Customer Satisfaction and Health Care Delivery Systems: Commentary with Australian Bias

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Abstract

As the health care industry strains the nation's financial resources it has come under increased pressure to provide evidence of quality controls and quality improvements. Increasing evidence that the service aspects of health care are closely linked to health care outcomes has caught the attention of industry leaders. The current health care consumer is better educated and the best informed it has ever been. Health care organizations must address those aspects of service that consumers most readily appreciate: access to care; relationships between physicians, meaningful and understandable information; and participation in their own health care and treatment decision making processes. One aspect of health care quality that is being increasingly recognized for its importance is the influence of patient perception. Even though the patient's perception of quality relies more on the service aspects of health care, it correlates well with objective measures of health care quality. A health care organization's ability to satisfy consumer demand for convenience and information can significantly influence the quality of health care it ultimately delivers.

The health care service industry is complex with multiple facets and levels of organization. Health care system management has previously been relatively inefficient, incoherent and supply driven, keeping customers on the outside of the product design, development and the delivery process. Today there is a shift to an organization model in which the customer influences every function and managers must adapt and be instrumental in establishing a cultural change within the system to meet the new quality focus. Many physicians doubt that the current emphasis on quality is really aimed at improving patient's health. There is paucity of evidence that, as a whole quality initiatives actually do anything to improve outcomes for patients. Physicians however are in the best position to make a case for improving quality. Showing leadership in assessing and improving the quality of care can not only improve outcomes for patients, but also give physicians renewed autonomy over the practice of medicine.

There are a number of ways in which the community and consumers may participate in the development of health care policy. These can range from passive consultations to structural participation is an engaged and developmental process in which community control predominates. Unfortunately entrenched biases of researchers and practitioners can limit community involvement. Reform of bureaucratic structures, curriculum and research methodology are all required to effectively involve the health care consumer.

Although there is strong evidence in favor of consumer participation care and due diligence however needs to be exercised to ensure that consumer rights are not over emphasized at the expense of health care quality.

INTRODUCTION

As the health care industry strains the nation's financial resources it has come under increased pressure to provide evidence of quality controls and quality improvements. Increasing evidence that the service aspects of health care are closely linked to health care outcomes has caught the attention of industry leaders. The current health care consumer is better educated and the best informed it has ever been. Consumers demand that the service industries accommodate their busy lifestyles and fulfill their need for information. Health care organizations must address those aspects of service that consumers most readily appreciate: access to care; relationships between physicians, meaningful and understandable information; and participation in their

own health care and treatment decision making processes. Without a doubt, consumerism will have a significant impact on shaping the health care industry as it has had on all other aspects of business.

Although the perspective of health care professionals is widely regarded to be important and useful, other facets of quality have also emerged to be of significance. The most important change has been the recognition that health care service must respond to the preferences and values of the consumers of the industry, and that their opinions about care are important indicators of its quality. In addition, there is increasing recognition of the complex nature of the service and the need to satisfy the demands of not only the ultimate consumer (patient) but also the internal consumers of the resources that make up the health care industry ([1]).

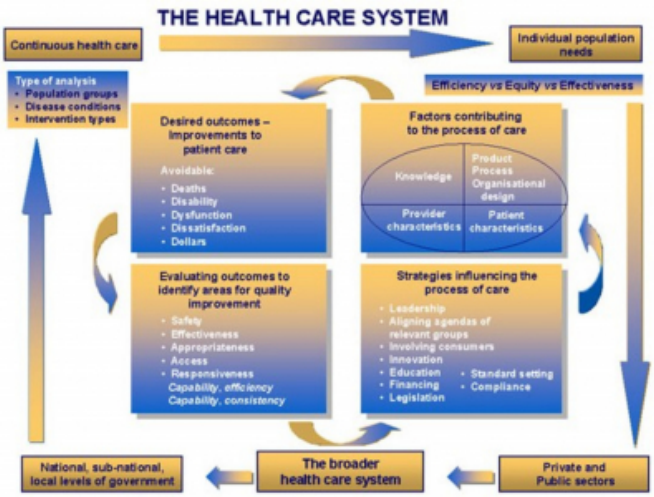
THE HEALTH CARE CUSTOMER/CONSUMER

Peter Lloyd ([2]) defines the term consumer as “an individual who purchases or uses a good or service". They point out that many countries are now shifting their thinking and classifying the population as a consumer of health service rather than as passive patients. It is becoming increasingly recognized that users of health care services regularly exercise their choice with respect to the available health care services.

