reminder mail-outs. Unfortunately, their costs exceeded the resources available for this study. In addition, recent changes to legislation (*Electoral and Referendum Amendment [Access to Electoral Roll and Other Measures] Act 2004* [Cwlth]) have made access to electoral rolls, the most suitable address database for each community of interest, more difficult. Since respondents to mailed health surveys are more likely to be female, older and find the topic relevant,^{17,18} a mail survey was appropriate given the target group for this study. More importantly, a mail survey provided a means of maximising consumer anonymity in small communities.

It was estimated that an unaddressed mail-out to 100% of private dwellings in the smallest towns, 50% in the mid-sized towns, 20% in the second largest town and 10% in the largest town would yield about 1000 replies in roughly equal numbers from each town size category, based on a likely 15%-20% response rate from a mail-out of 6000 questionnaires.

Survey distribution

For reasons of privacy, cost and the logistics of operating in such a vast rural region, Australia Post's "Unaddressed Delivery Service" (UDS) was used to deliver all the questionnaires.¹⁹ Survey

questionnaires (colour-coded by town) together with an explanatory letter and reply-paid envelope were delivered in March–April 2005 to 5965 Australia Post private mail distribution points (private dwellings, postal boxes, postal counters and roadside delivery) in the eight communities. Extensive advance publicity to inform residents of the purpose and timing of the survey took place through articles in each of the towns' local newspapers. Since use of the UDS did not allow the possibility of individual reminders to survey recipients, a thank you and reminder notice appeared in the newspapers about one month after the mail-out.

Sample town selection

The eight towns were selected on the basis of three main characteristics — population size (an indicator of the range of services available locally), previous complaints rates (a proxy measure of satisfaction), and distance from Melbourne (a measure of access to higher level and alternative care) (Box 1).

Questionnaire design

The survey sought information in relation to the most recent complaint about health services or providers; occasions when respondents wanted to complain about health services but did not; how respondents might complain about health serv-

ices in the future; and demographic information. Pre-coded formats with check boxes were used for all questions except those concerning to whom a complaint was made, the outcome of the complaint, why a complaint was not made and the invitation to make any other comments about local health services, where written responses were used.

Data analysis

Responses to open-ended questions were coded using qualitative content analysis.²⁰ For each open-ended question, two researchers each reviewed 40 responses and identified appropriate coding categories. These categories were discussed and modified, then applied to a second set of 40 responses. Iterations continued until a stable set of coding categories emerged, which was then used to code all responses. The survey data were analysed using SPSS for Windows (version 12.0.1; SPSS Inc, Chicago, Ill, USA) to generate descriptive statistics using frequencies and cross-tabulations. Statistical comparisons used the Pearson χ^2 2-sided test, 95% significance level.

Ethics

Ethics approval for this study was obtained from the Human Ethics Committee of Monash University.

I Characteristics of surveyed communities

Community	Population size	Distance from Melbourne	Complaints rate [†]	Percentage of private delivery points sampled
Town 1	<1000	< 350 km	Low	100%
Town 2	<1000	> 350 km	Medium	100%
Town 3	<1000	< 350 km	High	100%
Town 4	<1000	> 350 km	High	100%
Town 5	1000 – < 5000	< 350 km	Low	50%
Town 6	1000 – < 5000	< 350 km	Medium	50%
Town 7	> 10 000	< 350 km	Low	20%
Town 8	> 10 000	> 350 km	Low	10%

[†] Complaints rate is the percentage of complaints per capita made to the Health Services Commissioner over a 13-year period, where: low = < 0.5%; medium = 0.5% – 1%; high = > 1%. ◆

Results

Response rate

The UDS method employed for the survey distribution does not allow for an accurate estimate of the number of postal delivery points which were ineligible for inclusion (not private residences, not occupied at the time of the survey) but it is known from returns that some surveys were delivered to commercial premises. In addition, one reply from a recent arrival in a study town indicated she considered herself ineligible as she was not yet familiar with the local health services. It is therefore not possible to calculate an accurate response rate. Of the 5965 surveys distributed 987 were returned in time for analysis. Three of these were ineligible for inclusion in the analysis (not from private dwellings in the selected towns) and one was returned blank, leaving 983 useable replies.

