

Obtaining consumer feedback from clients of home based care services

A review of the literature

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Obtaining consumer feedback from clients of home based care services: A review of the literature

**Prepared for HACCC Officials in relation to the HACCC Service
Standards Consumer Appraisal Data Development Project**

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and
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1. Introduction

1.1 Aims and objectives of this review

This literature review examines methods for obtaining consumer feedback from the users of home based care services. Its aim is to provide an informed discussion of the advantages and disadvantages of various methodological approaches and to canvas issues that arise in the collection of these data. The review was undertaken to inform the development of a method or methods to be used in the collection of consumer feedback from clients of Home and Community Care (HACC) services, as part of the HACC Service Standards quality appraisal process.

1.2 Approach

This review summarises the findings of research and discussion papers that deal with the collection of consumer appraisals of service quality in health and welfare services. It focuses most specifically on studies that deal with populations similar to the HACC target groups. Consumers of HACC services fall into three main categories: frail and disabled older people; younger people with a disability; and their carers. This review also examines issues associated with special need groups within the HACC target population, in particular, people with dementia, people from non-English speaking backgrounds, Indigenous people, people who are financially disadvantaged and those living in remote and rural locations.

The review canvasses both international and Australian literature. A full description of the method used in the literature review is presented in Section 2 (Research Strategy).

1.3 Background

The HACC Service Standards Consumer Appraisal Data Development Project is being undertaken at the instigation of the HACC Officials Standards Working Group and is supported by HACC Officials. It represents a continuation of the Australian Institute of Health and Welfare's assistance to this group in implementing quality assurance initiatives in the Home and Community Care Program.

Previously the Institute assisted in the development and refinement of an Instrument to measure agency compliance with the HACC National Service Standards based on agency reports of service provision practices. The Consumer

Appraisal Data Development Project expands on one aspect of that earlier project by addressing the important contribution that client appraisals can make in the assessment of quality in HACC agencies.

The first stage of the HACC Consumer Appraisal Data Development project involved investigating and reporting on work that has already occurred in the area. This review of the current literature informed the second stage of the project, a field trial to test strategies for obtaining consumer input into the HACC quality assessment process. The field trial will be undertaken during 1999.

The literature review considers best practice models for the collection of consumer appraisal data. It examines options for data collection in terms of the usefulness of the method in informing assessors about the quality of the service provided by an agency. It assesses the viability of methods according to such criteria as cost, timeliness, practicality, acceptability to clients, and usefulness to service providers.

1.4 Structure

Section 2 of the report contains an outline of the methods used in preparing this literature review.

Section 3 contains a tabulation and annotated bibliography of studies published in Australia since 1996 that are concerned with the collection of feedback from consumers of health and welfare services. The tabulation provides an overview of survey methods currently in use and also provides a context for their use. Characteristics of the population to which each survey method is applied and the nature of the measures are described.

Section 4 draws on the full range of literature reviewed for this project. This included Australian and international literature from 1988 to the present. The section outlines the major issues that emerge for researchers and practitioners in the collection of valid and reliable feedback from consumers. A particular focus is given to issues relevant to the populations whose characteristics are shared by Home and Community Care consumers.

Section 5 canvasses the major research methods used to obtain feedback from such consumers and outlines the strengths and weaknesses of each approach.

2. Research strategy

The material presented in this report was obtained by two means: a library search and a search of unpublished reports. The method of conducting these two searches is described in Sections 2.1 and 2.2.

2.1 Library search

2.1.1 Keywords

The search was conducted using CD-ROM and internet databases, with the following keywords:

consumer survey
service quality appraisal
quality assurance
client satisfaction
methods / methodology
elderly / frail / aged
dementia
Indigenous / Aboriginal / Torres Strait Islander
non-English speaking background
financially disadvantaged
remote / rural

2.1.2 Databases

The databases used in the library search covered materials published between 1988 and the present, and included both Australian and international studies. Ten databases were searched:

MedLine, a CD-ROM database of medical journals provided by the US National Library of Medicine. A search of MedLine uncovered 27 records, of which 10 were considered relevant.

SocioFile, a CD-ROM database covering all aspects of sociology, including social planning policy and development. A search of SocioFile uncovered 38 records, of which 15 were considered relevant.

PsycLit, a CD-ROM database providing access to the international literature of psychology and related material in the disciplines of education, medicine, sociology and psychiatry. A search of PsycLit uncovered 32 records, of which 19 were considered relevant.

Health & Society, a CD-ROM database covering sociological issues relating to health. A search of Health & Society uncovered 12 records, of which 5 were considered relevant

HealthSTAR, a CD-ROM database of nursing and other medical journals. A search of HealthSTAR uncovered 14 records, of which 12 were considered relevant.

Rural, a CD-ROM database of journals and other publications dealing with issues in remote and rural populations. A search of Rural uncovered 11 records, of which 3 were considered relevant.

APAIS, a CD-ROM database covering public affairs issues. A search of APAIS uncovered 6 records, of which 4 were considered relevant.

Health References Center, an internet database available through the on-line *FirstSearch* facility, which covers sociological issues related to health. A search of Health References Center uncovered 13 records, of which 7 were considered relevant.

Inside, an Internet database provided by the British National Library that covers all academic disciplines. A search of Inside uncovered 13 records, of which 8 were considered relevant.

PubMed, an Internet database provided by the American National Health Institute, which covers both general and specialist medical journals. A search of PubMed uncovered 15 records, of which 8 were considered relevant.

The total number of relevant references uncovered with CD-ROM and Internet databases was 112.

2.2 Unpublished reports search

HACC agencies and peak bodies frequently undertake research on issues relating to service quality and evaluation. This work is often only for use by the service or only for local circulation. Attempts were made to obtain both published and unpublished work on large scale consumer surveys undertaken by agencies and peak bodies. This was done by contacting 70 key individuals in state and federal departments, non-government bodies, and university departments, and requesting information on such reports or persons who may know of such reports.

3. Review of Australian studies

3.1 Characteristics of Australian published consumer surveys (1996-present)

Twenty-four Australian consumer survey studies published since 1996 were located by the searches undertaken. Of these studies, the most common survey method used was self-administered questionnaires. This method was used in nineteen of the twenty-four studies (79%). In some cases more than one method was applied. Four of the studies (17%) used personal interviews, three (13%) used focus groups, and three (13%) used telephone interviews.

3.1.1 The relationship of survey method to survey purpose

The majority of the consumer survey studies examined measured consumer satisfaction with services. Only six of the twenty-three studies did not include satisfaction among the factors measured.¹ A number of other measurement foci were also present, resulting in seven summary topic areas presented in Table 3.1: consumer satisfaction and opinion of service quality; consumer outcomes; consumer characteristics; needs of consumers; consumer expectations and desired service improvements; service experiences and consumer knowledge.

Table 3.1 shows that self-administered questionnaires were used to measure consumer views on all seven of these topic areas. In many cases these questionnaires were used to collect data on a number of topics at once. Self-administered questionnaires are one of the most cost-effective methods for obtaining consumer feedback, a factor that no doubt accounts for its widespread use. In addition, questionnaires facilitate the coverage of a range of issues since their structured format allows questions to be concisely directed at areas of interest.

Focus groups and telephone interviews were primarily used to measure consumer satisfaction or, in the case of one telephone interview, to assess consumer knowledge. Focus groups provide a forum in which discussion is shaped by the shared experiences of the participants. As such, issues salient to the group emerge - a characteristic useful for collecting information on consumer satisfaction. However such a forum is less amenable to collecting information on individual consumer characteristics, such as service knowledge, individual needs, or expectations about the service. Telephone interviews, while allowing

¹ Satisfaction measures also tend to dominate consumer surveys conducted in other countries, as described in Section 4.

the collection of individual data, are generally kept short to minimise the strain on participants. This may account for the finding that they have primarily been used for only one purpose in each survey.

Personal interviews allow for the collection of detailed individual data. In the four personal interview studies reported in this review, consumers' views on a range of subject areas were measured. The cost of undertaking these studies may account for their low rate of use.

3.1.2 The relationship of survey method to participant characteristics

The consumers participating in the surveys listed in Table 3.1 range from the general population to clients of specific services in particular ages or from particular sub-groups such as persons from a non-English speaking background. Self-administered questionnaires were used for all of these participating groups.

Personal interviews were used by Brown and Doran (1996) to discuss issues of health for women, an area that could be considered by some respondents to be personal and confidential. They were also used by Dillon, Innes and Ginis (1997) when assessing the views of consumers with a communication disability. Small (1996) and Mackay, Gilchrist and Woodward (1998) used personal interviews in the process of developing and testing survey tools and methods.

The use of focus groups or telephone interviews was more a function of the purpose of the study than of the participants' characteristics. Focus groups were used as a first step or exploratory method to uncover issues salient to consumers in relation to their health care or welfare use (Small, 1996; McDonald, 1996; Stedman, Mellsop, Yellowlees & Clarke, 1996). For Sawyer, Miller, Pearson, Marino & Homer (1997), telephone interviews provided an efficient method of collecting data on patient satisfaction shortly after the care episode.

TABLE 3.1: Topics examined in published Australian consumer surveys since 1996, by method.

Author	Satisfaction quality	Patient outcomes	Characteristics of consumers	Needs of consumers	Need for improvement/expectations	Service experiences	Service health knowledge
Questionnaire method							
Adams, Tyrell-Clark, McLeod, Smith, Billett	X				X	X	
Boyhan		X					
Brown & Lumley	X	X				X	
Clark, Steinberg, Bischoff		X		X			
Dillon, James, Ginis	X	X					
E-QUAL	X		X	X		X	
Evans		X			X		
Fan, Boldy, Bowen	X	X	X	X		X	
Frank Small & Associates	X				X	X	
Germain, Manktelow	X					X	
Jimmieson, Griffin	X					X	
Johnston, Wong	X						
Lewis, Campain, Wright	X	X					
Mackay, Beer, Gilchrist, Woodward	X						
Phillips, Dennerstein, Farish	X						
Sanson-Fisher, Foot				X			
Stedman, Mellsop, Yellowlees, Clarke	X						
Webster, Forbes, Foster, Thomas, Griffin, Timms	X						
Weisberg, Fraser	X		X				X
Wood	X		X			X	

TABLE 3.1 (continued).

Author	Satisfaction quality	Patient outcomes	Characteristics of consumers	Needs of consumers	Need for improvement/expectations	Service experiences	Service health knowledge
Personal interview method							
Brown & Doran			X	X	X		
Dillon, James, Ginis	X	X					
E-QUAL	X		X	X		X	
Frank Small & Associates	X					X	
Mackay, Beer, Gilchrist, Woodward	X						
Focus group method							
Frank Small & Associates	X					X	
McDonald	X	X					
Stedman, Mellsop, Yellowlees, Clarke	X						
Telephone interview method							
E-QUAL	X		X	X		X	
Mackay, Beer, Gilchrist, Woodward	X						
Sawyer, Miller, Pearson, Marino, Homer	X						
Thomas, Clarke							X

3.2 Annotated bibliography of consumer survey studies conducted in Australia 1996-present

Adams P, Tyrell-Clark M, Macleod B, Smith M & Billett P (1996). Client satisfaction survey for child health. *Australian Journal of Primary Health Interchange*, 2(2): 86-89.

Survey Method: Questionnaire.

Objective: To evaluate consumer satisfaction with child health care in the Armidale Kelmscott Health Service. The questionnaire covered publicity, facilities, access to service (phone contact and waiting periods between seeking and gaining an appointment), nurse expertise/knowledge, service expectation and general satisfaction with the service.

Boyhan P (1996). Clients' perceptions of single session consultations as an option to waiting for family therapy. *Australia and New Zealand Journal of Family Therapy*, 17(2): 85-96.

