Informal complaints on health services: hidden patterns, hidden potentials

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Abstract

Objective. To examine the prevalence of informal complaints on health services among clients of Health Maintenance Organizations, and explore demographic correlates. Such complaints are a potentially important source of information regarding quality of healthcare.

Method. Primary data were collected by a phone survey from a nationwide random sample of 1500 persons aged 21+ in Israel.

Results. About 25% of the respondents reported a cause to complain, but only 9.5% actually complained. About 75% of the complainants submitted their grievances informally at the local level. Only a minority (17%) appealed to official bodies established by law. Minority groups and recent immigrants had significantly lower rates of reasons to complain and actual complaints.

Conclusions. Suggestions are made for outreach efforts to socially vulnerable groups and for developing organizational mechanisms for capturing and using future complaints submitted informally to front-line employees, which are the bulk of the complaints. Further research is needed regarding factors affecting customers complaining and non-complaining behavior, including factors that specifically affect the behavior of minority groups.

Keywords: customer complaints, healthcare quality, Ombudsmen, patient rights, patient satisfaction

Introduction

Health organizations are called upon by many stakeholders to pay serious attention to clients' complaints, either due to moral or legal obligations, or as a way to improve the quality and efficiency of health services as well as client satisfaction [1, 2]. Many countries have enacted laws which establish Ombudsmen offices and procedures to handle complaints on health services, and reporting of complaints to regulatory agencies is sometimes used as an indicator of quality of healthcare [3–5].

When clients are dissatisfied or perceive a service failure, they can choose one of several courses of action [2, 6–8], i.e. 'voice' a concern by complaining to the service provider or to the relevant authorities or by negative word of mouth to others; they can 'exit', i.e. cease to use the service provider; or opt for 'silence'. This article focuses on an aspect of voice which has hardly received attention in the literature, that of 'informal' complaints, i.e. made to front-line employees or other organizational entities not through written means or channels formally designated for processing complaints. This topic is important because it may mean that clients' voice cannot be heard, analysed or acted upon by service providers [9–11].

Several studies show that in diverse industries, only a portion of those who have a cause to complain actually do so; those who do complain vary in 'how' they do so and mainly lodge complaints informally [8, 12, 13]. However, very few studies have examined the phenomenon of informal complaints on health services [14]. Schlesinger et al. [15] used phone interviews with a representative nationwide sample of 2500 adults in the USA. Of those interviewed, 51% claimed that they had problems with their health service over the past year. (Similarly, Schauffler et al. [16] found that 42% of those insured with US health services encountered problems during a single year.) Of those who had a cause to complain in the Schlesinger et al.'s study, 55% complained to their HMO, yet only about a quarter of these complainants filed a 'formal' complaint with their health plan, even when they experienced serious problems.

This study was designed to examine the prevalence of informal complaints and their demographic correlates so as to address two limitations of the Schlesinger et al. [15] study, who did not specify what attributes distinguished between informal and formal grievances, and did not count

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grievances to formal Ombudsmen entities, only to health service providers or employer-based insurance plans. This study involved phone interviews with a large nationally representative sample of citizens in Israel, a country with a population of over seven million residents covered by a National Health Insurance Law. In relative terms, Israel enjoys a high standard of health services, medical resources and research, modern hospital facilities and a high ratio of physicians and specialists to population. These achievements are reflected in a low infant mortality rate (four per 1000 live births) and long life expectancy (81.8 years for women, 77.6 for men); the national expenditure on health (8.8% of the GDP) compares favorably with that of other developed countries [17, 18].

In Israel, as regulated by the National Health Insurance Law; citizens must choose one of four non-profit HMOs (‘health funds’) as their service provider. The four HMOs are autonomous organizations and compete with each other, i.e. clients can continuously switch between them. The Law sets specific complaint rights for all citizens, who can submit formal appeals to three types of bodies: (i) an Ombudsman in the Ministry of Health; (ii) an internal Ombudsmen within each HMO regarding services to members of that HMO; (iii) a Labor Court. Israel’s health system combines features of a single national system, such as the one in the UK or Canada, with a market-driven scheme in which multiple service providers compete, as in the USA. Thus, Israel offers an interesting natural case study in which it is possible to examine formal and informal complaints, since citizens have specific legal rights to complain both on a national level and within each HMO.

