Feasibility of National Benchmarking of Patient Satisfaction with Australian Hospitals

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Purpose: This paper discusses the feasibility of developing national benchmark questions on patient satisfaction with hospital care in Australian hospitals. The research was undertaken for the Australian government under the National Health Outcomes Programme.

Data sources and selection: The paper draws on a review of research with consumers to identify issues of importance to them about hospital care. The Australian sources were reports by consumer and community organizations, research reports by hospitals, governments and academics, and data from complaints authorities. The emphasis was on consumers' own views. The main debates on patient satisfaction methodology were reviewed. Published material from the USA and Britain highlighting organizational policy issues was reviewed, as well as literature on benchmarking. Material was obtained through journal searches and identification of organizations which undertake consumer-oriented or service development research.

Conclusions: The paper argues that national benchmarking of patient satisfaction is not reliable because patient satisfaction is a poorly understood concept and not a unitary concept. Also, the paper argues that benchmarking is about processes, and that the link between survey results and hospital processes is not well researched or understood. While patient satisfaction surveys appear to promote consumer perspectives, they remain caught within a passive approach to consumer participation in shaping service development and improving the quality of hospital care. The task of government is to mandate consumer feedback, resource the development of expertise and technologies, trial and evaluate approaches to obtaining feedback, disseminate research and effective models, and resource consumer organizations to be participants at all stages. This is described as providing the resources for benchmarking at local levels.

Key words: Patient satisfaction, hospitals, benchmarking.

PURPOSE

This paper discusses the feasibility of developing national benchmark questions on patient satisfaction with hospital care in Australia. The policy research arises from a project funded by the National Health Outcomes Programme, which set out to develop a set of national benchmarks for hospitals, including quality benchmarks [1]. This article presents the authors' views, not the Australian Government's view.

The experiences and judgements of patients have become an important input to service development and quality review in hospitals and to audits across hospitals. The shift towards purchasing, rather than funding, health services has resulted in attention being given in many countries to ways of measuring hospital performance and, within this, to measuring the quality of hospital care. Report cards on services are an outcome of this shift.

Received 6 April 1996; accepted 18 July 1996.

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The consumer movement in Australia has argued that any quality measures should reflect a consumer perspective [2]. This meant that quality measures should include those aspects of care which consumers had identified as important to them. One response from the Australian government was to examine whether benchmarks of patient satisfaction could be used alongside other measures, such as readmission rates or post-operative infections, for a process of national audit of the performance of public hospitals. At the same time, many state governments moved in a similar direction, with the development of state-wide patient satisfaction surveys, using various instruments.

This article sounds a cautious note about using measures of patient satisfaction in a benchmarking exercise. We argue for alternative approaches which are theoretically more sound and which offer hospitals ways to develop useful mechanisms for consumer feedback. In brief, the arguments are based on the problematic nature of the concept of patient satisfaction which emerges from the literature, considerations about the use of consumer information and feedback to improve hospital quality, and arguments stemming from the literature on benchmarking.

As part of the background, it needs to be noted that Australia has a federal political system, with responsibilities for health at both the national and state, or territory, level. This complex and sometimes fraught relationship is an important backdrop to the conclusions reached.

THE APPROACH TO THE RESEARCH

This article draws from research by analysis of a broad range of secondary sources [1]. First, a review and synthesis of 14 research reports by consumer and non-government community organizations were conducted in order to examine the main issues of concern to consumers of hospital care and the nature of people’s experiences. We then examined a range of sources of information on Australian patients’ experiences and ratings of care, including research by hospitals; government policy reviews; data on complaints made by consumers, and on adverse incidents; and research by academic researchers into various aspects of the hospital experience. This body of material was complemented by an analysis of the practice and content of patient satisfaction surveys in seven Australian states and territories. These sources were used to construct a profile of issues identified by consumers about their experiences of hospitals with an emphasis on consumers’ own voices.