The Australian health care system is complex. There are many interrelated structures and concepts within the system that relate to the development of a number of initiatives in safety and quality, clinical excellence and consumer information (Figure 1) ([3]). Given the complexities of the system, there is no one consumer; there exists in each department, office, and home, a series of customers, suppliers and customer supplier interfaces. These are “the quality chains", and they can be broken at any point by a person or machine not meeting the requirements of the customer, internal or external. Failure to meet the requirements in any part of a quality chain has a way of multiplying, and failure in one part of the system creates problems elsewhere, leading to yet more failure and problems, and so the situation is exacerbated.

Figure 1

Figure 1: The Australian health care system is a complex web of interactions between numerous internal and external consumers and suppliers (3)



CONSUMER PERCEPTIONS - WHY ARE THEY IMPORTANT

One aspect of health care quality that is being increasingly recognized for its importance is the influence of patient perception. Even though the patient's perception of quality relies more on the service aspects of health care, it correlates well with objective measures of health care quality. A health care organization's ability to satisfy consumer demand for convenience and information can significantly influence the quality of health care it ultimately delivers.

There is increasing evidence that appropriately addressing consumerism in health care leads to improved health care outcomes. Expectations about the quality of care are linked to perceptions of care, and when patients' perceptions are positive their clinical experience and outcomes are more likely to be positive ([4]). In its 1999 report, “The State of Managed Care Quality," the US National Committee for Quality Assurance found that health plans with the highest satisfaction scores for the service aspects of health care also have the highest clinical quality scores ([5]). Addressing those service aspects of health care that consumers most readily appreciate, such as access, provider relationship, availability of information, and opportunity for participation can influence health care quality outcomes.

ACCESS

Improving access can have positive effects on health care outcomes. For example, by providing convenient, culturally sensitive programs in prenatal care, a number of organizations have raised the quality of care for pregnant

women, decreased premature delivery rates, and saved money. Similarly, by removing barriers to access and providing preventive services such as mammograms, organizations have improved quality of care by allowing earlier diagnosis and more favorable outcomes ([6]). Poor access also has quality and economic consequences. In a recent community based study, people who perceived that they had poor access to medical care had a higher rate of hospitalization for common medical conditions ([7]). Unnecessary hospitalizations expose patients to nosocomial risks and represent an inappropriate use of expensive resources.

RELATIONSHIPS

The quality of physician-patient relationships and interactions are themselves important in influencing health outcomes. Clear explanation of procedures by physicians and decision-making participation by patients has been shown to positively influence clinical outcomes ([8,9]). Positive physician-patient interactions have been shown to improve parameters such as blood pressure and blood sugar, and to improve overall functional status ([10,11]). Physicians' relationships with health care organizations also influences health care service and quality. Nearly 40 percent of primary care physicians in a 1996 self-reported study from the United States indicated that their contracts included some form of incentive. Using the right incentives, organizations can improve their relationships with physicians and improve job satisfaction ([12]).

INFORMATION

Providing patients with relevant and useful information is linked to increased patient compliance ([13]). But in spite of significant service improvements, many physicians still struggle to fully understand patient information needs. A recent study surveyed 74 physicians and a sample of their patients in order to compare the importance of information delivery as an indicator of the quality. While patients and physicians agreed that clinical skills were the most important, provision of information was ranked second in importance by patients but only sixth by physicians ([14]). A report by the U.S. Congress, Office of Technology Assessment, concluded that consumer guides may improve the quality of health care and reduce costs by promoting clinical and provider accountability ([15]).

PARTICIPATION

In a recent survey of 5,464 adults, 25% were considered passive consumers and did not think much about their health care while 40% were aware of medical issues but chose to actively go against medical advice. The other 35% were activists who sought out information and tried to make informed choices about various aspects of their health ([16]). The latter group is leading consumerism in health care today and in the future will most certainly influence the health care industry in ways that will also have some beneficial effects on all consumers.

Consumers' activism in directing their own health care is further corroborated by a rising trend in the use of alternative and complementary medicine. In a US survey, the use of alternative medicines increased from 33.8% in 1990 to 42.1% in 1997. During that same time period, visits to all primary care physicians dropped slightly, while the number of visits to alternative practitioners increased by 50% ([17]). Some studies have even reported better outcomes in terms of satisfaction, speed of clinical improvement, and cost when patients chose to use alternative therapies compared to standard treatment ([18,19]).