Survey Method: Questionnaire.

Objective: To ascertain what consumers of family therapy think about single session consultations. The families surveyed were asked to indicate the benefits which they gained from the therapy session and whether they felt that a single session was sufficient. These responses were then compared to those of families which had received multiple session consultations.

Brown W & Doran F (1996). Women's health: Consumer views for planning local health promotion and health care priorities. *Australian and New Zealand Journal of Public Health*, 20(2): 149-154.

Survey Method: Personal interview.

Objective: To establish (1) the health problems experienced by women, (2) the problems with which women would have liked more help, and (3) women's perceptions of how their health care experiences might have been improved. The interviews explored the prevalence of health problems such as tiredness, stress, premenstrual syndrome and arthritis. They also gathered suggestions as to how to improve both access to health services and the provision of health information from doctors and other health care professionals.

Brown S & Lumley J (1997). Reasons to stay, reasons to go: Results of an Australian population-based survey. *Birth*, 24(3): 148-158.

Survey Method: Questionnaire.

Objective: To investigate women's opinions about shorter postnatal stays and to assess the impact of early discharge on maternal health outcomes. Women's views and experiences of length of hospital stay were gathered by means of a state-wide postal survey of all women who gave birth in Victoria during two weeks in 1993. The questionnaire gathered data on a variety of dimensions, including: length of stay, level of obstetric intervention, incidence of post-natal depression, satisfaction with hospital services, and concerns about possible adverse consequences of shorter hospital stays.

Clark M, Steinberg M & Bischoff N (1997). Admission and discharge policies and the elderly: A survey of Queensland public hospitals. *Australian Journal on Ageing*, 16(4): 151-154.

Survey Method: Questionnaire.

Objective: To examine the impact of casemix funding on the frail and disabled older people. Older patients in public hospitals in Queensland were surveyed to determine whether their needs were catered for by the hospitals' admission and discharge policies. The policies investigated by the questionnaire related to the length of waiting lists, accessibility, expertise of nurses, pre-operative preparation, length of stay, and post-operative treatment.

Dillon H, James A & Ginis J (1997). Client Oriented Scale of Improvement (COSI) and its relationship to several other measures of benefit and satisfaction provided by hearing aids. *Journal of the American Academy of Audiology*, 8(1): 27-43.

Survey Method: Personal interview/questionnaire.

Objective: To develop methods for measuring the self-reported benefit and satisfaction provided by a hearing aid. The methods tested included a new tool called the Client Oriented Scale of Improvement, in which the client effectively writes the self-report questionnaire by nominating up to five listening situations in which help with hearing is required.

E-QUAL (1998). *Review of approaches to satisfaction surveys of clients of disability services.* Report prepared for the steering committee for the review of Commonwealth/State service provision. Subiaco: E-QUAL.

Survey Method: Questionnaire/telephone interview/personal interview

Objective: To review the appropriateness of a variety of consumer satisfaction surveys for use with clients of disability services. The review was conducted in order to "provide advice to the Disability Services Working Group on an appropriate mix of methodology for a survey to provide nationally comparable

information on the satisfaction of clients of disability services". The instruments examined were:

- the Disability Services Commission (WA) Telephone consumer satisfaction survey
- the Health and Community Services (VIC) Adult Training and Support Services consumer satisfaction survey
- the Department of Human Services (VIC) Public Mental Health Services consumer satisfaction survey
- the Colorado Department of Human Services (USA) Colorado Progress Assessment Review
- the National Association of State Directors of Developmental Disability Services and the Human Services Research Institute (USA) Core Indicators Project.

Evans M (1996). Care of the elderly. *Worldwide Attitudes*, 5 August 1996: 1-8.

Survey Method: Questionnaire.

Objective: To explore the issue of how frail and disabled older people should be cared for. The 1995 International Social Science Survey (Australia) asked a random sample of individuals for their opinions on how well a variety of different individuals and organisations cared for the aged. The individuals and organisations in question were: daughters, sons, other relatives, neighbours, private homes for the aged, and government homes for the aged.

Fan Y, Boldy D & Bowen D (1997). Comparing patient satisfaction, outcomes and costs between cataract day surgery and inpatient surgery for older people. *Australian Health Review*, 20(4): 27-39.

Survey Method: Questionnaire.

Objective: To examine the characteristics of older people undergoing cataract surgery, and to compare the opinions, satisfaction, outcome, costs, reported health problems and social circumstances of day surgery patients with those of hospital inpatients. The study sample was drawn from the client database of a health insurance fund and covered people aged 60 years or more who had recently undergone cataract surgery. The subjects were asked to rate their satisfaction with pre-operative preparation, the expertise and courtesy of nurses, the bedside manner of doctors, and post-operative treatment.

Frank Small & Associates (1996). *Research report on Home Care's customer satisfaction survey.*

Survey Method: Personal interview/focus group/questionnaire.

Objective: To assess the Home Care Service of NSW in terms of its service delivery and staff performance, as perceived by the consumers of its services. The first phase of the study was exploratory, consisting of in-depth interviews and small group discussions with consumers, carers and staff. The second phase examined the service cycle from referral to service delivery. Questionnaires asked service consumers to rate the level of importance and the level of performance of various aspects of service, staff qualities and whether overall expectations were met.

Germain E & Manktelow N (1997). Consumer satisfaction with health services: A cross-cultural comparison of Anglo-Australian and migrant Australian women residing in north Queensland. *Northern Radius*, December, 11-13.

Survey Method: Questionnaire.

Objective: To examine women's responses to health services in North Queensland. Women from such diverse backgrounds as Japan and the Middle East, as well as Anglo-Australian women, were surveyed. They were asked about their experiences with health professionals, with special reference to the use of technical jargon and ambiguous phrasing, and whether cultural and linguistic representatives can be found at health centres.

Jimmieson N & Griffin M (1998). Linking client and employee perceptions of the organization: A study of client satisfaction with health care services. *Journal of Occupational and Organizational Psychology*, 71(1): 81-96.

Survey Method: Questionnaire.

Objective: Previous studies of client satisfaction with health care services have concentrated on the socio-demographic and predispositional characteristics of the client. This survey also included organisational characteristics as predictors of client satisfaction. Participants in the research were clients of a public-sector health care organisation; they were asked to indicate how satisfied they were with the organisation's services, structure, efficiency, and concern for their well-being.

Johnston A & Wong L (1997). Bubbles before birth. *Journal of the Australian College of Midwives*, 10(1): 25-27.

Survey Method: Questionnaire.

Objective: To determine the satisfaction of patients with a spa bath in the maternity unit of a hospital in Western Australia. Respondents were asked to indicate what they thought of the spa bath as an alternative method of pain management, and to compare it to other more conventional methods.

Lewis J, Campain A & Wright F (1997). Accessibility and client satisfaction with dental services in Melbourne. *Australian and New Zealand Journal of Public Health*, 21(2): 191-198.

Survey Method: Questionnaire.

Objective: To compare the accessibility of and client satisfaction with the two main types of public dental service providers in Victoria as well as with private practice services. The survey was administered to clients of the Royal Dental Hospital in Melbourne, Northcote Community Health Centre and private practices in Melbourne; satisfaction was measured in terms of availability, convenience, waiting times, pain relief, expertise of dentists, and continuity of care.

Mackay S, Beer J, Gilchrist J & Woodward M (1998). *Development of a model for benchmarking and quality improvement in aged care.* Bundoora, Centre for Applied Gerontology.

Survey Method: Personal interview/telephone interview/questionnaire.

Objective: To determine the effectiveness of commonly used techniques for assessing client satisfaction, with particular reference to their application to older clients. A literature review examined the advantages and disadvantages of the following consumer survey methods: focus groups, personal interviews, telephone interviews, questionnaires, and comment cards. The findings of this review were used to develop a new client satisfaction tool, which was trialed with clients of a community rehabilitation centre, using three different survey methods (personal interviews, telephone interviews, and questionnaires).

McDonald I (1996). Qualitative and quantitative approaches to consumer information. In: *Integrating health outcomes measurement in routine health care conference, August 1996: Proceedings.* Canberra: AIHW, 69-74.

Survey Method: Focus group.

Objective: To tap into the beliefs, attitudes and feelings of patients who suffered a heart attack during a twelve-month period. Focus groups were convened in order to investigate the relationship between patient satisfaction and compliance with directions from doctors and other health care professionals. The assessment of patient satisfaction was qualitative, being based on the focus group discussions, while the measurement of non-compliance with medical advice was quantitative, being based on the number of reports of non-compliance by doctors, social workers and other carers.

Phillips N, Dennerstein L & Farish S (1996). Progress and evaluation of a consultation-liaison psychiatry service to an obstetric-gynaecology hospital. *Australian and New Zealand Journal of Psychiatry*, 30(5): 703.

Survey Method: Questionnaire.

Objective: To evaluate a psychiatric consultation-liaison service in a Melbourne obstetric-gynaecology teaching hospital. Patient satisfaction was assessed using a questionnaire which asked respondents to rate (on five-point Likert scales) how helpful the consultation-liaison service was to them during their stay.

Sanson-Fisher R & Foot G (1996). How to collect information from patients . . . The development of a needs-based questionnaire. In: *Integrating health outcomes measurement in routine health care conference, August 1996: Proceedings*. Canberra: AIHW, 84-86.

Survey Method: Questionnaire.

Objective: To develop a reliable and valid needs assessment instrument for cancer patients. The instrument tested in this study was the Cancer Needs Questionnaire, the items of which were generated after an extensive literature review, semi-structured interviews with cancer patients and discussions with a variety of service providers. These items investigated patient needs in five different areas: (1) psychological needs, for problems such as anxiety, anger and depression, (2) health information needs, relating to the need for information about the disease, treatment and prognosis, (3) physical and daily living needs, (4) patient care and support needs, relating to staff sensitivity, and (5) interpersonal communication needs, relating to awkwardness in talking and relating to others.

Sawyer M, Miller L, Pearson C, Marino B & Homer C (1997). Health outcomes at a children's hospital: Parent satisfaction with services. In: *Integrating health outcomes measurement in routine health care conference, August 1996: Proceedings*. Canberra: AIHW, 176-179.

Survey Method: Focus Group/telephone interview.

Objective: To investigate parent satisfaction with inpatient care provided to children at the Women's and Children's Hospital in Adelaide. Focus groups with parents, children and hospital staff were used to establish the content of the questionnaire, whose dimensions included: respect for children's values and preferences, coordination of care, information and education to child, emotional support, surgery care, pain care, visiting arrangements, and discharge planning.

Stedman T, Mellso G, Yellowlees P & Clarke R (1996). Field testing of selected measures of consumer outcomes in mental health. In: *Integrating health*

outcomes measurement in routine health care conference, August 1996: Proceedings. Canberra: AIHW, 50-56.

Survey Method: Questionnaire/focus group.

Objective: To assess the opinions of consumers of mental health services about the applicability, practicality, reliability and validity of certain mental health outcome measures. The consumers surveyed had diagnoses of schizophrenia, affective disorder or anxiety disorder, and were nominated by service providers from three practice settings (public sector, private sector and general practice). The questionnaires were presented to these consumers using a laptop computer, with the data being entered by the participant directly onto the computer screen. In addition, focus groups were convened to allow the consumers to discuss with the research team various issues relating to the assessment and measurement of mental health outcomes.

Thomas R & Clarke V (1998). Community (mis)understanding of colorectal cancer treatment. *Australian and New Zealand Journal of Surgery*, 68(5): 315.

Survey Method: Telephone interview.

Objective: To assess community understanding of colorectal cancer symptoms and treatment. Men and women aged 40-60 were asked if they could name any of the symptoms of bowel cancer, and treatments other than surgery. The subjects were also assessed for their awareness of the screening programs available to detect the development of colorectal cancer.