**Methods**

**Subjects and sampling**

The study employed a phone survey of a national stratified probability sample of 1500 subjects aged 21 and above. The sample was created by random selection from a national phone directory; 1250 respondents from townships and communities with Jewish inhabitants and 250 from non-Jewish (primarily Arab) locations. These proportions roughly equal the proportion of Jewish and non-Jewish citizens in Israel of age 21 and above. Of the 1500 subjects, 801 (53.4%) were females and 699 (46.6%) males; 14.5% were aged 65 or more. The HMOs to which they belonged were Klalit (54.6%), Maccabi (24.3%), Meitav (11.7%) and Leumit (9.1%), in proportions almost exactly identical with the national HMO membership statistics for 2004. Analysis of the distribution of major background variables showed that, in general, the research sample is representative of the general population of Israel of age 21 and above.

**Research tools**

Questions related to complaining and non-complaining analysed in this study were part of a larger national survey of client satisfaction and behavior. Items were mostly forced-choice though a few were partially structured or open-ended. All subjects were first asked two screening questions: (i) whether over the past 12 months they had wanted to complain, or had a reason to complain about any matter connected with their HMO, or with a hospital where they had received treatment or other health care service paid for by their HMO; (ii) if they had such a reason, have they actually complained in any way. If they have made a complaint, further questions asked how and to which entity it was submitted. All respondents were questioned regarding their knowledge of complaining options and for demographic information.

**Procedure**

The questionnaire was developed through a multi-stage pilot project and was administered by the Survey Center of the University of Haifa, a professional survey firm. Interviews were conducted in Hebrew, the language spoken by the majority population, and in Russian and Arabic, each spoken by roughly 16% of the population. Responses to open-ended or semi-structured questions were content-analysed; coding categories were constructed based on a sample of questionnaires and validated on further replies.

**Results**

Of the 1500 subjects, 74.5% reported that they had no cause for grievance during the past 12 months, whereas 382 (25.5%) reported that they had had a grievance (hereinafter ‘aggrieved’), and 143 (9.5%) had actually complained (hereinafter ‘complainants’). Thus, 37.4% of the aggrieved complained, whereas two-thirds did not. These data, as well as complaint patterns in key subgroups are shown in Table 1. As can be seen, complaint rates were quite similar with respect to gender, age and educational subgroups, and the differences were not statistically significant using a $\chi^2$ test. There were some minor differences in complaint rates (not shown in Table 1) between clients of the four different HMOs and between clients with different income levels (below, around and above the national average) which also were not statistically significant.

A noticeable pattern in Table 1 is that the proportion of aggrieved respondents in non-Jewish (i.e. Arab) residential areas was only half of that in the Jewish sector (17.6 vs. 39.4, respectively). Further, the number of actual complainants in the Jewish sector was close to 11%, more than four times as great as the 2.4% in the non-Jewish sector. The association between residential area and the pattern of complaining (no cause for grievance, aggrieved but no complaint, complaint) was significant. In addition, there was a significant association between immigration status and the pattern of complaining: those born in Israel or who immigrated and reside in the country for over 20 years, which constitute the majority of this national sample, tended to have higher proportions of aggrieved persons when compared with those who immigrated to the country during the last 20 years.
Two questions examined how the 143 complainants, who constitute 37.4% of the aggrieved, made their complaints. One question asked about the ‘recipients’ to whom a complaint was made; replies were categorized into three types: ‘local recipients’ (administrative staff, clinic nurse, etc.); ‘senior HMO administration’ (such as when a client contacts regional or national management); and ‘official bodies’ legally designated to deal with complaints described earlier, i.e. one of the Ombudsmen or a Labor Court. (We also looked for indications of contacts with other external bodies such as consumer advocacy organizations, media channels or lawyers, but only three were reported and due to the small number were excluded from the analysis.) Another question asked was about the ‘method’ used to submit the complaint; replies were divided into ‘oral’ (i.e. face-to-face discussion, phone call) and ‘written’ (i.e. letter, e-mail, printed complaint form, ‘contact us’ form on the HMO website).