The next stage was to review the methodological literature on patient satisfaction to identify the main debates about the nature of patient satisfaction. The purpose was to see what practitioners in the field were saying about conceptual and methodological issues, rather than a systematic literature review of all aspects of satisfaction surveys. The review was undertaken by a hand search of British and American journals in the fields of quality of care, social sciences, health policy and evaluation. This was complemented by suggested reading from researchers who were conducting large-scale patient satisfaction surveys. Reference lists were checked to ensure critical reports had been collected.

The third step was to identify organizational and policy issues about patient satisfaction surveys. We canvassed a range of published material from organizations researching quality of care and service development issues, in Britain and the USA.

The final task was a review of Australian and international literature on benchmarking, in order to identify how the process of benchmarking is used to improve practice.

In conclusion, this article draws from all these strands of research, but has a primary focus on the reasons why the authors rejected the use of patient satisfaction surveys as the means of providing national benchmarks on quality of care for consumers.

PATIENT SATISFACTION AS A PROBLEMATIC CONCEPT

The concept of patient satisfaction requires critical scrutiny. What emerges from the literature is recent and serious questioning of the idea that satisfaction is a unitary concept whose causal variables can be measured. An earlier seminal article by Locker and Dunt [3] had suggested that it was rare to find the concept of satisfaction defined and there was little clarification in studies of what the term meant, either to
the researcher or the respondents. The cautionary tone of their article appears to have been largely unheeded, until the widespread experience of conducting patient satisfaction surveys in the 1980s led to a critical reappraisal in the 1990s.

A review of patient satisfaction research in the USA by Aharony and Strasser [4] concluded that most work has been empirical rather than "theory-testing" or "theory-building", and that there were a multitude of methodological dilemmas. They found no standard approaches to surveying, and little clarity and consistency in understanding the determinants of satisfaction. It could be argued that this stems from the absence of an accepted theoretical model of satisfaction.

Carr-Hill [5], writing in Britain, is critical of the conceptualization of satisfaction, particularly of the notion of satisfaction being a unitary concept, arguing that patient satisfaction is a "complex concept that is related to a number of factors including life style, past experiences, future expectations and the values of both individual and society" (p. 237). Patient satisfaction, he argues, is predominantly a derived concept. Because it is derived, as Locker and Dunt [3] had earlier suggested, the search for sources of dissatisfaction is the most important aspect of patient satisfaction research.

Satisfaction varies over time, as a number of authors note. Not only do people define it very differently, but one person may make different judgements at different times. This is because the sources of dissatisfaction vary so widely [5]. As there is no underlying unity to "satisfaction", it is not correct to combine satisfaction scores with various dimensions of care into one single index of satisfaction [5]. High levels of satisfaction with care overall may mask dissatisfaction with particular elements. People may be dissatisfied with doctors who communicate poorly, but who are nevertheless technically proficient. Satisfaction with the outcomes of care also may mask areas of dissatisfaction with particular elements of care.

An Australian study illustrates this point. A consumer survey in the state of Victoria, which was undertaken in the context of a government review of birthing services, concluded (p. 101):

While only a minority of women rated their antenatal care as "mixed", or "poor", half did not feel that caregivers had been considerate of their needs or that the information given to them before the birth had been a good aspect of their care [6].

Instead of seeing satisfaction as a fixed artefact in the patient waiting to be measured, research on patient satisfaction for the Royal College of Surgeons in England has assumed it is "fluid and emergent" [7]. The researchers, Meredith and Wood, found that a patient’s assessment of a surgeon’s communicative abilities could change if, in the course of treatment, the diagnosis changed dramatically. Given this assumption, in the surveys of surgery patients for the College, the questionnaire is administered twice over a period of 8 weeks to capture this emergent view.

Williams [8] has been highly critical of patient satisfaction research which is built on the assumption that satisfaction is an "independent phenomenon". Surveys force people to actively construct a notion of patient satisfaction, he argues, by forcing them to express their views in terms that are artificial. Consequently, inferences are made from results which may misrepresent service users’ beliefs. This goes to the concerns of consumer organizations, that patient satisfaction surveys seem to misrepresent what consumers have to say.