Webster J, Forbes K, Foster S, Thomas I, Griffin A & Timms H (1996). Sharing antenatal care: Client satisfaction and use of the "patient-held record". *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 36(1): 11-14.

Survey Method: Questionnaire.

Objective: To investigate the opinions of women about care received during pregnancy and the use of patient records which they themselves retain. Likert-type scales were used to examine satisfaction with the use of patient-held records.

Weisberg E & Fraser I (1997). Knowledge and use of emergency contraception among women seeking termination of pregnancy in New South Wales. *Medical Journal of Australia* 166(3): 336.

Survey Method: Questionnaire.

Objective: To discover what women seeking abortions in free-standing clinics in New South Wales know about emergency contraception (the "morning after" pill). The study also examined the use of other contraceptives and satisfaction with the availability of advice on birth control.

Wood G (1996). Consumer / patient satisfaction: The SA experience. In: *Integrating health outcomes measurement in routine health care conference, August 1996: Proceedings*. Canberra: AIHW, 87-94.

Survey Method: Questionnaire.

Objective: To determine the satisfaction of patients with health services in South Australia, and to examine how levels of satisfaction relate to the patient's demographic details, length of stay, health changes during stay, and intention to return to the hospital. The questionnaire used was *The Patient's Viewpoint*, developed by the Health Corporation of America; its measurement of patient satisfaction includes variables such as provision of information, skill of nurses, competence of doctors, provision of privacy, quality of food, and the conditions of rooms or wards.

4. Review of issues

4.1 Surveys of home care clients

4.1.1 Extremely high levels of satisfaction

Of the many different findings made by surveys of home care service consumers, perhaps the most striking is the consistently high level of satisfaction recorded. Twardon and Gartner (1991), for example, found that 100 percent of older clients of a home care service in Pennsylvania were satisfied with the quality of care. Similar findings have been made by Owens and Batchelor (1996), whose study of the British District Nursing Service revealed a 98 percent satisfaction rate. A poll of older patients conducted by Huehns (1988), in which all 52 subjects made positive evaluations of nursing staff, is another case in point. Many surveys of home care clients also contain unsolicited handwritten comments on the kindness and helpfulness of nurses or carers:

“They just couldn’t do better” (Levkoff & DeShane, 1979, p. 59)

“Nothing else I could ask for” (Levkoff & DeShane, 1979, p. 59)

“I cannot say anything detrimental of any kind about them...I really mean it. They’ve been excellent!” (Forbes, 1996).

As Stallard and Lenton (1992) point out, it is clearly in the interest of service providers that their clients make positive evaluations of the services which they receive. The pressure to produce a favourable report is, presumably, increased as contracting out of services becomes more common and service providers are placed in direct or indirect competition with other providers. However, overwhelmingly positive evaluations are not confined to studies conducted by institutions with a vested interest in demonstrating high rates of satisfaction; they are also prevalent in the findings of academic investigations and reports by non-commercial and community organisations (for example, Reeder and Chen, 1990; St John Ambulance Australia SA Inc., 1996).

How then do we account for the strikingly skewed levels of satisfaction in home care research? It is by no means inconceivable that home care clients report a high degree of satisfaction because that is what they truly perceive. However, the preponderance of positive evaluations is seen as being problematic by an increasing number of researchers, and prompts the question as to just how useful findings of almost total satisfaction really are. At a theoretical level, uniformly positive evaluations of services point to a lack of discriminant validity in the survey instruments used and/or to biases or confounds in the data-gathering process. At a practical level, uniformly positive evaluations offer little information on the relative merits of different service providers or on how

services can be improved. These sources of doubt about the findings of previous research suggest the need to delve deeper into the reasons for such high levels of satisfaction, to determine if they are indeed genuine.

4.1.2 Factors which may artificially inflate levels of satisfaction

A number of explanations for the skewing of satisfaction data have been proposed. They are: social desirability, acquiescent response, fear of reprisal, gratitude, low expectations, and loyalty to carers.

Social desirability

Social desirability, in which individuals give answers consistent with what they perceive to be the prevailing social norms, rather than accurate personal opinions, afflicts many different kinds of social research. Survey participants who manifest social desirability have been shown to consistently bias upwards their responses to items requiring a personal response (Hays and Ware, 1986). However, these same participants' opinions about *other* people's perceptions are generally free from bias (Hays and Ware, 1986). This may explain Forbes and Neufeld's (1997) finding that satisfaction rates are higher when clients give their personal opinion than when they give a more general assessment of how the service provider is viewed.

Acquiescent response

Ware (1978) demonstrated that between 40 and 60 percent of respondents to satisfaction questionnaires exhibit some degree of acquiescent response, which is the tendency to agree with statements regardless of the content. Acquiescent response has been shown to account for significant upward bias in satisfaction scores computed from favourably-worded questionnaires (McCusker, 1984). Some researchers have argued that the problems of acquiescent response can be circumvented by phrasing some items positively and some negatively. However, while this strategy can resolve problems of acquiescent response, it can also introduce problems of social desirability. Forbes and Neufeld (1997, p. 71) provide an example: "patients who are uncomfortable disagreeing with a positively worded statement may be comfortable agreeing with a negatively worded item, because they view the presence of such statements as acknowledgment that negative things can and do happen. Thus a negative statement may permit or sanction an honest response in a way that a positive statement does not."

Fear of reprisal

Most older people who can no longer care for themselves want to remain in their homes. Many view the prospect of entering a nursing home with trepidation, to say the least:

We like to be independent. Oh yes, the idea of going in to a home. You see them there, you know, because they go there to die it seems to me. Old people's homes we've visited, including private ones, all the same, they get into one central room, that's all they'll do all day.

I don't want to go in no home. If I go in a home they're gonna have the lot of me and what have I got? Nothing. I'll lose my home. I'll have no life at all just sitting in a nursing home.

(quoted in Owens & Batchelor, 1996, p. 1487)

Many recipients of home care services are only able to stay in their own homes by virtue of the assistance which they receive. Most are afraid of what would happen to them if they lost access to home care services (Forbes & Neufeld, 1997). Their awareness of their dependence often makes them unwilling to express any dissatisfaction which they feel, for fear of antagonising service providers. A number of studies have shown that home care clients often "fear repercussions from staff" (French, 1981, p. 21) or believe they will lose some or all of their services unless they make a positive assessment (Gordon, 1981). This fear is especially great when the researcher is affiliated with the service provider (Forbes & Neufeld, 1997).

Gratitude

Closely linked to the fear of losing access to services is gratitude that they are delivered. Home care clients generally understand that the availability of home care services is limited, and that without them they may be forced to relinquish their independence. It seems high likely that the gratitude which most clients feel has a significant impact upon their expressions of satisfaction.

I don't have any likes. I just like what I get. If people do things for you, you don't grumble. (Peace, Hall & Hamblin, 1979, p. 11)

Some recipients of home care are so grateful for the service that they are willing to overlook deficiencies that most people would find intolerable. Forbes (1996, p. 380) describes the case of an older woman whose caregiver stole from her and caused damage to her property. The woman did not file a complaint, saying "if you want somebody, I guess you have to put up with these things so forget it. So that's what I've done."

Low expectations

Although most home care clients are grateful for the services which they receive, few appear to have any clear expectations about the level of care to which they are entitled. Surveys of home care services typically find that clients either have fairly low expectations:

They [nurses] have a lot of work to do. I don't expect impossibilities.

You couldn't have anything better – with so many patients. They [nurses] couldn't spend all the time with you. I look around and think some are so much worse than I am.

(Bond, Fall, Thomas, Fowler, and Bond, 1990, p. 15)

or else have no expectations whatsoever:

I'd no idea. I'd never been in a hospital before and I'd never been ill like that before, so I really had no idea. (Owens & Batchelor, 1996, p. 1486)

Satisfaction with home care services is generally assumed to be dependent upon the fulfilment of client expectations (Williams, 1994). The lower these expectations are, the easier it is to fulfil them, and the more likely it is that the client will report being satisfied. Hence it is possible that satisfaction with home care services is high because even the most basic assistance will exceed the client's low expectations.

Loyalty to paid carers

It is not unusual for home care clients to form close personal attachments to their paid carers. Clients tend to view their carers not solely as health care professionals but as good and valued friends, or even as members of the family. Many come to trust their carers implicitly:

She has a key to the house, the back door. And if I'm out she'll come in and just carry on. So what I mean is...there's a lot, there's a hell of a lot of trust there to begin with. And I would say that some of my friends, I wouldn't trust them as far as I would with young Nancy. (Forbes, 1996, p. 380)

These attachments sometimes cause clients to refrain from criticising home care services lest the criticism reflect badly on the paid carer. It is not unusual for clients to feel that to complain about the service which they receive is to betray and/or inconvenience their carer (Bond & Thomas, 1992). A number of respondents in the survey conducted by Owens and Batchelor (1996) refused to make any suggestions for improvements, as they believed that doing so could result in an increased workload for nurses.

4.1.3 The subjective nature of the service experience

The loyalty of clients to their paid carers raises broader questions as to the subjective nature of the assessment of home care services. Client satisfaction is typically considered to be a principal indicator of the quality of care. Other indicators include input measures (for example, quality of staff, staffing hours), process measures (for example, number of clients seen, meals delivered, referrals made, and clients discharged), and outcome measures (for example, quality of life, provision of pain relief, prevention of unnecessary institutionalisation). Satisfaction is, however, unlike these other indicators in that it is a subjective

perception on the part of the client. The characteristics which define a positive or satisfying service experience are ambiguous; what satisfies one client may not satisfy another. The subjective nature of service assessments makes identifying and implementing the appropriate measurement particularly challenging.

Some professionals have gone so far as to question whether clients are competent to judge certain aspects of care, since clients' judgments tend to focus on the personality and demeanour of the caregiver (Reeder & Chen, 1990). It does appear to be the case that frail and disabled older people value the affective dimension of the client-caregiver relationship as much as, or more than, any other – including the services themselves (Morishita, Boulton, Boulton, Smith & Pacala, 1998). The fact that most home care clients develop a close relationship with their caregiver has been used to argue that clients have difficulty distinguishing between the caregiver and the institution which he or she represents (Grossman & Weiner, 1988). This, it is argued, may prevent home care clients from giving a balanced appraisal of the service provider.

However, Owens and Batchelor's (1996) study of the British District Nursing Service suggests that clients *do* make distinctions between caregivers and service providing agencies. Like most other researchers, Owens and Batchelor (1996, p. 1488) found that the majority of clients developed close personal relationships with their nurses:

I mean we're more or less close friends. They come here so often and they know me by my first name and I know them by their first names.

If she comes in the evening she might stay a bit longer, 'cos she'll sit and talk to me, but that's friendship then because that's off duty.

As a consequence of these relationships, the clients were unwilling to make any comment which would reflect badly on their nurses. However, they *were* willing to criticise factors which were not the responsibility of the nurses, such as the heavy workload which they felt the nurses bore. They blamed the workload for nurses not being able to spend enough time with them; as this was outside the control of the individual nurses, it was seen as a legitimate area for criticism (Owens & Batchelor, 1996).

Of the few negative statements which the clients were willing to make, almost all were directed at the less personal, organisational aspects of the service. While all of the nurses escaped criticism, the managers of the service provider were not so fortunate:

There's too many managers walking around here with wonderful high paid salaries. The money is going in the wrong direction, the nurses should get it and the people who do the work. (Owens & Batchelor, 1996, p. 1488)

This finding is consistent with the verdict of Judge and Solomon (1993) that most dissatisfaction is expressed in relation to health care administrators, while least criticism is voiced against health care professionals.