HURDLES TO CROSS

As outlined above the health care service industry is complex with multiple facets and levels of organization. There exist interactions between internal and external consumers and suppliers. In this section an exploration of the barriers such a complex structure can introduce in accommodating consumer perceptions is presented. Barriers related to the organization itself, the physician and the consumer level are discussed with implied changes that are likely to occur to improve the overall level of consumer participation.

MANAGEMENT CHANGE

Health care system management has previously been relatively inefficient, incoherent and supply driven, keeping customers on the outside of the product design, development and the delivery process. Historically health care organizations have viewed customer service as an independent, non-critical function best left to professional judgment of physicians. Today there is a shift to an organization model in which the customer influences every function. Health care organizations, which have taken up challenge of full scale restructuring, did and probably still are encountering difficulties in full and proper implementation ([20]). Among the reported difficulties have included the inability of the workforce to cope with the rapidity change, eroding of established power patterns leading to tensions among middle and senior management.

Also, restructuring can sometimes be derailed or delayed due to unforeseen secondary system breakdowns such as information technology resources (20).

Quality management in a health care organization, at what ever level, is an approach to improving the effectiveness and flexibility of the organization for the benefit of all stakeholders. It is a way of planning, organizing and understanding each activity, and of removing waste. It ensures the leaders adopt a strategic overview of quality and focus on prevention not detection of problems. Whilst it must involve everyone, to be successful, it must start at the top with the leaders of the organization. All senior managers must demonstrate commitment to quality, and middle managers must, as well as demonstrating their commitment, ensure they communicate the principles, strategies and benefits to the people for whom they have responsibility. A fundamental requirement is a sound quality policy, supported by plans and facilities to implement it. Leaders must take responsibility for preparing, reviewing and monitoring the policy, plus take part in regular improvements of it and ensure it is understood at all levels of the organization. The failure to address the culture of an organization is frequently the reason for many management initiatives failing. There is widespread recognition that major change initiatives will not be successful without a culture of good teamwork and cooperation at all levels in an organization.

PHYSICIAN DOUBTS

The interaction between patient and physician is paramount in the delivery of quality health care ([21]) and as such the role of the physician in delivering quality health care is essential. After two decades of preoccupation with costs of health care, more attention is being devoted to quality. But much of the attention is coming from unlikely sources - organizations more often associated with efforts to reduce costs. Physicians may be forgiven if they are dubious. In the 1970's peer review was supposed to improve quality, in the 1980's, it was quality assurance. Quality improvement is the current chosen phrase.

Many physicians doubt that the current emphasis on quality is really aimed at improving patient's health. Firstly, physicians see little difference between new “quality improvement" efforts and the quality programs of the past. Physicians believe that such programs rarely deal with issues they regard as important in patient care. Traditional quality assurance efforts have focused on issues identified by regulatory authorities whose methodology has typically been and continues to be centered on document checking, credentialing processes and committee review processes. Rarely do they try directly to improve health outcomes for patients. The second reason for skepticism is the paucity of evidence that, as a whole, previous quality initiatives actually did anything to improve outcomes for patients. Data documenting the effectiveness of newer approaches are likewise scant. Many who try to bring a more co-operative spirit to improving quality find that there is a third reason for being skeptical. Much of what passes for quality improvement can justifiably be viewed as thinly veiled cost containment or marketing.

Although health care organizations and governments may emphasize lowering costs, physicians are in the best position to make a case for improving quality. Showing leadership in assessing and improving the quality of care can not only improve outcomes for patients, but also give physicians renewed autonomy over the practice of medicine. By working with organizations and governments to reduce costs, physicians can ensure that considerations of quality rise to the top of the agenda. Pursuing this strategy can avert the need to control costs with blunt instruments such as patient co-payments and restricted freedom of choice, which may lower costs but also pose serious barriers to necessary and appropriate care. Unfortunately, developments in private health care in Australia over the past few years have gone the way of restricted choice with the most private health funds offering greater levels of coverage if the customer agrees to reduce choices of treating physician and/or hospital.

CONSUMER PARTICIPATION - EASIER SAID THAN DONE

The primary health care approach ([22]) nominates community participation as one of its underpinning principles. Similarly, a socio-environmental model of health promotion encourages people to participate in health development and foster collective action for health ([23]). People can only participate fully in decisions about research, services and programs that influence their health if their voices are heard and taken into account.