It is not known how people evaluate services or indeed whether "satisfaction" is the way people evaluate their experiences of care. Williams [8] argues that "simple expressions of satisfaction" are not able to convey an understanding, or embody what are important and complex beliefs. A rating of satisfaction may mask reservations which the person has about their care. The reductionism the methodology necessitates may rob the collected data of any meaning and collapse people’s complex responses to a simple rating of satisfaction. This is suggested, according to Williams, by the number of qualitative studies showing levels of disquiet about their hospital experiences not picked up by conventional surveys. An Australian study of the social impact of echocardiography (ultrasonic imaging of the heart), for example, found that interviews revealed higher levels of anxiety and doubt about test results than questionnaires [9]. A study of people’s use of hospital and community services for the Office on Ageing in the Australian state of New South
Wales followed telephone interviews on satisfaction with services, with focus groups [10]. In the focus groups, people who originally had registered satisfaction in the telephone interview were now keen to relate stories that revealed considerable breakdowns in processes of care. Aharony and Strasser report in their literature review that there had been no studies of a systematic analysis of the comments written at the end of patient satisfaction surveys, having noted earlier that open-ended questions produce more negative ratings and comments than closed questions [4].

There seems to be no clear relationship between expectations and patient satisfaction. In a review of work which attempted to model a correlation between expectations and values and people's satisfaction with care, Williams [8] noted that, while there was some correlation found, "very little satisfaction has been explained in terms of expectations and values" (p. 512). While they may be related, it is not a simple relationship. Like Meredith and Wood [7], he speculates that expectations may be modified during the process of care, which would influence subsequent evaluations.

There is also a question about the standards against which consumers might expect to make judgments about their care. Patient satisfaction surveys rarely inform consumers about such standards [11], so that the question "compared to what?" arises. Research in the childbirth field suggests that the dissatisfaction expressed by women who were socially disadvantaged in some way should not be seen in isolation from the restricted choices of care these women had [6].

In summary, researchers are highly critical of the assumption that patient satisfaction is a unitary concept present in the patient waiting to be discovered by researchers with questionnaires. Satisfaction is a construct, not a given. There is no agreement in the literature about what determines satisfaction. This, in our view, makes the measurement of satisfaction a poor candidate for simplistic benchmarking processes.

WHAT HAPPENS AS A RESULT OF PATIENT SATISFACTION SURVEYS?

Vuori concluded in 1991 that a review of the literature yielded no evidence of whether the measurement of satisfaction led to improved care [12]. In Australia, a state-wide survey identified problems in accident and emergency departments. The area was then the target of focus group research. The findings led hospitals to make changes which were then identifiable in a subsequent survey [1]. This example suggests the importance of, first, an ongoing commitment to review and, second, the need for a variety of methods to uncover problems and seek solutions. However, hospital staff involved with quality assurance reported to the authors that their institutions were often reluctant to act on the results of one-off surveys. Those who undertook the surveys were too often powerless to influence some of the organizational and resource issues that arose from the results. It is a problematic assumption that surveys which have primarily focused on measuring satisfaction and linking this to variable causal agents of dissatisfaction, give service providers and administrators information they can act on to improve services. A hospital with a comparatively poor result may not get from the surveys the type of information about how to improve their services. For example, a long wait in the queue may lay the ground for unsatisfactory communication in an outpatients consultation, but would only register as a communication issue [13].

To be useful, Carr-Hill argues, the measurement of satisfaction must be sensitive to changes in quality [5]. This rules out the majority of inpatient satisfaction questionnaires, which tend to report that the majority are satisfied. Of more use for hospital managers are feedback mechanisms which explore why the minority, and why particular groups, are dissatisfied. Patient satisfaction surveys commonly report very high levels of satisfaction, much to the delight of administrators and governments, who too often use them to deflect criticism of services. This approach tends to confirm the suspicions of consumer groups that patient satisfaction surveys are more about public relations than obtaining consumers' views.