The fact that most home care clients are unwilling to criticise their caregivers may not be as problematic as it first appears; it has been shown that between 80 and 94 percent of the damage done by poor service quality is traceable to managerial actions, or to the system set up by management (Ford, Bach & Fottler, 1997). The 85/15 rule suggests that if one traces problems back to the source, about 85 percent of the time the fault lies with the system, processes, structure and practices of the organisation; only 15 percent can be traced to someone who didn't care or wasn't conscientious enough (Ford, Bach & Fottler, 1997). Nevertheless, the fact that typically none of this 15 percent shows up in home care satisfaction surveys suggests that significant biases are indeed at play.

One conclusion which can be drawn from these findings is that client appraisals of the quality of care constitute a complex phenomenon which must be examined carefully. Even where most clients make positive evaluations, there can be intimations of negative sentiment which should be followed up by researchers. Probing client opinions about particular features of a service can uncover sources of dissatisfaction that would otherwise remain undetected. How to go about this is discussed further below.

4.1.4 Response bias and representativeness

Psychometric issues

Of the various methods which have been used to assess the views of home care clients, questionnaires have been the most popular. While questionnaires offer a number of advantages to the researcher, they are often plagued by response bias. The response rate of 45.5 percent achieved by Westra, Cullen, Brody, Jump, Geanon & Milad (1995) is among the higher figures found by studies of home care services; the literature is replete with reports describing the difficulty in obtaining sufficient survey responses to ensure representativeness (Grotzinger, Stuart & Ahern, 1994).

Low response rates are particularly problematic in satisfaction surveys, since, as Pascoe, Attkisson and Roberts (1984) have noted, dissatisfied clients may express their dissatisfaction by not returning their surveys. This excludes dissatisfied clients from the sample and may be another explanation as to why satisfaction rates are so high. The presence of response bias can undermine the legitimacy of a survey, and tends to limit the generalisability of its findings.

Reeder and Chen (1990) had some success in improving the response rate by having nurses hand deliver questionnaires to clients. They achieved an 87.5 percent response rate by using this method. However, this technique may introduce further biases into the data gathering process; as noted above, clients often fear reprisal when the researcher and the service provider are seen to be affiliated (Forbes & Neufeld, 1997).

Moreover, special measures such as this come at a cost, and researchers must ask themselves how important a representative sample is to their study. For studies which attempt to measure satisfaction with home care services, unrepresentative data can be a serious problem. Measurements of satisfaction which do not take account of all segments of the population will not be entirely valid. However, for studies which are more interested in breaches of service standards, representativeness may be less vital. This is because only one report of failure to meet an obligation may be enough to conclude that the service provider does not meet the performance standard in question. If the researcher finds evidence of a single breach of a performance standard, it is not necessary to seek the opinions of all other segments of the client population; the single failure may be evidence enough. This issue does not, however, appear to have been canvassed in the current literature.

Surrogate respondents

It is not uncommon, especially in research making use of questionnaires, for a caregiver living with a client to respond on his or her behalf. This may be done in four ways:

- a) the caregiver may simply acting as a spokesperson for a client who has difficulty reading or writing;
- b) the caregiver may provide input to the client's decisions about how to respond;
- c) the caregiver may fill in all of the questions in the way s/he believes the client would respond if s/he were able to; or
- d) the caregiver simply giving his/her own views.

The use of proxy or surrogate respondents represents a potential source of bias which has only come to be recognised recently as a validity issue in the collection of consumer feedback from older persons. Three pioneers in this area are Llewellyn, McConnell and Bye (1998), who investigated the perceived service needs of parents with intellectual disabilities. They found that there were substantial differences in the perception of need according to who was making the appraisal. The perceptions of the parents themselves differed greatly from the perceptions of workers and from the perceptions of significant others nominated by the parents. Ford, Bach & Fottler (1997, p. 76) caution health care practitioners to be aware of "biases associated with the use of proxies such that a patient's relatives or proxies rank care more negatively than do patients themselves."

There have been no substantive investigations of this bias as it affects the appraisal of service quality among users of Home and Community Care. It is difficult to say what effect it may have on these client appraisals. It may be that the effect is negligible; after all, many caregivers living with clients, whether they are children, spouses, friends or neighbours, are also consumers of HACC

services (as recipients of respite relief), and as such their opinions are of equal interest to those of other home care clients. However, discussions of the use of surrogate respondents will remain largely speculative until this phenomenon has been investigated more thoroughly.

4.2 The dimensions of care

4.2.1 Direct versus indirect measures of service quality

The consensus which developed out of early research on home care services was that client appraisals of quality are unidimensional. It was believed that clients' attitudes towards their service providing agencies are not clearly differentiated from their attitudes towards the various features of the services provided (Levkoff & DeShane, 1979). Hypothesised dimensions of "caring" and "curing", for example, emerged as a single factor in a study by Ware and Snyder (1975). The apparent unidimensionality of service quality was recognised as being problematic by contemporary researchers, who realised that it made quality a "black and white" issue, and prevented the identification of specific problem areas (Levkoff & DeShane, 1979).

However, more recent research suggests that clients are in fact able to differentiate between a number of separate aspects of their care. McCusker (1984) found that clients have distinct opinions about features of care such as cost, convenience, availability, technical competence, and professional manner. Similar findings have been made by Edlund (1997), who identified accessibility, technical quality, interpersonal care, communication, choice, continuity, and outcomes as separate dimensions of service quality. These studies are examples of what Pascoe, Attkisson & Roberts (1984) term *direct* measures of quality; they ask clients to evaluate various aspects of the service rather than the service itself. Direct measures stand in contradistinction to *indirect* measures of quality, which assess home care services at a macroscopic or superordinate level (Pascoe et al, 1984).

Indirect measures of service quality typically yield high levels of satisfaction, often in the order of the 98 percent rate reported by Owens and Batchelor (1996). Direct measures, on the other hand, sometimes reveal sources of dissatisfaction which indirect measures do not detect. It has been shown that when patients are randomly assigned to alternative medical care strategies and complete both direct and indirect measures, only the direct measures differentiate the patient groups (Alpert, Kosa, Haggerty, Robertson, & Heagarty, 1970). Roberts, Pascoe and Attkisson (1984) conducted a psychometric comparison of direct and indirect measures of satisfaction, and found that the direct measure provided clearer, more efficient, and more useful information for program planning and evaluation. It would appear, then, that client appraisals of specific aspects of a home care service (such as those included in the preliminary client survey which

formed part of the HACC National Service Standards Instrument Project, (Jenkins, Butkus, & Gibson, 1998)) are more useful for gathering information about the service provider's strengths and weaknesses than are appraisals of global aspects.

It is important to note, however, that direct and indirect measures are not simply different methods of examining the same phenomenon. They assess different types of satisfaction, a micro domain for the direct approach, and a macro domain for the indirect approach (Pascoe *et al*, 1984). Nonmetric multidimensional scaling of direct and indirect measures of satisfaction with physicians has shown that items from the two measures do not mix well and do not constitute a single dimension (Zastrowny, Roghmann & Hengst, 1983). It has also been shown that the micro and macro domains are differentially related to overall appraisals of the quality of care. In a study by Counte (1979), multiple sclerosis patients completed both micro and macro measures of satisfaction together with an overall rating of the quality of care they had received. The overall rating was simultaneously regressed on the satisfaction scores and only the micro (direct) measure demonstrated a statistically significant relationship. This is further evidence that direct measures are more useful in developing an accurate picture of the strengths and weaknesses of service providers.

4.2.2 The contents of the micro domain

It would appear from these findings that concentrating on specific aspects of home care services is likely to be more profitable than examining more global aspects. However, which of the specific aspects a researcher should examine is a question worthy of consideration. It has been noted that one of the problems with recent research has been that it has examined aspects of home care considered important by the researcher but which may not be afforded the same prominence by clients (Bond & Thomas, 1992). Forbes (1996) argues that it is important to conduct preliminary, qualitative studies which explore clients' opinions before embarking on large-scale surveys. In her study of Canadian home care programs, she develops an "inductive" approach which enables the investigator to "gain a fresh perspective from the participants' point of view in an area that has previously been strongly influenced by professionals' perspectives" (Forbes, 1996, p. 378). While such measures may be beyond the means of some studies, it is nonetheless important to assess the dimensions of care which clients see as being important rather than the dimensions which researchers see as being the most interesting. This is a reassuring finding for the HACC Service Standards Consumer Appraisal Data Development Project, given that the draft survey instruments are based on the HACC National Service Standards, which were developed in a two year process of consultation with consumers, service providers, and other interested parties. The question as to what it is that clients expect from home care services is considered further below.

4.3 Consumerism

4.3.1 Frail and disabled older people as “good consumers”

Government intervention in financing and providing health care has, until recently, been motivated by the belief that individuals have difficulty in judging the quality of health care. The decisions which individuals make about health care, it was assumed, are characterised by uncertainty and a lack of knowledge. It was consequently government policy to protect the public from unqualified providers of care (“quacks”), and perhaps also from qualified but inadequate providers (Donaldson, Lloyd & Lupton, 1991). Protection came in the form of professional standards for health care practitioners, as well as the public finance and delivery of health and welfare services.

However, in the course of the past decade, the policies of economic rationalism have transformed the Australian public sector, reshaping it in the mould of the private sector, and bringing it into compliance with the principles and practices of the market. Health care has not escaped this transformation, having seen the privatisation of many of its constituent organisations and the introduction of a market-based approach to service provision.

The changes in the structure and practices of the health care system have been mirrored by changes in its philosophy. In today’s less regulated health care system, the need to protect patients from themselves is less prominent. The market-oriented government policy which now dominates tends to assume that patients are in fact “good consumers” of health care after all. Good consumers are “those who are able to judge the quality of health care and who, furthermore, have the ability and the desire to ‘shop around’ in order to obtain the best deal for themselves and/or their family in terms of cost and quality” (Donaldson *et al*, 1991, p. 280). Advocates of the consumerist approach to health care argue that it facilitates communication between health care providers and users, and empowers patients to make their own decisions.

There is some doubt about the validity of these arguments, especially with respect to services for frail or disabled older people (Gibson, 1995). Donaldson *et al* (1991) conducted a survey of patients at general practices in northern and western Sydney; their objective was to assess the extent to which patients critically select and evaluate their general practitioner, as a good consumer might be expected to do. They found that there was a lack of consumerist behaviour both in general and among older respondents in particular. Similar findings have been made by two recent studies conducted in the United States, which showed that older respondents tend towards more favourable views of their doctors and rarely exercise independent judgment about their health (Haug & Lavin, 1983; Rudolph & Densmore, 1985).

Donaldson *et al* (1991) infer that there is a lack of desire and/or ability on the part of older people to act as good consumers. They believe that “older people,

by virtue of increased vulnerability and dependence related to their age, may want, or need, to be more trusting of their doctor than other groups in society” (Donaldson *et al*, 1991, p. 285). It would appear that frail and disabled older people, having become accustomed to the more highly regulated health care system of the past, have not adapted to the less regulated, market-oriented system of the present. Typical comments from home care clients are:

They know what they are doing. I don’t know what they are doing. I am in their hands.

We are not trained. You can’t talk to them [health care professionals] about something in which you’re not trained yourself, not really. We must accept that they know better than we do.