Characteristics of respondents

Respondents were more likely to be women, and in

the older age categories than the town adult population average,²¹ with very few aged under 25 years (Box 2). Households were more likely to have a member aged 60 years or more (42.9%) than they were to have a child under 16 years (32.2%). Single-person households were under-represented, with an average household size of 2.6 people. Respondents represented a total of 2530 people, 622 (24.6%) of them children under 16 years.

As neither distance from Melbourne nor previous complaint rate differentiated the responses to the survey, the results are presented by town size or totals only.

Reported complaints

One hundred and four respondents (10.9%) reported having made a complaint about a health service or health care provider in the previous year. These 104 respondents raised 198 issues in their most recent complaint. Box 3 provides details of these complaints by town size, showing the nature of the complaint issue, to whom the complaint was

2 Characteristics of respondents

	Town size			Total sample	ABS census Loddon-Mallee statistical region
	Small	Medium	Large		
Adult women	71.8%	73.4%	75.3%	73.4%	51.2%
Age of adults					
18–24 years	2.0%	2.5%	2.9%	2.4%	12.5%
25–44 years	21.8%	26.3%	31.5%	26.3%	31.4%
45–59 years	30.3%	40.0%	28.9%	33.0%	27.1%
60+ years	45.9%	31.1%	36.7%	38.3%	29.0%
Household size					
1 person	17.9%	16.1%	20.7%	18.2%	25.1%
2 people	44.7%	45.2%	41.0%	43.7%	34.3%
3 – 5 people	33.9%	32.3%	34.3%	33.5%	37.3%
6+ people	3.4%	6.5%	4.0%	4.6%	3.3%
Households with child under 16	29.7%	34.5%	32.9%	32.2%	na
Households with adult 60+	48.3%	37.3%	42.3%	42.9%	na
Total no. people	357	318	308	983	193 544

Census sex, age group and total no. people figures are for adult population (18+ years). Based on adjusted Australian Bureau of Statistics (ABS) census 2001 data.²¹

made, and the outcome of the complaint. Most complaints involved access issues, and most were made to the service provider involved. Eighty complainants reported 88 outcomes of their complaints, over half of which involved no change or action or any response of which the complainant was aware. Response profiles were similar for each town size.

Complaints not reported

Three times the number of respondents who actu-

ally did make a complaint in the preceding year reported that they wanted to complain about a health service, but did not (332; 33.8%) (Box 4). Access again emerges as the most common issue, accounting for 72% of complaints not reported. Complaints were most commonly about doctors (60%) and hospitals (31.8%). The most common reason for not making a complaint, that it was pointless to do so, expressed a lack of confidence that any action or response to the complaint would bring about any improvements to health services.

3 Details of most recent complaint about health services made by respondents in the previous year

Details of complaint	Town size			Total (% [no.])
	Small	Medium	Large	
Issue of complaint (pre-coded)*	<i>n</i> = 34	<i>n</i> = 35	<i>n</i> = 35	<i>N</i> = 104
Access: eg, waiting times for treatment, location of services	53%	57%	54%	54.8% (57)
Treatment: eg, consultation, tests, medication	29%	37%	51%	39.4% (41)
Communication: eg, how information provided, rudeness	26%	23%	37%	28.8% (30)
Cost: eg, information about charges and rebates	29%	9%	43%	26.9% (28)
Administration: eg, reception services, cleanliness	21%	23%	20%	21.2% (22)
Rights: eg, privacy, confidentiality, consent, access to records	21%	20%	11%	17.3% (18)
Other issues	6%	0	0	1.9% (2)
Complaint made to (open question)†				
The health service concerned	63%	73%	71%	69% (61)
Hospital	18%	20%	13%	17% (15)
Friends or family	11%	3%	10%	8% (7)
Politician	0	0	10%	3% (3)
Health Services Commissioner	0	3%	3%	2% (2)
Department of Human Services	4%	0	0	1% (1)
Others	11%	7%	26%	15% (13)
Outcome of complaint (open question)‡				
No effect: eg, no change, no response/not taken seriously, don't know	50%	46%	73%	58% (46)
Resolved: eg, explanation given, apology, action taken, promise of better care	32%	50%	20%	34% (27)
In progress	9%	4%	13%	9% (7)
Sought treatment elsewhere	0	14%	7%	8% (6)
Other	9%	0	0	3% (2)

* Percentage of complainants indicating each issue (104 complainants, 198 issues, multiple issues per complainant).