While one aspect of hospital care may rate the greatest amount of dissatisfaction, Scott and Smith suggest that it is not necessarily the aspect consumers would wish to change first [14]. Surveys, they argue, do not ask people to rank particular aspects of the service they value. While some elements of care may be rated very poorly, patients may not consider these aspects
to be critical in improving outcomes. For instance, there is little in the consumer literature to support the preoccupation by surveyors with "hotel services", an aspect of hospitals that seems to dominate many of the surveys. An additional and related point is that the resource costs of improving an aspect of care to the degree that satisfaction is maximized may be too great for the benefit.

The focus on the aggregated views of individuals' satisfaction with care masks the balancing role of public services, which have to meet the needs of a community as well as the needs of individuals, as McIver argues [15]. The promotion of marketing tools to gain feedback ignores the reality that for many using hospital services, choices are limited. Asking Aboriginal and Torres Straight Islanders if they would recommend the hospital on Thursday Island (a small island off the coast of northern Australia, with a predominantly indigenous population) to their family and friends is not realistic, given the absence of choices available to them [16]. Groups in the population are rarely involved either in making judgements about the trade-offs inherent in questions about, for instance, satisfaction with access, such as comparing the amenity of local, but less specialized services, with access to specialized but centrally located services [17].

WHO IS A CONSUMER, AND WHOSE NEEDS ARE BEING SURVEYED?

There are a complex set of issues about whose views are sought in patient satisfaction surveys. The term "consumer" is one of beguiling simplicity, but contains the potential for conflicting and competing interests to emerge within the group it denotes. Patient satisfaction surveys seek the views of those who have successfully negotiated the process of being a patient and who are not too ill to be excluded from the sample. In Australia, surveys tend to be confined to the inpatient component of hospital care, and some groups of consumers — children and adolescents, people with a mental illness and people seriously ill — are routinely excluded. The term "consumer" also includes potential patients, those who have not been admitted, as well as, in a secondary sense, family members and carers.

The report of one Australian state-wide patient satisfaction survey suggests that patients are very forgiving about the shortfalls in their care [18] and many writers note the difficulty of getting past the gratitude response [13]. There are suggestions in the literature, however, that family members and carers may be more critical [4]. The interests and needs of the patient may not always coincide with the interests and needs of family or carers, e.g. when shorter lengths of stay may involve family and carers in longer periods of care for sicker family members [19]. To date, the views of carers and family members have commonly not been sought in Australian hospital surveys.

While patient satisfaction surveys are seen by hospitals and governments as a response to the rising voices of consumers, they tend to be a very passive way of obtaining consumers' views. McIver argues that patient satisfaction surveys often treat consumers impersonally, as providers of information that hospitals may or may not do anything with and that they do not empower consumers [11,15]. Consumers are often passive recipients of questionnaires which have been couched in terms of the researcher's or the hospital's preoccupations. A finding of the qualitative research for patient satisfaction survey of the Royal College of Surgeons in England was that patients sometimes blamed themselves when they judged communication to be poor [13]. This suggests that improving communication is something that needs to be addressed by increasing patient capacity and confidence to pursue questions about their concerns, as well as improving the communication skills of doctors and attending to the organizational environment.

WHAT THEN IS THE PURPOSE OF undertaking satisfaction surveys?

Scott and Smith write that most surveys are commonly viewed as an end in themselves, rather than being a means to an end [14]. Hospitals and governments can embark on surveys before agreement is reached about how the hospitals plan to act on the results. The British literature which was reviewed highlighted these issues very strongly [20,21].

We argue that policies and strategies to
improve the quality of hospital services should use information from consumer feedback mechanisms as one part of the picture and that this could come from multiple sources. To date, the main method of obtaining feedback has been patient satisfaction surveys and these are usually restricted option questionnaires. This means of gaining feedback may not be the only, or the best means to do this and their methodological complexities are rarely understood. Qualitative approaches can often be more valuable, especially in understanding issues for particular groups and populations. The issues raised across the comparatively inexpensive consumer research projects were not very different from what the larger surveys found at considerably more expense [1]. Deriving benchmarks from patient satisfaction, or components thereof, runs the risk of pushing hospitals in the direction of patient satisfaction surveys when other methods may suit their purposes to better effect and provide better information on which to improve services. Clarity of purpose was part of our consideration in assessing the feasibility of benchmarking patient satisfaction nationally.