The four types of community participation summarized by Baum ([24]) differ in the extent to which participation involves a transfer of power from the state or experts to communities, as follows.

Consultation as a means asks for people's opinions and

reactions to plans for services and policies. The consultation is limited, initiated by organizations outside the community and usually controlled by the organization initiating consultation.

Participation can also be used to achieve a defined end. Again it is initiated by organizations outside the community. An example is the establishment of community panels for priority setting in health services.

Substantive participation occurs when people are actively involved in determining priorities and implementation, but when the initiative is externally controlled. Although people outside the community may initiate it, this type of participation may lead to structural participation over time. If the initiative becomes developmental it may involve a shift in power to the community. Examples include self-help groups initiated by a community health center's staff and community heart health programs working with local agencies

Structural participation is an engaged and developmental process in which community control predominates. The initiative may have come from outside the community initially, but eventually control is handed over to the community. It is a developmental, ongoing relationship, which is driven by the community and potentially hands back power to individuals, organizations and communities. Examples include Aboriginal-controlled health services and resident action groups.

A recent development in Australia designed to increase opportunities for community participation in the health system is the Consumer Focus Collaboration. This emerged from a National Expert Advisory Group on Safety and Policy in Australian Health Care that was established by health ministers at the Australian Health Ministers Conference in October 1996 (Consumer Focus Collaboration Strategic Plan 1997/8-2001/01 1998).

Unfortunately entrenched biases of researchers and practitioners can limit community involvement. Researchers who adopt a positivist paradigm are less likely to use results or methods that take the time to distil ordinary theories from in-depth interviews or focus groups (24). Bureaucratic structures frequently do not value community knowledge and seem impenetrable to community members ([25]). In many countries health promotion approaches operate within free market inspired policy settings that require evidence-based practice in organisations that either charge a fee for service or which have won a contract to provide a service (24). Research is required on whether it is possible to build in use of consumerism as best practice within evidence based and tendering out policy. Professional training is more likely to prepare workers for a role of professional dominance than one of enhancing community participation ([26]). Curriculum design and teaching and learning methodologies that will critique professional dominance and promote the values and skills in a range of professions that promote community participation are becoming more common.

IS THE CONSUMER ALWAYS RIGHT?

Can we take consumerism and individual patient's rights too far? Is there a point at which pursuing individual rights could actually destroy the healthcare system and increase health inequalities? Two examples of the potential pitfalls are litigation and direct advertising of prescription drugs to the public.

Making a complaint, compensation and redress are basic consumer rights. Consumers expect particular standards from health services and to feel aggrieved if these were not met. Who wins and who loses is haphazard and unfair in our system of redress. When the complainant wins, hospitals have to pay compensation immediately, even if it means cutting services. Experience in the US shows that litigation affects clinical practice and leads to defensive medicine. ([27])

The rights to redress and compensation are important, but they are unfair and costly. What are the alternatives? No-fault compensation schemes are a possibility. These schemes operate in New Zealand, Sweden and Finland. Although compensation awards tend to be lower, more people receive compensation. But the downside is that such schemes make it difficult for people to find out what happened and professionals may not be held to account. ([28])

In the US, pharmaceutical companies can advertise prescribed drugs directly to the public. In Australia they can only advertise their products in the professional press. Many patient groups, want to change this, they argue that the public has the right to the information and they also argue, that many doctors do not keep up to date and so patients cannot rely on them to know the latest treatments.

The counter argument is that direct advertising will lead to an inappropriate demand for drugs which may be ineffective or at least of uncertain benefit. It will push up costs because it will increase consultation times and drug consumption. Advertising costs will be passed on to the purchaser of the

drugs. Direct advertising will also contribute to a culture that sees more medicine as the answer to health problems, rather than other approaches. Direct advertising may also lead to more treatment for a few articulate people, and so diminish resources for other services, which may be addressing public health inequalities.

CONCLUSION

Today's overworked, well-informed consumers demand a health care system that accommodates their busy schedules, provides them with useful information, and involves them in decision-making. Those health care providers and organizations that understand the implications of consumerism on health care quality will have a clear advantage in the future, and society will reap the benefits of this enlightenment. All facets of the health care system will need to understand the interplay between internal and external consumers and suppliers and change their management practices accordingly to accommodate the needs of the modern health consumer. Care and due diligence however needs to be exercised to ensure that consumer rights are not over emphasized at the expense of health care quality.

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