† Percentage of complainants indicating complaint made to each agent (88 complainants, 102 agents, up to 3 agents per complainant).

‡ Percentage of complainants indicating each outcome (80 complainants, 88 outcomes, up to 2 outcomes per complainant).

Fear of either personal consequences or the potential impact of a complaint on future service provision for the community were more common reasons in the smallest towns, although this difference was not statistically significant.

Intentions for future complaints

Respondents were asked to indicate what they would do if ever they wanted to make a complaint about their health services in the future. Box 5 gives details of the 949 responses. While many respondents reported they would discuss

the matter with family or friends, the majority would or would also discuss it with the health service involved and would lodge the complaint with the provider (health service or hospital) concerned. Of note is the very small proportion who would discuss or lodge a complaint with the HSC. Even those who considered it futile to complain were no less likely than the rest to indicate they would lodge a future complaint with the health service concerned (26% of those thinking it futile to complain would lodge a complaint with the service v 29% of the rest, $\chi^2 =$

4 Details of complaints not reported by respondents who wanted to but did not complain

Details of complaint	Town size			Total (%[no.])
	Small	Medium	Large	
Issue of complaint (pre-coded)*	<i>n</i> = 102	<i>n</i> = 118	<i>n</i> = 112	<i>N</i> = 332
Access: eg, waiting times for treatment, location of services	77.5%	70.3%	68.8%	72.0% (239)
Treatment: eg, consultation, tests, medication	31.4%	26.3%	37.5%	31.6% (105)
Communication: eg, how information was provided, rudeness	22.5%	22.9%	27.7%	24.4% (81)
Cost: eg, information about charges and rebates	34.3%	22.9%	27.7%	28.0% (93)
Administration: eg, reception services, cleanliness	12.7%	16.9%	13.4%	14.5% (48)
Rights: eg, privacy, confidentiality, consent, access to records	12.7%	9.3%	8.0%	9.9% (33)
Other issues	1.0%	1.7%	0	1.0% (3)
Complaint was about (pre-coded)†				
Doctor	60.8%	61.8%	57.3%	60.0% (198)
Hospital	26.8%	29.3%	39.1%	31.8% (105)
Dentist	14.4%	10.6%	15.5%	13.3% (44)
Pharmacist	1.0%	3.3%	3.6%	2.7% (9)
Physiotherapist	3.1%	4.9%	0	2.7% (9)
All others (imaging, pathology services, nurse, receptionist)	23.7%	17.9%	20.0%	20.3% (67)
Why did not make complaint (open question)‡				
Futile/waste of time	46.3%	43.6%	57.0%	49.1% (132)
Apprehension/fear of consequences	34.2%	25.5%	22.6%	27.1% (73)
Did not know how/who to	12.2%	14.9%	16.1%	14.5% (39)
Fault not with provider/systemic problem	11.0%	18.1%	11.8%	13.8% (37)
No time/too difficult	11.0%	3.2%	8.6%	7.4% (20)
Sought care elsewhere	3.7%	1.1%	3.2%	2.6% (7)

* Percentage of 332 complainants indicating issue (multiple issues per complainant). † Percentage of 330 complainants indicating provider type (multiple providers per complainant). ‡ Percentage of complainants indicating reason (269 complainants, 308 reasons, up to 3 reasons per complainant).

0.43, not significant) and no more likely to lodge complaints outside the service, such as with the Department of Human Services (DHS) (5% v 12%), Members of Parliament (13% v 15%) and the HSC (6% v 9%, all non-significant). Differences by town size were minimal, with only the proportion who did not know what they would do being significantly higher in the medium towns, and those who would discuss the problem with friends being higher in the larger towns.

Additional comments

Survey participants were also given the opportunity to comment on what could be done with health services in their community to improve their satisfaction with them. The 1000 responses from 617 respondents were coded into seven broad categories. Box 6 shows the percentage of

all 983 respondents whose responses were coded into each category. Responses were coded into a category if one or more issues from that category were mentioned. Thirty-seven percent of respondents made no comment in this section, and a further 5% indicated they were satisfied with the current services. Concerns about access issues account for the largest proportion of all comments, with more than half of all respondents from small and medium-sized towns making at least one comment about an access issue. Access to services comes out well ahead of the next most used category, costs. Residents of larger towns were more likely to comment on aspects of service cost, acceptability and effectiveness, while those in medium and small towns were more likely to comment on service accessibility.