Given the earlier point about the passivity inherent in questionnaires and the absence of a purpose of using consumer feedback to improve services, greater consideration needs to be given to the development of policies which strengthen the participation of consumers at all levels. For example, a hospital with a significant proportion of patients from a non-English speaking background may wish to have identified places on its board for relevant community representatives and could examine its policies on use of interpreters. These strategies may complement the use of surveys, most importantly in terms of setting a policy climate receptive to consumer needs. Consumers should also be playing an active role in terms of deciding what services should be reviewed, having input to the survey design, and reviewing the priorities for change which may emerge from the survey data.

There are tensions between what governments or purchasers want for their purposes and what is useful to hospitals. This particularly goes for questions about the kind of detail sought and adequate sampling of particular subpopulations to provide useable information. The kind of survey that may suit governments to report performance comparisons may not be what is of most use to hospitals. There are issues about whether the information obtained is general or related to the local hospital context and concerns. It may depend on whether a hospital is interested in market share or equity concerns. Many groups are not well represented amongst the respondents to surveys in relation to their presence in the target population. Key groups may also be omitted, yet the nature of their disadvantage may be of critical importance in delivering appropriate care. For example, it is rare to find the issue of literacy, either in English or non-English language, mentioned in discussions of survey design or number of refusals [1], yet the extent of illiteracy is known to be problematic in Australia and in the United States [22,23]. These issues are critical, yet often ignored, despite the wider recognition of the multi-cultural nature of those countries pursuing satisfaction surveys, or the relations between lower socioeconomic status and literacy, and lower socioeconomic status and health. Surveys commonly have problems about getting adequate sub-samples of some subpopulations, e.g. people from non-English speaking backgrounds. Of the Australian surveys, only the Victorian state-wide Birthing Review survey was clear about its population sample and which particular subpopulations were under-represented [6,24].

Many of the issues raised here are very similar to the debates about the value of league tables of hospital performance and "report cards" [25]. In particular, they raise the potential for conflict and tension between measuring performance for the purposes of continuous quality improvement and measuring performance for external accountability. To be useful for quality improvement, sources of dissatisfaction need to be sought and explored, but for the purposes of a league table or report card, hospitals will want to maximize indicators of satisfaction. As Epstein notes [25], risk adjustment is not well handled in performance measures, and patients' assessments of care do seem to be affected by condition, although this aspect is under-explored in the literature [13]. In addition, the statistical complexity of measurements are concealed in league tables [26]. All this is amplifed in patient satisfaction by the softness of the concept itself and the substitution of a simplified aggregated measure for what need to be iterative processes.
Our assessment was that the best patient satisfaction surveys which emerged from the review were good on methodological questions, but also were undertaken with a clear sense of purpose, so that this shaped the questions that were asked and how they were asked. The Victorian Birthing Review survey was undertaken, for example in the context of a state government review in order to check the representativeness of submissions made to the review [6]. It was claimed by some of the review members that these were the views of middle-class women with high expectations. Amongst other findings, the research established that such critical views were held even more strongly by women who were disadvantaged in various ways. The survey also sought to find out about what women thought of different models of care.

Finally, there are particular problems in using patient satisfaction surveys to compare results in a national benchmarking exercise, because of the difficulty of ensuring that like is being compared to like. This problem is not unique to patient satisfaction [25], but there is enough evidence to suggest that results are affected by the survey used, timing, auspice, the response format and ways of distributing questionnaires. In addition, there is recent evidence of the effect of casemix on patients' evaluations [13]. This is backed by the profiles discussed by Gerteis and colleagues [27], which indicated that teaching hospitals in the United States performed less well. Whilst organizational factors probably contribute to this, it is likely that there are also casemix effects here, given the role of the teaching hospitals in providing free care to disadvantaged people and their role in treating substantial numbers of more serious cases and less common conditions. Little is usually known about non-respondents and the bias resulting. Few surveys are based on population samples, and samples are constructed on different assumptions. While these can be controlled in smaller, focused, purpose-built studies, the chances of controlling these is unrealistic in national comparisons, particularly given the tensions between state and national governments in a federal system such as Australia's.