(Owens & Batchelor, 1996, p. 1489)

These findings resonate with the Parsonian model of illness, which has passivity and acceptance of the paternalism of health care professionals as central tenets (see Parsons, 1951). Owens and Batchelor (1996) consequently suggest that findings about non-consumerist behaviour among frail, sick or disabled older people may also apply to other groups which occupy the Parsonian sick role, such as young people with a disability and those who are chronically ill. Shackley and Ryan (1994) focus on the doctor-patient relationship in the context of these latter groups, exploring patients’ ability to critically evaluate their doctors. Their investigation left them doubtful as to the extent to which it is possible for these patients to fulfil the role of consumer, and more fundamentally whether they even want to fulfil it. It seems plausible, then, that reluctance to act as a consumer is present not only among older people, but also among other groups who receive HACC services.²

Moreover, while some home care clients are simply reluctant to act as consumers, others are actually incapable of doing so. For these people, dependence is not so much a psychological issue relating to passivity as a physical one relating to the inability to make (or to make known) their own choices. Gibson (1995) describes how classic theories of rights – which include the right to choose, the fundamental right of the consumer – are based on assumptions of human rationality and agency which may be absent for some members of dependent older populations. Home care clients who are mentally alert but profoundly physically disabled may have trouble in communicating the choice which consumer society expects them to make, while clients who are physically able but suffering from dementia may not be able to assert their rights as a consumer in an effective way (Gibson, 1995).

² It is important to note that there is a vocal minority of young people with a disability who are outspoken in campaigning for their rights, and are not in the least content to play the Parsonian sick role. This group constitutes a notable exception to the generalisation that home care clients may well be reluctant to act as consumers. This point is discussed further in Section 4.4.4.

4.3.2 Problems with the consumerist approach to service appraisal

The vast majority of recent studies of home care service quality have focused on the satisfaction of clients with the services they receive. This research has been largely consonant with the new consumerist approach to service provision. It has cast these clients in the role of consumers of health and welfare services and assessed their satisfaction using consumer surveys similar in design to those used for more traditional market research. Despite substantial investment, client satisfaction studies have often been disappointing (Owens & Batchelor, 1996). As described above, they have yielded artificially inflated rates of satisfaction and have provided few recommendations as to how home care services can be improved.

Judging from the findings of studies such as that of Donaldson *et al* (1991), the problems with client satisfaction studies extend beyond their methodologies to their basic approach to appraising service quality. They assess home care services in a way which is not particularly compatible with the way clients see the services. This disparity is most likely another factor contributing to the high level of satisfaction recorded in most home care surveys. Clients have difficulty in critically evaluating home care providers because they see health services as a benefit provided by the government, and they have faith that the government has chosen the service most suited to them. They do not see health care as something to be satisfied or dissatisfied with, and they do not see home care services in terms of choice.

Williams (1994) locates the failings of client satisfaction surveys in three implicit, but unproven, assumptions. The first assumption which Williams identifies is that if satisfaction is expressed with a particular aspect of care, this implies client approval. Williams (1994) argues that it is possible that clients' evaluation of a service may be largely independent of the actual care received. This argument is supported by evidence of biases which inflate satisfaction rates. The reader will recall the example of the woman who had no complaints to make about her home care service despite the fact that her caregiver was stealing from her; it seems clear from evidence such as this that client satisfaction can be largely unrelated to actual service quality.

The second unproven assumption described by Williams (1994) is that there is a link between satisfaction and the fulfilment of client expectations. As noted above, home care clients typically have low expectations of the services which they receive. The high ratings of satisfaction which they provide *may* be due to these low expectations being exceeded, or alternatively they may be due to the fact that there is no simple or straightforward relationship between expectations and satisfaction (Williams, 1994). Also noted above was the observation that some clients have no expectations whatsoever; this casts doubt on the assumed link between expectations and satisfaction. This doubt has recently been reinforced by Owens and Batchelor (1996), who conducted a detailed analysis of

clients' expectations, and found no significant relationship with ratings of satisfaction.

The third, perhaps most significant, assumption is that where values and expectations exist and are utilised by clients in evaluations of care, the nature of these expectations does not undermine the meaning and utility of expressions of satisfaction (Williams, 1994). The trouble with this assumption is that even where clients have expectations of some aspects of home care, there may be other aspects where they do not have existing expectations on which to base their evaluations (Owens & Batchelor, 1996). Indeed, if the Parsonian sick role and its associated passivity hold true then clients may consider the very idea and legitimacy of an evaluation unfounded (Williams, 1994). This is because "the full acceptance of paternalism is the acceptance of a role which abdicates the right to evaluate and a rejection of consumerism and participation within health care" (Williams, 1994, p. 513). It seems that many home care patients may prefer, and indeed expect, to remain passive in relation to the paternalism of health care professionals. Expressions of satisfaction which reflect a fulfilment of this expectation may therefore reveal little about the actual quality of home care (Owens & Batchelor, 1996).

This suggests that consumer satisfaction surveys are of limited usefulness in assessing service quality. They are not only prone to several different kinds of bias, but are also largely inappropriate for use with the groups which receive HACC services. In order to develop an instrument which produces accurate and useful assessments of home care service providers, it is necessary to find an alternative to the consumerist approach to service quality appraisal. An approach which views home care clients not as consumers but simply as users may be more in touch with the way the clients themselves see the services, and may produce a more realistic and legitimate picture of service quality.

4.4 Special needs groups

The issues arising from the literature on home care services have, until this point, been discussed mainly in the context of frail or disabled other people. There are, however, issues relating to other groups of HACC recipients which also need to be discussed. Each of the groups which receive HACC services has different characteristics and needs; the approach taken to service appraisal must be examined carefully to ensure that it is appropriate to the particularities of all HACC recipients. With this in mind, issues relating to Aborigines and Torres Strait Islanders, people from non-English speaking backgrounds, people living in rural and remote areas, and younger people with a disability will now be discussed.

4.4.1 Receiving feedback from Aboriginal and Torres Strait Islanders

The most recent nationally collated figures show that 3% of HACC service users were Aboriginal and Torres Strait Islanders (Jenkins, 1996). These consumers of HACC services vary markedly in characteristics that affect the way service quality feedback would be obtained from them.

Aboriginal and Torres Strait Islander consumers experience the same barriers to participation in feedback activities as other HACC consumers. However a substantial proportion of these service users face further hurdles to participation. Many Aboriginal and Torres Strait Islanders access services in rural and remote locations and hence are affected by the difficulties of participation in feedback activities associated with this. Language barriers also inhibit the participation of some Indigenous groups. In some Aboriginal communities literacy levels are low and English may be a second language. Bearing these factors in mind, it is unrealistic to propose that a single survey tool or method would be appropriate for all Aboriginal and Torres Strait Islander consumers.

Cultural practices pose some challenges to collecting consumer feedback from Indigenous groups. According to Draper and Hill (1996), different Indigenous groups have concerns about different aspects of service quality. Different groups also have different cultural practices about speaking that may inhibit participation. Nankivell (1993) warns that those collecting feedback data must be aware that cultural protocols can vary from group to group and that different events can require different behaviours.

The Australian Bureau of Statistics (ABS) regularly undertakes surveys of the Indigenous population of Australia. A recent report by this the ABS summarised the experience of this work. According to this report, standard interviewing procedures used by the organisation were not effective in obtaining good quality data from people living in Indigenous communities and having more traditional lifestyles. For Indigenous people living outside these communities, standard interviewing procedures were reported to produce data of acceptable quality (ABS, 1998).

The collection of survey data from Indigenous groups requires particular strategies that take into account the characteristics of the individual or community being surveyed. A strategy promoted by the Australian Bureau of Statistics for collecting data from Indigenous people living in discrete communities involved making use of existing collections held by community officers and service providers. However these administrative collections are of little use for the purpose of making assessments of service quality unless service providers regularly undertake such surveys in a manner that allows consumers to comment freely on this topic.

Cultural awareness training for those conducting interviews and surveys is one way to overcome cultural barriers to obtaining feedback on service quality. Making use of individual connections and networks already established within

the Indigenous community also aid in this task (Sinor, 1996). Nankivell (1993) argues that Aboriginal people are more likely to cooperate in an open manner with someone who has spent time in their community. This author reports that Aboriginal people are reluctant to speak with government workers who do not stay long in their community. These workers fail to establish the friendships and trust in the community that is necessary for open communication with Aboriginal people. "As one Aboriginal person so aptly said, 'government workers are like seagulls, they land, they shit, and they leave.'" (Nankivell, 1993, p. 25).

Sinor (1996) advises that Aboriginal people communicate best through informal networks and that formal meetings can be found intimidating. Draper and Hill (1996) reported that a study of hospital satisfaction in Western Australia had found that personal interviews on a one-to-one basis were effective as a means of eliciting feedback from this group. They were only effective, however, when the interviewer was Aboriginal. Written questionnaires were not reported to be effective. Draper and Hill (1996) noted that it was also important that survey questions were developed in consultation with Aboriginal consumers.

4.4.2 Receiving feedback from consumers of non-English speaking background

The voice of people of non-English speaking background is often not heard in relation to views on health and welfare services although they make up some 12% of the HACC population (Jenkins, 1996). Turner (1997) found this to be true in a recent study on consultation and complaints mechanisms for HACC consumers in Melbourne. Misic (1995) found that older ethnic people were more likely to withdraw from a service than complain when service provision was inappropriate to their needs. Similarly, Draper and Hill (1996) observed that these consumers were reluctant to contribute during public meetings to express their views about hospital services.

Draper and Hill (1996) report that participation in feedback activities by people of non-English speaking background is beset by the same difficulties as those who do speak English. In addition, however, participation by people of non-English speaking background may be further inhibited by lack of interpreter services. Even where interpreters are available, consumers may be reluctant to use them. The South Australian North West Suburbs Health and Social Welfare Council and the Migrant Health Services (1993) reported on the results of a telephone and mail survey of consumers and health workers regarding the use of interpreter services. Consumers expressed a reluctance to use interpreter services where they had concerns about breaches in confidentiality or where their experience of the service had been that the interpretation was not sufficiently full or adequate.

Other issues that were reported to affect consumers' use of interpreter services were that these services often had limited availability after hours, there was a lack of flexibility in choice of interpreter, or there was a need for interpreters who specialised in certain areas such as mental health or aged care. Consumers expressed a reluctance to criticise interpreter services because they feared that this criticism would lead to the removal of these services. This fear may have been founded in the experience of some consumers who were told that interpreter services could not be provided to them in hospital because of lack of funding. It may also be of issue in areas where it is difficult to obtain and keep staff such as in remote areas, or where the service requires staff of a very specialised nature.

The language barriers that may affect some consumers of non-English speaking background have implications for obtaining consumer feedback beyond requirements for interpretation and translation services. McVicar and Reynolds (1995) note that lack of information and education about services and how they should be provided are a barrier to consumer participation in feedback activities since consumers cannot make informed appraisals without such information. Consumers from non-English speaking background are a group particularly at risk of being overlooked in the delivery of this information. Additionally, Bartlett and Pennebaker (1990) note that consumers of non-English speaking background may face restrictions in access and choice of services due to their special needs. The authors suggest that this may in turn result in greater dissatisfaction.

The reticence of non-English speaking background consumers in feedback activities may be cultural, they may fear retribution, or they may be unwilling to endanger their relationship with the service provider (Draper and Hill, 1996). Kuhn (1997) reported on the participation of Hispanic women in pre- and postnatal care programs in the United States. The authors found that the key to high levels of program participation by people of non-English speaking background was to establish a level of trust within the community and to demonstrate an understanding of the culture of the community. According to Hess (1994) and Russell (1996), cultural understanding should include beliefs, gender roles, religious practices, experiences of immigration and education levels.

Craw and Gilchrist (1998) concluded that problems of inappropriate or unsatisfactory services for non-English speaking background consumers were in part occurring because of a failure to hear the views of these groups. The authors conducted focus groups and interviews with older people from non-English speaking backgrounds regarding their use of Home and Community Care Services in the Northern Metropolitan Region of Melbourne. These alternative strategies, they suggested, allowed consumer contribution in an impartial setting. Mailed surveys and even telephone interviews were not recommended as being effective in sufficiently overcoming language and cultural barriers to participation. McVicar and Renolds (1995) after reviewing the literature, also

concluded that focus groups were an effective method of obtaining feedback from consumers of non-English speaking background in so far as a skilled facilitator was used who understood the language and culture of the participants.