The results pertaining to the above two questions are cross-tabulated in Table 2. Looking at the method, the majority of the complaints, three-quarters, were submitted orally. At the local level, 88% of the complaints were oral. When the complaint was submitted to the central administration or to an Ombudsmen office, the proportion of oral complaints was lower, but still over 40%. Looking at the recipients, the majority of the complaints, two-thirds, were submitted only at the local level; only 17.1% were made to one of the appointed Ombudsmen bodies. Overall, more than half of the complaints (57.9%) were submitted only orally and at the local level in this nationally representative sample. There were no significant differences between men and women, different age groups, those of different educational levels or levels of income, or those living in Jewish or non-Jewish residential areas, regarding either the recipient or the method for submitting a complaint.

Finally, respondents were asked if they have seen any publication, such as by their HMO, regarding rights to submit a complaint. The majority (83.9%) indicated they have not seen such information, and many of them (3.7%) were unsure. Only 10.4% reported seeing a publication about complaint rights (e.g. poster or leaflet of the HMO), and the rest were exposed to information through other informal sources such as the media (2.5%) or through talking to a HMO employee or a friend.

**Discussion**

This study replicates and extends findings from previous studies [13, 15] in showing that formal complaints on health issues are only a fraction of the pool of potential complaints. Our findings show that two-thirds of the aggrieved do not complain at all; those who do complain generally approach local bodies in their HMOs, and most of the complaints are made orally only. Further, complaining rates are lower in two
Informal complaints

Table 2 Recipients and methods of submitting complaints

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Method</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Written</td>
<td>Oral</td>
</tr>
<tr>
<td>Local</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>81</td>
<td>92</td>
</tr>
<tr>
<td>12.0</td>
<td>88.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>(29.7)</td>
<td>(78.6)</td>
<td>(65.7)</td>
</tr>
<tr>
<td>HMO senior management</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>(50.0)</td>
<td>(50.0)</td>
<td>(100.0%)</td>
</tr>
<tr>
<td>(32.4)</td>
<td>(11.7)</td>
<td>(17.1)</td>
</tr>
<tr>
<td>Official Ombudsmen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>(58.3)</td>
<td>(41.7)</td>
<td>(100.0%)</td>
</tr>
<tr>
<td>(37.8)</td>
<td>(9.7)</td>
<td>(17.1)</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>103</td>
</tr>
<tr>
<td>(26.4)</td>
<td>73.6</td>
<td>(100.0%)</td>
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<tr>
<td>(100.0%)</td>
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</table>

Each cell includes cell count and percentages in rows (columns).

Minority groups: non-Jewish citizens and those who immigrated in the last 20 years to Israel. Finally, the level of awareness regarding rights to complain is very low.

The findings are alarming, in the context of the health care system in Israel, where the National Health Law has established over 10 years ago the rights of all citizens to complain about health services to appointed bodies. Since most of the aggrieved do not submit a complaint and most complaints are made informally and at the local level, this situation hurts the ability of HMOs and the Ministry of Health to amass a reasonable amount of information about the criticisms or allegations of aggrieved persons as a whole, and of specific subgroups of a lower social status. As a result, the health system loses important information regarding areas of redress and has a weaker basis of evidence to design corrective actions that can improve health services quality and increase client satisfaction.

Before further discussing our findings, it is useful to reflect on what counts as a ‘formal’ complaint. We considered all oral complaints as informal, because the various health-related Ombudsmen in Israel accept only written complaints. Further, we assumed that when a complaint is submitted orally to a recipient at the local or even senior administration level, there is no assurance that it is recorded in writing, analyzed by the HMO, or counted and treated as an official complaint by the Ombudsman office or by other internal or external entity involved in monitoring service quality. However, these are postulates which may not generalize—oral complaints may be considered as formal complaints in other contexts (see [4] for an example from New Zealand).