**BENCHMARKING**

- The literature on benchmarking backs the conclusions that emerge from the review of methodological issues in satisfaction surveys, as well as clarifying the necessity to focus on the purpose of the exercise. Benchmarking emerged from manufacturing as one of the tools of continuous quality improvement. Behind it are two ideas — identifying organizations that are particularly good at something and learning from them how they do it. Spendolini [28], one of the major authors in the field, writes (p. 9):

> with benchmarking, the focus is extended beyond the scope of the finished product or services to concentrate extensively on process issues. The emphasis (is) not only on what another organization produced but also on how the product or service was designed, manufactured, marketed and serviced.

The development of benchmarking is a step beyond comparing performance and outcomes to understanding how organizations accomplish these.

A number of overseas and Australian authors emphasize the point that benchmarking is a continuous process, concerned more with understanding best practice processes than the numbers that establish best practice at any time [29]. Robert Camp, one of the advocates of benchmarking, introduced it at Xerox. He commented that 90% of the benchmarking they used was process benchmarking [30]. By this, he meant that processes and not results were benchmarked. Camp argues that in the benchmarking approach, the danger is that: “measures are overemphasized and processes are overlooked” [31].

Benchmarking is a tool aimed at driving change. Targets are set that are continually moving and changing, as the organization looks for change directed at improvement. It is not a static once-a-year effort, but a process of continuous quality improvement.

**BENCHMARKING IS ABOUT IDENTIFYING BEST PRACTICE**

The literature makes a clear distinction between benchmarking and comparative performance measurement. Performance measurement says nothing about how organizations get there [30]. The point of benchmarking theory is to move beyond knowing how other organizations perform, to understanding why their perfor-
formance is excellent. Benchmarking, according to the literature, is about identifying the processes that lead to best practice — the factors, process methods, practices, skills, systems, technologies, resource distribution and so on [30]. It is this type of information that organizations need to inform change.

Benchmarking is not just about being compared against the industry average. A common approach described as benchmarking is the publication of industry data, with standardized performance information so that organizations can be compared against the rest of the sample. The Australian government's own Best Practice Programme is critical of this approach and argues that (p. 3):

Databases can be useful, and performance indicators and targets are essential aspects of any well managed benchmarking approach. However, they will only be used effectively if combined with a change programme based on shared and detailed understanding of the practices and structures which produce exemplary performance levels. Furthermore, because of problems arising in making genuine "like with like" comparisons, numbers tend not to be particularly effective drivers of change [32].

BENCHMARKING PATIENT SATISFACTION

This raises questions about patient satisfaction. What is the best practice in patient-centred care? Which good practice in hospital care reflects consumer priorities and perspectives? Methodological complexities aside, it is not sufficient to publish league tables of hospital scores in patient satisfaction, or even to compare individual hospitals with the national or state average. This is not benchmarking. Its best effect may be to break "paragdems of comfort" by highlighting shortfalls in performance [30]. However, it is not benchmarking until it leads to an understanding of what the best performing hospitals, clinics or wards do, which improves consumers' experiences of particular aspects of their hospital care.

It could be argued, as Epstein does [25], that there is some merit even in an imperfect measure and that imprecise measures such as a single patient satisfaction index may highlight the extremes of performance and cause hospitals to explore the area in more detail. While this is a plausible argument, there is reason for caution. There is a considerable investment in time and money in conducting patient satisfaction surveys that needs to be justified by the effectiveness of the effort. Consumers (and hospital staff) also become sceptical if they do not think that hospitals act on the feedback they provide. Undertaking surveys where the only purpose is to rank hospitals runs the risk of reducing the credibility of surveys in general. Nevertheless, there may be a role for nationally based surveys that aim to highlight particular aspects of patients' experiences with hospitals, as part of a programme to stimulate innovations around those elements of care.