4.4.3 Receiving feedback from those from rural and remote areas

The characteristics of services and service users in remote and rural locations have implications for the feedback obtained from this group. The population of these communities may vary greatly in age, ethnic composition, racial mix, and socio-economic status. Extreme geographic and climatic factors can also substantially affect the character of a rural and remote community. These factors impact on the service requirements of consumers and on the types of issues relevant to service quality appraisals. An accurate picture of the needs and characteristics of rural and remote communities is necessary to ensure reliable and valid feedback.

The needs of the community will affect the types of things consumers believe are important in the services they receive. Where the needs are great, the benchmark of quality may fall considerably lower than in a community where basic needs are more routinely met. For consumers in these more needy communities, the finer points of good service management fall away as issues of concern. Where the greatest concern is with obtaining a meal or a blanket for the night, consumers may be less likely to be concerned with having assurance of the confidentiality of their records or involvement in service management. Similarly, consumers will be less concerned with negotiating a comprehensive care plan if they only want to obtain help on a one-off basis in single incidents of need.

Those in rural and remote areas generally have less access to the range of services that those living in metropolitan areas have (DCSH, 1991). Where agencies exist, they often provide services across a range of needs. Furthermore, there may be few workers qualified or available to undertake the required work. Consumers are, under these circumstances, dependent on the same few individuals for the delivery of services. As noted earlier in this report, fear of losing a service and gratitude for services received are both factors that contribute to the unwillingness of consumers to complain. These factors are also further exacerbated by limitations on the availability of services or the availability of choice in services.

There is also some evidence that consumers in rural and remote areas use services less even when they are available.³ When consumers make limited use of a service they are less equipped to comment on various aspects of service delivery. For example, someone who makes use of an emergency respite service

³ For example, according to Medicare statistics people in country areas consult their doctors less often than those in metropolitan areas (DCSH, 1990).

on a single occasion would be able to provide little comment on some agency practices such as the appropriateness of the agency's referral process or the provisions the agency has made to ensure confidentiality and privacy of personal details.

Transport difficulties in rural and remote areas have implications for the likelihood of obtaining service appraisal feedback from these consumers. Methods of collecting feedback that would involve face-to-face contact, such as focus groups or one-to-one interviews become more expensive because of travel requirements. This affects some groups more seriously than others, in particular, Aboriginal people (as discussed earlier) and people from non-English speaking backgrounds.

People from a non-English speaking backgrounds are present in rural and remote areas, albeit in small numbers, and widely dispersed. As a consequence, their needs are often over looked. In rural areas there are difficulties in obtaining feedback from people of non- English speaking background and English speaking background alike. In addition, however, language and specialist services for people of non-English speaking background are difficult to provide in a cost-effective manner. There may be insufficient resources available to obtain feedback in the most effective manner, particularly where this would involve face-to-face interviews or focus group discussion.

4.4.4 Receiving feedback from young people with a disability

The problems encountered in surveying young people with a disability depend primarily on the nature of the disability. Physical disabilities which prevent verbal and/or written communication can act as a serious barrier; in these cases there can be little choice but to resort to the use of proxy respondents, as described above. An example of this approach is the research conducted by Llewellyn, Dunn, Fante, Turnbull and Grace (1996), in which families with young children with disabilities made assessments of service providers. Disabilities which do not prevent communication are generally less problematic, although there can be difficulties associated with transporting the subjects to a special venue, as is the usual practice when using focus groups. The *Review of Approaches to Satisfaction Surveys of Clients of Disability Services* prepared for the Steering Committee for the Review of Commonwealth/State Service Provision in 1998, recommended telephone interviews and face-to-face interviews as useful methods of obtaining feedback from people with a disability (E-QUAL, 1998).

Intellectual disability can pose more serious problems to the researcher. Survey responses from people with an intellectual disability may be invalidated by subjects tending to agree with questions (acquiescent response), choosing the most recent of alternatives (recency effect), or misunderstanding questions (E-QUAL, 1998). These problems can be countered by including validity checks such as:

- Asking key questions in reverse (perhaps spaced by a few other questions): for example, “Do you like your job?” / “Do you dislike your job?”
- Screening for acquiescence: for example, “Did you choose who you live with?”; “Did you choose your neighbours?” Answering yes to the second question is taken as evidence of acquiescence.
- Asking contradictory pairs of questions: “Are you sad about...?” / “Are you happy with...?” in alternating order. (E-QUAL, 1998, p. 17).

The *Review of Approaches to Satisfaction Surveys of Clients of Disability Services* reported that younger people, such as those under 45, generally provided lower ratings of satisfaction with services compared to older people (E-QUAL, 1998, p. 17). This suggests that younger people with a disability may, in general, be less susceptible to a number of the difficulties and problems described with regard to the frail and older disabled client groups.

Discussions of measures of service outcomes for the young disabled reflect the life stage of this consumer population. Kozleski and Sands (1992) described quality of life measures as being the ultimate measure of service outcome. The authors propose that quality of life measures can be applied across community groups, allowing comparison between the quality of life of people with a disability and the quality of life of other community groups. This type of measure may not be as applicable as a service outcome measure for older HACC service users. The Colorado Progress Assessment Review conducted by the Colorado Department of Human Services (cited in E-QUAL, 1998) reported that older people provided lower ratings on quality of life scales. Furthermore, the factors that underlie quality of life for an older person may be qualitatively and substantially different to those that underlie quality of life for a younger person.

5. Methodologies

Most client appraisal surveys have been quantitative in nature, calculating the number of people satisfied with home care services by adding up their ratings on pre-coded questions. Quantitative methods are generally cheaper than qualitative methods, and have tended to dominate research in the home care area. Some researchers have argued that quantitative methods can sometimes fail to detect processes which qualitative methods can pick up. Daly and McDonald (1993), for example, conducted a study of the social impact of echocardiography, showing that interviews revealed higher rates of doubt and anxiety than questionnaires.

However, qualitative studies inevitably deal with small sample sizes, being limited by the requirement that the researcher observe each interaction and conduct each interview. The intensive nature of qualitative research techniques precludes their application in a large number of disparate research settings (as presented by the HACC program with over 4,000 agencies nationally). For this reason, qualitative methods are not really suitable for the large scale survey requirements of HACC, and are not considered in detail in this review.

Comprehensive analyses of the strengths and weaknesses of different methodologies have been conducted by Ford, Bach and Fottler (1997) and Mackay, Beer, Gilchrist and Woodward (1998). The more important findings of these and other methodological analyses are summarised below.

5.1 Questionnaires

Whether completed at a health care facility or in the client's home, questionnaires allow clients to reflect and take time to consider their service experience. They provide researchers with the ability to target particular groups of clients, and to analyse client appraisals of service quality in relation to various demographic features. Questionnaires are less expensive than some other methods, and allow researchers to take larger samples of the client population (Mackay *et al*, 1998).

The amount of data which can be gathered is limited by the fact that the content of the questionnaire is decided on in advance and particular topics of interest cannot be explored further. This can be countered by including open-ended questions, but these can be time-consuming to analyse (Mackay *et al*, 1998). Another problem with questionnaires relates to low response rates and the associated risk of sampling error. As described above, response bias can be a serious problem for surveys of aged care services. Poor questionnaires can act as a form of censorship imposed on clients (Ford *et al*, 1997). For example, when the content of a questionnaire does not address all of the relevant aspects of care or when poorly constructed questions stifle consumers' ability express their opinion

accurately, the questionnaire may be inadvertently silencing or misrepresenting opinion. However, ensuring that questionnaires are well-designed and effective can be costly.

5.2 Personal interviews

Face-to-face interviews allow researchers to probe for details about a topic in a way which is not possible with questionnaires. They can provide very rich information when they are conducted by trained interviewers who can detect nuances in responses and probe for further information (Mackay *et al*, 1998). They can also allow the researcher to build up a personal rapport with the client, making him or her more at ease and more willing to speak frankly (Ford *et al*, 1997). Some researchers (for example, Gray & Sedham, 1997) have used personal interviews with frail or disabled older clients as a way of compensating for the subjects' difficulties with reading and writing.

The costs associated with personal interviews are typically high, especially if the interviewer is travelling to the client's home. As a consequence, smaller samples tend to be used, and this can limit the representativeness of the data gathered. Another problem with personal interviews is that, unlike questionnaires, responses are not anonymous (Mackay *et al*, 1998). Also, depending on the time lag involved, the recollection of specific service encounter details may be lost, or may have become biased by subsequent service experiences (Ford *et al*, 1997).

5.3 Telephone interviews

With repeated call-backs, the telephone interview can yield the highest response rates, and can do so in a relatively short period of time (Edlund, 1997). They allow clients to provide detailed feedback, although they tend to be shorter than personal interviews, as clients may consider them intrusive if they last longer than fifteen minutes (Ford *et al*, 1997). Telephone interviews involve greater anonymity than face-to-face interviews, and may encourage more forthright feedback. Like personal interviews, they allow a researcher to probe for details that are difficult to obtain in a written survey (Ford *et al*, 1997).

A difficulty associated with telephone interviews is the bias introduced by poverty and mobility. Some clients do not own a telephone, and others move frequently and cannot be reliably contacted (Edlund, 1997). Most telephone interviews are conducted during business hours; it can be difficult to contact people at work, while contacting them at home can be inconvenient (Ford *et al*, 1997). Telephone interviews can also be hampered by the difficulties suffered by older or disabled populations, such as hearing, speech and cognitive impairments. Trained telephone interviewers can be expensive to hire, although interview by telephone is substantially less costly than face to face interviews. Telephone interviews are generally of shorter duration than face to face

interviews and the costs of travel and other related expenses are avoided (Mackay *et al*, 1998).

5.4 Managerial observation

Having the managers of home care services observe the interactions between employees and clients is one of the easiest and least expensive ways of assessing service quality. Managers' familiarity with their businesses means that they know where to look for problems and can do so in a way which does not inconvenience clients. Another advantage is that the incremental cost for data gathering is typically minimal (Ford *et al*, 1997).

However, managers may be unable to accurately interpret what they are seeing because of a lack of training, or may allow personal biases to interfere with the objectivity of their perceptions (Ford *et al*, 1997). Moreover, the presence of managers may influence both the way in which employees do their jobs, and the behaviour of clients. Since they constitute an essentially subjective appraisal of service quality, managerial observations lack the validity and reliability of more objective measures (Edlund, 1997).

5.5 Focus groups

Participants in a focus group engage in a discussion that remains focused on particular topic with the assistance of a moderator. The unique feature of the focus group is the opportunity for interaction among participants and the group support which follows. Participants hear and respond to the expressed views and experiences of other participants. This support can provide participants with the confidence to voice concerns which they may have kept to themselves in other contexts. This could be especially beneficial for dependent or vulnerable clients, who can sometimes be intimidated by one-on-one interviews. Focus groups are a very effective method for identifying issues that are important to participants.

As a qualitative data method, focus groups are time consuming. The in-depth responses they provide to specific issues allow more insight than may be gained by other data collection methods but the range of topics covered is necessarily limited by the open nature of discussion. Krueger (1998) recommends that focus group discussions contain only two or three key questions that are central to the research endeavor.

Gaining a representative cross-section of a target population is difficult with focus groups. Ford *et al* (1997) reports that it is difficult for organisations such as those involved in health care to assemble groups that represent their targeted demographic profile. Sampling in such cases may require the use of participants whose experiences are not recent, introducing inaccuracies or absences in the

recall of experiences. Obtaining a representative sample also requires repeated sampling of small groups; a time consuming and costly exercise.