5 Respondents' intentions for any future complaints

	Town size				
What I will do if I want to make a complaint in the future	Small	Medium	Large	Total (%[no.])	χ^2
Discuss with: (pre-coded)*					
The health service involved	62.2%	61.9%	61.7%	62.0% (588)	ns
Family	36.9%	40.7%	45.5%	40.9% (388)	ns
Friends	20.1%	20.8%	28.1%	22.9% (217)	6.85 ($P < 0.05$)
Member of Parliament	11.2%	11.1%	11.2%	11.2% (106)	
Department of Human Services	6.2%	7.5%	6.9%	6.8% (65)	
Health Services Commissioner	5.0%	6.5%	4.6%	5.4% (51)	ns
Others	2.4%	2.3%	2.6%	2.4% (23)	ns
Lodge complaint with: (pre-coded)*					
The health service concerned	56.9%	51.8%	57.1%	55.3% (525)	ns
The hospital	13.6%	15.6%	15.5%	14.9% (141)	ns
Member of Parliament	11.2%	11.7%	9.6%	10.9% (103)	ns
Department of Human Services	9.4%	7.2%	5.9%	7.6% (72)	ns
Health Services Commissioner	5.9%	6.8%	7.9%	6.8% (65)	ns
Others	0.9%	0.3%	2.0%	1.1% (10)	ns
Don't know what I would do	9.1%	18.6%	10.9%	12.8% (121)	14.24 ($P < 0.001$)
Do nothing	4.7%	6.8%	4.6%	5.4% (51)	ns
Total respondents (no.)	339	307	303	949	

* Multiple responses per respondent.



Discussion

This study provides the first empirical survey of rural consumer behaviour relating to complaints about health services in Australia. The research canvassed the views of consumers from a representative selection of rural and remote communities in the Loddon-Mallee region. The results provide several significant insights into previously published research based on the secondary analysis of complaint data.^{10,11}

The study did, however, have some limitations. While falling within expectations for the method used, the survey response rate was relatively low. Respondents over-represented women and older age-groups, those expected to have a greater interest in or responsibility for household health issues. They provide a representation of the views of those likely to be the more frequent users of health services. Consequently, the views of young adults and members of single-person households are under-represented.

Despite these limitations, the survey produced several important findings. Firstly, the results echo the findings of the focus groups¹³ in that they indicate a general disaffection with the complaints process as a mechanism for redressing issues and problems with health care services, with the most common reason given for not making a complaint being the perception that it was futile to do so. Over half of those who did complain (and the majority of these complained to the provider concerned), reported the outcome as no change or action or no response to the respondent. In addition, both the focus groups and the survey found that concern about the possible consequences of making a complaint, both personally and for the community, was an important contributor to the decision not to complain. Clearly, there is a consumer perception that providers are not responsive to complaints, or possibly not recognising when a complaint is being voiced, suggesting that further investigation

6 Additional comments about what could be done with health services to improve respondents' satisfaction

Categories of response to the open question

"Are there any comments that you would like to add about what could be done with health services in your community to improve your satisfaction with them?"*

	Town size			Total (%[no.])	χ^2
	Small	Medium	Large		
Service accessibility: service availability, increases or improvements to existing services, appointment availability, service after hours, travel and transport	50.1%	50.3%	39.9%	47.0% (462)	8.99 ($P < 0.05$)
Costs: bulk-billing, out of pocket expenses	7.0%	9.4%	15.3%	10.4% (102)	12.57 ($P < 0.005$)
Acceptability: cultural, communication, hygiene	5.0%	4.4%	9.4%	6.2% (61)	8.06 ($P < 0.05$)
Effectiveness: clinical effectiveness, competency, co-ordination of care	3.6%	5.3%	9.4%	6.0% (59)	10.13 ($P < 0.01$)
Workforce: rural incentives for health professionals, rural training experience, reduce workload to prevent burnout	3.9%	2.5%	4.9%	3.8% (37)	ns
Choice: able to see practitioner of choice, continuity of care	2.8%	1.9%	1.3%	2.0% (20)	ns
Satisfied: satisfied with services as they are	5.0%	5.0%	4.5%	4.9% (48)	ns
No comment recorded	37.5%	35.5%	38.6%	37.2% (366)	ns
Total respondents (comments) (%[no.])	357% (358)	318% (326)	308% (316)	983% (1000)	

* Percentage of 983 respondents indicating at least one issue within the category (1000 responses, up to 4 issues and categories per respondent, multiple issues per category count only once). ◆

of the way in which complaints are identified and managed by providers may be warranted.