Our findings are bounded by the characteristics of the national health system and culture in a single country, Israel. Yet, being based on a large national representative sample, and given the similarities between the health system in Israel and in several other countries, it is possible to point out several implications for research and practice.

More attention to causes of non-complaining and informal complaints in general, and to complaint patterns in minority groups. A complaint, whether formal or informal, starts with the existence of a grievance. However, as Felstiner et al’s seminal work [19] pointed out, a grievance results from a perceived dispute or service gap which exists in the mind of the disputant. Hence, attention has to be paid to the processes involved both in the creation of perceived disputes or service gaps and in their transformation to grievances and later to actual complaints. As well, more thought has to be paid to barriers and factors which stop the many clients who do perceive service gaps or disputes from complaining [15, 16].

Marketing researchers are turning more attention to customer complaining behavior (CCB), and are beginning to examine factors affecting complaining and non-complaining [12, 20]. However, relatively little is known about psychological, demographic or contextual variables affecting the choice of complaining method or recipient along the informal—formal continuum. For example, a behavior related to dissatisfaction with services, that of exit [9], has been shown to be affected by intergroup differences in race, gender, rural status and others [21]. The results of the present study show that those with lower social standing (e.g. minority groups, recent immigrants) are less likely to perceive a cause to complain or actually complain. These findings are consistent with those in some other countries [22], and may be found in socially vulnerable groups for multiple reasons, such as language and accessibility barriers, lack of knowledge about legal rights, a perception of lack of power in society, lower expectations for quality public services due to perceived lower social status or lack of appreciation for differences between health services in the country of origin and the country to which people immigrated.

Outreach and client education efforts may improve knowledge about complaining rights. Accessibility to complaining for low-literacy and other populations can be improved by more flexibility in complaining modes, such as by accepting both written as well as oral complaints (i.e. taken over the phone or face-to-face when a complainant visits an Ombudsman office). Such and other efforts may increase the proportion of citizens or those insured with health services who can exercise their legal and moral rights regarding quality of health services, if and when complaining is called for by the circumstances.

Relationship between complaining and satisfaction. The research literature claims that the way in which complaints are dealt with, and customers’ satisfaction with the complaint-handling process, can increase customers’ overall service satisfaction and loyalty to the service provider [10, 12], or even reduce future malpractice suits. However, the literature has not distinguished between formal and informal complaints which this study has shown to be the majority of complaints. Informal complaining may enable clients to vent negative emotions as much as formal complaining which has already
been shown to raise satisfaction levels due to venting effects [23], but more research in this regard is needed.

**Improvement of organizational processes.** Health services are paying increasing attention to recovery from service failures as part of the efforts to improve quality of service. If complaints are to be an important instrument for the improvement of health services, management should have a full picture of all types of complaints [24]. Since most complaints are submitted at the local level to front-line workers, it is recommended that HMOs develop processes for harvesting and analyzing the information front-line workers already possess. Further, HMOs should consider establishing structured organizational processes to enable front-line employees to report, perhaps even anonymously, information gained from handling informal complaints so that their existence and content can be communicated to higher management. This requires careful attention to the factors affecting workers’ willingness to take extra-role behaviors [25], since workers’ tendency to disclose or take action regarding problems discovered via an informal complaint process, or otherwise remain silent, is affected by managerial factors and organizational culture [26, 27] as well as by cultural factors [28].

Overall, health organizations that want to enforce organization-wide procedures for handling complaints and ensuring that clients or patients feel their complaints are treated fairly [14] face a challenge, as most complaints occur outside the purview of formal reporting procedures or depend on informal interactions between clients and diverse types of employees. The ubiquity of informal complaints and their potential for improving the quality of medical care imply that proper guidance [11] in complaint handling should be given to front-line workers, who shoulder the bulk of the complex work of handling complaints on health-related service matters.

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**References**


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