An example of useful benchmarking is illustrated in the work of Gerteis and colleagues [27]. Here, a patient satisfaction survey was undertaken in the context of the Picker-Commonwealth Program for Patient-Centred Care in the United States, as part of a process of improving models of care (reported also by Cleary and colleagues [33]). Profiles of hospitals were constructed from the results and analysed to try to understand what characterized the most patient-centred hospitals and what were the organizational and management practices that contributed to this. Interdisciplinary teams then visited the high-performing hospitals to try to identify those management practices and organizational characteristics which led to patient-centred care. This approach is consistent with the idea that the benefits of best practice lie in the opportunity for organizations to learn from concrete examples of good practice [30].

Epstein, when discussing the use of report cards, concluded that a single national report card may be a mistake and that regionally defined indicators may enable local priorities to be addressed [25]. This seems to derive from similar concerns. Some of the better surveys address particular aspects of hospital care. In Australia, as elsewhere, some of the most informative consumer feedback comes from studies that are condition- or service-specific.

The survey of the research by Australian consumer organizations [1] indicated that the more discursive and qualitative research preferred by these groups allows people to highlight models of care which are preferred, giving some insight into those organizational characteristics.
consumers consider maximize their chances of good care.

Benchmarking — in practice — supports our view that patient satisfaction surveys are useful when undertaken with clear objectives in mind about the role the feedback will play in improving health services. Consumer feedback, in order to be useful, should be derived from a variety of sources reflecting both quantitative and qualitative research approaches, so that the picture behind the figures can take some shape. Benchmarking is likely to focus on particular aspects of consumers’ experiences, such as being treated with dignity as a person, communication, provision of information, coordinating care, or discharge planning. The “learning” is in how the results are achieved, not in the figures themselves. This is not to say that comparison of performance is not relevant, but that it needs to be set in a context where “benchmarking partners” have set up a dialogue and where a range of stakeholders, including consumers are involved.

There are genuine dilemmas about patient surveys. The focus on local relevance often is not accompanied by expertise available at that level [11,21]. The sample sizes may not lend themselves to the detailed statistical analyses that larger samples make possible. We argue that there is a case to build centres of expertise, which are in the public realm and which contribute to better survey design and analysis, as well as theory building [1]. This enables local efforts to be supported by high levels of expertise. Hospitals, for example, that are part of a wider patient satisfaction study, may negotiate to over-sample and include particular areas of concern to them.

CONCLUSION

We conclude that as patient satisfaction is not a unitary or given concept and as results are open to variation on methodological grounds, reliable national comparative data are an illusory comfort. While the term “benchmarking” is used to describe this exercise, it is a loose use of language. As indicated, the problems of reliable comparisons, competing incentives at hospital level and the treatment of statistical variation are not unique to patient satisfaction, but are amplified by the problematic nature of the concept itself.

This is not to argue that comparative and systematic studies are not possible or useful. On the contrary, the best examples reviewed were of this kind: well researched; with clear sampling rationales; able to take advantage of large samples and sufficient subsamples, as well as analytical sophistication to provide detailed analyses; and providing valuable contributions to the literature. They usually had a well-developed purpose in relation to reflecting consumer perspectives and improving service quality. Often these were focused on particular types of services, such as childbirth services or surgery.

The starting point has to be at the level of health services and the test of policy is that it produces change at this level. This is accomplished by genuine and effective programmes to obtain consumer feedback and to use it as part of planning and quality improvement. This is a collaborative effort with consumers, who are partners in the process, not passive informants. Multiple sources of information are used, drawing on qualitative and quantitative approaches. To drive change, this needs to be a process of iterative research, rather than one-off exercises producing simplistic and single measures of satisfaction.

We argue that the task of central government in this is a policy one — to mandate consumer feedback, stimulate its development, resource the development of better expertise and technologies, trial and evaluate innovative approaches to obtaining feedback, disseminate research and effective models and resource consumers and consumer organizations to be active participants at all stages. This could be described as providing the resources for benchmarking at more local levels. Financing arrangements between governments and services may provide the opportunity to do this.

Acknowledgements: This work was undertaken in the Department of Social Science, Royal Melbourne Institute of Technology, where Mary Draper is a Senior Lecturer and Sophie Hill was a contract researcher.

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