The qualitative data obtained from focus groups are generally used for exploratory purposes associated with problem identification, planning, implementation and assessment (Morgan, 1998). In health and welfare service contexts, focus groups are able to gather information on perceived gaps in the service in addition to providing a useful forum for producing suggestions about how services can be improved. Focus groups are frequently followed by a formal survey. In this way, quantitative data can be gathered on the issues identified as important by the focus group results. The formal survey is used to gain a representative sample. When used in this manner the limitations of focus groups do not pose serious research problems.

The key to a successful focus group is a skilled and experienced facilitator, who comes at a significant cost (Mackay *et al*, 1998). Also adding to the expense of the focus group technique are costs relating to travel to the venue, meeting space, and incentives for attendance (Ford *et al*, 1997). Considerable organisation is required when using focus groups to survey frail and disabled older populations (Mackay *et al*, 1998). A further problem associated with this method is that clients from a non-English speaking background may be reluctant to voice their concerns in a public forum (Mackay *et al*, 1998).

5.6 Comment cards

Comment cards are widely used in service industries in various forms and by various methods. Most typically, they rely on voluntary respondent participation. Respondents may be asked to rate aspects of service quality on a simple scale or provide written comments on their service experience. Completed cards are returned to the organisation by mail, by depositing them in a convenient box or handed directly to the service provider.

Comment cards can be used to gather feedback on features of a service which have been identified as potential problem areas. As the data-gathering process relies on clients volunteering to participate; it does not produce a random sample or yield statistically representative data. Nevertheless, comment cards can be valuable in building up a picture of the situation as it is perceived by clients. Comment cards are relatively inexpensive and results are easy to collate and analyse (Ford *et al*, 1997).

The main problem is that the data gathered tends to reflect either extreme satisfaction or extreme dissatisfaction; opinions falling between these two poles are usually under-represented. Also, physical limitations which make it difficult for respondents to read and write can be just as problematic in filling in comment cards as they are in filling in questionnaires (Edlund, 1997).

6. Conclusions

6.1 Summary

Research which has attempted to assess the attitudes of clients towards home care services has been dominated by satisfaction surveys. Although a great deal of time and effort have been expended upon them, the results of these satisfaction surveys have been disappointing. Rates of satisfaction have been artificially inflated to extremely high levels by the presence of biases such as social desirability, acquiescent response, fear of reprisal, gratitude, low expectations, and loyalty to carers. As a consequence, the findings of satisfaction surveys have been of little use in gathering information about the relative merits of different service providers or about which services can be improved.

The subjective nature of the service experience has prompted some researchers to argue that home care clients are simply not in a position to provide a balanced appraisal of the service provider. However, it has been shown that while clients are indeed reluctant to criticise their carers, they are still prepared to criticise the more impersonal, organisational aspects of a service. It seems that genuine client appraisals of service quality can be gathered if the researcher knows where to look, is aware of the various biases which can distort client appraisals, and uses research techniques which minimise the likelihood that such distortions will occur.

The most useful of these research techniques appear to be those which focus on specific aspects of the service. Direct measures of service quality often reveal problems and sources of dissatisfaction which indirect, global measures do not. Direct measures are better at differentiating client groups from one another, and are more useful in developing an accurate picture of the relative strengths and weaknesses of service providers.

Another directive which emerges from the literature is to approach users of HACC services as clients rather than as consumers. In recent years, government policy has reshaped home care service providers in the mould of agencies in the private sector, and most current research is consistent with this market-based approach. It casts older people in the role of consumers who critically compare different providers and select the one best suited to their needs, and it assesses their opinions with tools developed for more traditional market research. However, this approach is inconsistent with the perspective adopted by the clients themselves, who do not see home care in terms of choice and are often characterised by the passivity and acceptance of paternalism prescribed by the Parsonian model of illness. This inconsistency is another reason why satisfaction

surveys are of limited usefulness in assessing service quality, and it is important that researchers make an effort to see HACC services through a client's eyes.

The last directive emerging from the literature relates to the heterogeneity of HACC service recipients. Each of the groups which receives HACC services has its own particular characteristics, and must be approached in ways appropriate to those characteristics. Cultural practices and language differences, for example, can be a barrier to collecting client feedback from Indigenous groups. It may be necessary for the researcher to spend time in a community and use informal methods of gathering information. Clients from a non-English speaking background can be difficult to survey because of both cultural and language barriers. Rural and remote users of HACC services have substantially different priorities to urban users, and transport difficulties can make the application of some research techniques (for example, focus groups) problematic. And, finally, some groups of HACC clients (for example, younger people with a severe intellectual disability) may be unable to communicate their opinions, while others (for example, those with particular physical disabilities) may find it difficult to attend special venues as required by focus group techniques, or may need methods of data collection that provide an alternative means of communication to that of telephone interviews or mailed questionnaires.

6.2 Representativeness and response rates

The biases which plague data collection in surveys of home care clients make it difficult to ensure that the sample is representative of the population from which it is drawn. A lack of representativeness can undermine the credibility of findings, and limits the conclusions which the researcher can make about home care clients as a whole.

This can be a serious problem if the researcher is attempting to establish the level of satisfaction with home care services. An assessment of consumer satisfaction is asking the research question: "how successful has the agency been in satisfying the market?". Thus it follows that measurements of satisfaction which do not take account of all segments of the population will not be entirely valid. This is not to say that such measurements will necessarily be invalid, but there is nevertheless a risk that the absence of a particular segment will distort the rates of satisfaction (and it seems clear from the evidence reviewed here that such distortions are anything but rare). A lack of representativeness underlies all of the potential biases described in this review, and goes to the heart of the deficiencies of studies which attempt to measure consumer satisfaction with home care services.

However, unrepresentative data need not be so problematic if the researcher has other goals. Consumer satisfaction is not the only context in which appraisals of service quality can be made; they could also be made in terms of assessments of the service provider against specific service standards, such as those in use for

the HACCC program. This approach involves asking the research question: “does the service provider fulfil the specific obligations described in the service standards?”. Whereas the consumer satisfaction approach yields a measurement of service quality which (at least in theory) is graduated and ranges from very low satisfaction to very high satisfaction, the performance appraisal approach yields more of an either/or measurement of service quality. Either the service provider fulfils the obligations spelled out in the service standards, or it doesn't. Representative data is not as crucial to this service standards approach as it is to the satisfaction approach. This is because only a small number of reported failures to meet an obligation may be enough to conclude that the service provider does not meet the service standard in question. If the researcher finds evidence of breaches of a service standard, it is not necessary to seek the opinions of all other segments of the client population; the observed failures are evidence enough.

How seriously this failure affects service quality (and how badly it reflects on the service provider) depends on the nature of the service standard. If the standard is, for example, that “Consumers are provided with information about the service”, a single breach may not be particularly serious. However, if the standard is that “Consumers have access to fair and equitable procedures for dealing with complaints and disputes”, then even a single breach is likely to be cause for concern.

For certain kinds of standards, the regulating agency may want to decide upon a critical number of complaints which, if exceeded, will signify that the service provider has failed to meet the standard. For other types of standards, on the other hand, the regulating agency may decide that the service standard has been breached after only one or two such failures. In either case, a representative sample is not crucial.

It should be remembered, however, that even where only a small number of complaints are required for a service standard breach to be deemed to have occurred, it may sometimes be the case that the only clients likely to complain are those that are unlikely to respond to a client survey. Consider the example of a caregiver who steals from a client who is cognitively intact but unable to communicate, with the caregiver preying on this client precisely because the caregiver knows that the client will be unable to complain. In this instance, the failure to collect representative data may result in some performance standard breaches going undetected. This is something to be aware of, but it seems clear that this problem does not compromise data quality as seriously as the lack of representative data compromises client satisfaction data. For this reason, representative data may be of less relevance for the performance standards approach than it is for more traditional surveys of client satisfaction.

6.3 Specificity and generalisability

A consumer survey to assess service standards in HACC funded agencies must attempt to draw information from consumers of diverse characteristics and receiving varied services. This information must allow a comparison across services in order to provide a program level summary of service quality. While questions must be relevant and appropriate to each consumer they must also be able to be universally applied across services and consumers.

Kozleski and Sands (1992) suggest that outcome measures for younger people with a disability should ask about their quality of life, however, those factors that contribute to quality of life for younger people with a disability may not be the same as those for aged persons. Rather, comparability of outcomes may be better obtained by focussing on more proximal outcomes of care. Questions closely related to service standards such as whether services are received in the manner the agency promised them would avoid confounding measures of service outcomes with issues associated with characteristics of the sampled group. The focus on proximal outcomes of care facilitates comparability of services outcome data for services for younger people with a disability and older people with a disability.

Both language and cultural barriers affect the relevance of the consumer survey for Indigenous people and people from non-English speaking backgrounds. While some translation and language change may be necessary for any survey tool, where possible, the content of the questionnaire should remain the same but the method of collecting the information may vary to accommodate the communication and participation needs of consumers. Face-to-face interviews, focus groups and in some cases, telephone interviews, may offer a way to overcome respective barriers to participation. In this way the reach of the survey is extended without extensive loss of comparability of content.

Reference list

- Alpert J, Kosa J, Haggerty R, Robertson L & Heagarty M 1970. Attitudes and satisfactions of low-income families receiving comprehensive pediatric care. *American Journal of Public Health*, 60:499-506.
- Australian Bureau of Statistics 1998. *Directions in Australia's Aboriginal and Torres Strait Islander Statistics*. Canberra: ABS.
- Bond S, Fall M, Thomas L, Fowler P & Bond J 1990. *Primary nursing and primary medical care: A comparative study in community hospitals*. Newcastle upon Tyne: University of Newcastle.
- Bond S & Thomas L 1992. Measuring patients' satisfaction with nursing care. *Journal of Advanced Nursing*, 17:52-63.
- Boreham P & Gibson D 1978. The informative process in private medical consultations: A preliminary investigation. *Social Science and Medicine*, 12(5):409-416.
- Bartlett H & Pennebaker D 1990. Consumer views of maternity services in Western Australia. In Report of the ministerial task force to review obstetric, neonatal and gynaecological services in Western Australia. Volume III, Survey Reports. Health Department of Western Australia, January:1-66.
- Counte M 1979. An examination of the convergent validity of three measures of patient satisfaction in an outpatient treatment center. *Journal of Chronic Diseases*, 32:583-588.
- Craw M & Gilchrist J 1998. *Use of home and community care services by the ethnic elderly in the northern metropolitan region*. Bundoora: Centre for Applied Gerontology.
- Daly J & McDonald I 1993. *The social impact of echocardiography*. Australian Institute of Health and Welfare. Health Care Technology Series No 9. Canberra: AGPS.
- Department of Community Services and Health 1991. *National Rural Health Conference - A fair go for rural health*. Toowoomba: Department of Community Services and Health.
- Department of Community Services and Health 1990. *Department of Community Services and Health: Annual report 1989-90*. Canberra: AGPS.
- Donaldson C, Lloyd P & Lupton D 1991. Primary health care consumerism amongst elderly Australians. *Age and Ageing*, 20:280-286.
- Edlund C 1997. An effective methodology for surveying a medicaid population: The 1996 Oregon Health Plan Client Satisfaction Survey. *Journal of Ambulatory Care Management*, 20:37-45.
- E-QUAL 1998. *Review of approaches to satisfaction surveys of clients of disability services*. Report prepared for the steering committee for the review of Commonwealth/State service provision. Subiaco: E-QUAL.