Secondly, the results confirm the focus group outcomes identifying access to health services as the predominant issue of concern for rural consumers of health services. This finding is the case for complaints actually made, situations where the respondent wanted to make a complaint but did not, and responses to the general question on what would improve satisfaction with local health services. These results support the conclusion that the lower rural complaint rate to the HSC reflects the reduced rural access to services from which complaints might otherwise arise, rather than higher levels of satisfaction with available services.¹¹

Thirdly, the findings indicate that complaints lodged by rural consumers with the HSC by themselves fail to adequately reflect the primacy of access issues for rural consumers. That complaints to the HSC are more likely to concern treatment, communication and rights than access issues^{11,12} may be because consumers do not see the HSC as the appropriate avenue for complaints about access. Similarly, consumers may be less likely to see providers as the appropriate target for complaints about access, since access problems tend to be largely dependent on funding resources and workforce supply, which are generally beyond the provider's control. Arguably, these complaints could appropriately be directed to representatives of local, state and federal governments, but the question as to how consumers can make effective complaints about access issues warrants further research.

Fourthly, the lack of consumer awareness about how and to whom complaints can be made is highlighted by these findings and corroborates those from the focus groups.¹³ Even respondents who believed complaints to providers to be ineffective were unlikely to use alternative complaint options. It was apparent from the survey results that few respondents recognised or appreciated the role of the HSC. Education and information about how to make effective complaints which might contribute to the quality assurance cycle are needed by consumers. Informal complaint

handling processes (such as discussion with family, friends or local providers) may solve the immediate problem, but are unlikely to lead to system change, which requires at least the lodgement of a formal complaint. In this regard, the role of the HSC includes making recommendations for systemic change where investigation of a complaint or number of complaints identifies systemic problems.

Finally, the results raise the question as to whether consumer complaints do lead to improvement in service quality, where appropriate, or whether the pervasive consumer disaffection with the process reflects the absence of effect. Research which comprehensively tracks complaints from the consumer, through the complaints management process, to recommendations for change, and on to verification of the extent to which recommendations were adopted and service quality improved, is required to address this question. Evidence from this research could be used both to refine the systems and improve consumer confidence.

Conclusion

Clearly, providers are not seen by rural health consumers as sufficiently responsive to their complaints. Rural consumers' disaffection with health complaints mechanisms poses a significant barrier to consumer participation in those quality assurance processes which ensure that consumer concerns are addressed within the quality framework of the health services system. Loss of, or failure to respond appropriately to consumer feedback of this type constitutes lost opportunities for service improvement, allowing poor quality service to continue or further deteriorate, with possible catastrophic consequences. Education and information are required to improve consumer awareness about how and to whom effective complaints can be directed — complaints which will contribute to improvements in health services quality.

In addition, providers can address consumer scepticism by exploring other ways to engage consumers in quality assurance and service plan-

ning, such as more use of consumer reference groups and greater consumer representation on boards of governance.

While public hospitals have complaints liaison officers and accredited general practices have some formal process for dealing with consumer feedback, the way in which complaints are managed can vary greatly between providers. The adoption of and adherence to the approach to complaint handling practices detailed in either the Victorian²² or the National²³ guidelines for complaints management in health services, both recently released, is recommended for all health care providers. This approach ensures that complaints are captured and dealt with in a way that contributes to service quality improvement, and that keeps consumers informed of the progress and outcomes of their complaints. Providers are also urged to ensure that any recommendations resulting from complaint investigations are acted upon in a timely manner, and any changes evaluated with respect to service quality improvement.

Finally, the findings have clear implications for health authorities and policymakers. The underrepresentation of complaints from rural consumers cannot be taken to mean greater satisfaction with services in rural areas. Issues of access to services have the highest priority for rural residents and require a whole-of-government approach encompassing service location, transport and financial assistance, as well as the training, distribution and support of the health workforce.

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Competing interests

The authors declare they have no competing interests.

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