- Forbes D 1996. Clarification of the constructs of satisfaction and dissatisfaction with home care. *Public Health Nursing*, 13:377-385.
- Forbes D & Neufeld A 1997. Strategies to address the methodological challenges of client-satisfaction research in home care. *Canadian Journal of Nursing Research*, 29:69-77.
- Ford R, Bach S & Fottler M 1997. Methods of measuring patient satisfaction in health care organizations. *Health Care Management Review*, 22:74-89.
- French K 1981. Methodological considerations in hospital patient opinion surveys. *International Journal of Nursing Studies*, 18:7-32.
- Gibson D 1995. User rights and the frail aged. *Journal of Applied Philosophy*, 12:1-11.
- Gordon M 1981. The Irish elderly who live alone: Patterns of contact and aid. *Journal of Comparative Family Studies*, 12:493-508.
- Gray Y L & Sedhom L 1997. Client satisfaction: Traditional care versus cluster care. *Journal of Professional Nursing*, 13(1):56-61.
- Grotzinger K, Stuart B & Ahern F 1994. Assessment and control of nonresponsive bias in a survey of medicine use by the elderly. *Medical Care*, 32:989-1003.
- Grossman H & Weiner A 1988. Quality of life: The institutional culture defined by administrative and resident values. *Journal of Applied Gerontology*, 7:389-405.
- Haug M & Lavin B 1983. *Consumerism in Medicine*. Beverly Hills: Sage.
- Hays R & Ware J 1986. My medical care is better than yours: Social desirability and patient satisfaction ratings. *Medical Care*, 24:519-523.
- Hess M 1994. Current inadequacies in identifying the linguistic and cultural dimension of need for NESB frail aged. *Australian Journal on Ageing*, 13(2):87-89.
- Huehns T 1988. The nurses are wonderful but what are these pills for? *Geriatric Medicine*, June:45-50.
- Jenkins A 1996. Client profiles for aged care services in Australia. Welfare Division working paper no. 11. Canberra: AIHW.
- Jenkins A, Butkus E & Gibson D 1998. *Developing Quality Measures for Home and Community Care*. Aged Care Series No. 4. Canberra: AIHW
- Judge K & Solomon M 1993. Public opinion and the National Health Service: Patterns and perspectives in consumer satisfaction. *Journal of Social Policy*, 22:299.
- Kuhn K 1997. Improving maternal and child outcomes of hard-to-reach populations. *Caring Magazine*, 1997:68-71.
- Kozleski EB & Sands DJ 1992. The yardstick of social validity: Evaluating quality of life as perceived by adults without disabilities. *Education and Training in Mental Retardation*, 56(3):55-68.
- Krueger RA 1998. *Developing questions for focus groups*. The Focus Group Kit, Volume 3. Thousand Oaks, California: Sage Publications Inc.

Levkoff S & DeShane M 1979. Evaluation of services by clients: An idea whose time is yet to come! *Journal of Gerontological Social Work*, 2:55-65.

Llewellyn G, Dunn P, Fante M, Turnbull L & Grace R 1996. Families with young children with disabilities and high support needs: Report to the Ageing and Disability Department. Unpublished paper.

Llewellyn G, McConnell D & Bye R 1998. Perception of service needs by parents with intellectual disability, their significant others and their service workers. *Research in Developmental Disabilities*, 19:245-260.

Mackay S, Beer J, Gilchrist J & Woodward M 1998. Development of a model for benchmarking and quality improvement in aged care. Bundoora: Centre for Applied Gerontology.

McCusker J 1984. Development of scales to measure satisfaction and preferences regarding long-term and terminal care. *Medical Care*, 22:476-493.

McVicar & Reynolds Pty Ltd 1995. Obtaining effective consumer feedback in HACC services – issues and approaches. Report prepared for the Northern Metropolitan Region HACC Service Development Project Involving Local Governments in the Region: Approaches for improving service quality and equity for people using home care services. Unpublished manuscript.

Morgan DL 1998. The focus group guidebook. *The Focus Group Kit, Volume 1*. Thousand Oaks, California: Sage Publications Inc.

Morishita L, Boulton C, Boulton L, Smith S & Pacala J 1998. Satisfaction with outpatient Geriatric Evaluation and Management (GEM). *The Gerontologist*, 38:303-308.

Misic, A 1996. The hidden society: A study of non-English speaking background carer issues in the western Sydney region. Sydney: The Carers Association of NSW.

Nankivell R 1993. The Intellectual Disability Services Council and its service provision to aboriginal people with intellectual disabilities. Thesis prepared for the Bachelor of Social Work, Whyalla Campus of University of South Australia.

North West Suburbs Health and Welfare Council and the Migrant Health Service 1993. Speak out on interpreter services. South Australian health system. Adelaide: North West Suburbs Health and Welfare Council and the Migrant Health Service.

Owens D & Batchelor C 1996. Patient satisfaction and the elderly. *Social Science and Medicine*, 42:1483-1491.

Parsons T 1951. *The Social System*. Glencoe: Free Press.

Pascoe G, Attkisson C & Roberts R 1984. Comparison of indirect and direct approaches to measuring patient satisfaction. *Evaluation and Program Planning*, 6:359-371.

Peace S, Hall J & Hamblin G 1979. The quality of life of the elderly in residential care: A feasibility study of the development of survey methods. London: LSE Press.

- Reeder P & Chen S 1990. A client satisfaction survey in home health care. *Journal of Nursing Quality Assurance*, 5:16-24.
- Roberts R, Pascoe G & Attkisson C 1984. Relationship of service satisfaction to life satisfaction and perceived well-being. *Evaluation and Program Planning*, 6:373-383.
- Rudolph B & Densmore M 1985. Marketing medical services: How patients view physicians. In Winston W, *Health Marketing and Consumer Behaviour*. New York: Haworth.
- Russell, H 1996. Issues for the ethnic aged in Victoria: An overview. Melbourne: Lincoln Gerontology Centre.
- Shackley P & Ryan M 1994. What is the role of the consumer in health care? *Journal of Social Policy*, 23:518.
- Sinor S 1996. Aboriginal community action on disability: Developing accessible services for people of aboriginal and Torres Strait Island background. Intellectual Disability Services Council.
- St John Ambulance Australia South Australia Incorporated 1996. Neighbourhood care programme client survey. Eastwood: St John Ambulance Australia SA Inc.
- Stallard P & Lenton S 1992. How satisfied are parents of pre-school children who have special needs with the services they have received? A consumer survey. *Childcare, Health and Development* 18:197-205.
- Stimson G & Webb B 1975. *Going to See the Doctor*. London: Routledge & Kegan Paul.
- Twardon C & Gartner M 1991. Empowering nurses: Patient satisfaction with primary nursing in home health. *Journal of Nursing Administration*, 21:39-43.
- Turner, F 1997. Consultation with HACC consumers in the Western Metropolitan Region of Melbourne. *Health Issues*, December 1977:29-31.
- Ware J 1978. Effects of acquiescent response set on patient satisfaction ratings. *Medical Care*, 16:327.
- Westra B, Cullen L, Brody D, Jump P, Geanon L & Milad E 1995. Development of the home care satisfaction instrument. *Public Health Nursing*, 12:393-399.
- Williams B 1994. Patient satisfaction: A valid concept? *Social Science and Medicine*, 38:509.
- Ware J & Snyder M 1975. Dimensions of patient attitudes regarding doctors and medical services. *Medical Care*, 13:669-682.
- Zastrowny T, Roghmann K & Hengst A 1983. Satisfaction with medical care: Replications and theoretic reevaluation. *Medical Care*, 21:294-322.

Bibliography

Material gathered during the literature search but not cited in the review.

- AGB McNair 1993. Survey of clients and carers: Final report. Sydney: AGB McNair.
- Allen I, Hogg D & Peace S 1992. Elderly people: Choice, participation and satisfaction. London: Policy Studies Institute.
- Allen A & Hayes J 1994. Patient satisfaction with telemedicine in a rural clinic. *American Journal of Public Health*, 84:1693.
- Alzheimer's Association of Queensland 1995. Standards and procedures manual. Gold Coast: Alzheimer's Association of Queensland.
- Alzheimer's Association of Queensland 1995. Staff manual. Gold Coast: Alzheimer's Association of Queensland.
- Australian Council on Healthcare Standards 1996. EQUIP - The ACHS library and publications. Canberra: Australian Council on Healthcare Standards.
- Australian Institute of Health and Welfare 1995. Report on methodology to the disability services subcommittee. Canberra: AIHW.
- Australian Institute of Health and Welfare 1996. Health outcomes: Integrating health outcomes measurement in routine health care. Canberra: AIHW.
- Australian Institute on Inclusive Communities 1995. Reviewing the service: An assessment manual. Canberra: Australian Institute on Inclusive Communities.
- Australian Institute for Healthy Communities 1998. Comparison of HACC service standards / Australian health and community services standards. Canberra: Australian Institute for Healthy Communities.
- Baker L, Zucker P & Gross M J 1998. Using client satisfaction surveys to evaluate and improve services in locked and unlocked adult inpatient facilities. *Journal of Behavioral Health Services and Research*, 25:51-63.
- Barrett J 1995. Quality at Royal Blind Society. *The Quality Magazine*, October:18-23.
- Bartlett H 1996. Evaluating the care of older people: Quality dimensions and their measurement. *Geriaction*, 14:5-10.
- Biderman A, Carmel S & Yeheskel A 1994. Measuring patient satisfaction in primary care: A joint project of community representatives, clinic staff members and a social scientist. *Family Practice*, 11:287-291.
- Bowman D 1994. Listen to the carers! The many voices of care. Adelaide: SA Carer's Association.
- Braithwaite V 1996. Understanding stress in informal caregiving: Is burden a problem of the individual or of society? *Research on Aging*, 18:139-174.
- Braithwaite V 1996. Between stressors and outcomes: Can we simplify caregiving process variables? *The Gerontologist*, 36:42-53.

Brown C & Ringma C 1989. The myth of consumer participation in disability services: Some issues for social workers. *Australian Social Work*, 42:35-40.

Byron C 1994. Unmet needs: An investigation into the unmet needs of carers of people with dementia in our community. *Alzheimers Association of Queensland, Gold Coast Branch*.

Capitman J, Abrahams R & Ritter G 1997. Measuring the adequacy of home care for frail elders. *The Gerontologist*, 37:303-313.

Carers' Association of Australia 1995. Community care... The next 20 years - A future policy conference. Carers' Association of Australia.

Carscaddon D, George M & Wells G 1990. Rural community mental health consumer satisfaction and psychiatric symptoms. *Community Mental Health Journal*, 26:309-318.

Draper M & Hill S 1996. The role of patient satisfaction surveys in a national approach to hospital quality management. Canberra: AGPS.

Cullen T, Dunn P & Lawrence G 1990. Rural Health and Welfare in Australia. Wagga Wagga: Centre for Rural Welfare Research, Charles Sturt University.

Cummins R, McCabe M, Romeo Y, Reid S & Waters L 1997. An initial evaluation of the comprehensive quality of life scale - Intellectual disability. *International Journal of Disability, Development and Education*, 44:7-19.

Dahlin-Ivanoff S, Klepp KI & Sjostrand J 1998. Development of a health education programme for elderly with age-related macular degeneration: A focus group study. *Patient Education and Counseling*, 34:63-73.

Department of Community Services and Health 1994. Administrative review and funding programs (A case study of community services programs). Canberra: DCSH.

Department of Health and Family Services 1995. DHFS annual report. Canberra: AGPS.

Doern G 1993. The UK citizen's charter: Origins and implementation in three agencies. *Policy and Politics*, 21:17-29.

Donabedian A 1988. The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260:1743-1748.

Dressel P 1982. Policy sources of worker dissatisfactions: The case of human services in aging. *Social Service Review*, 22: 34-67.

Dyck D 1996. Gap analysis of health services. *Aaohn Journal*, 44:541-549.

Fine M & Thomson C 1995. Factors affecting the outcome of community care service intervention: A literature review. Canberra: ANU.

Glickman L, Stocker K & Caro F 1997. Self-direction in home care for older people: A consumer's perspective. *Home Health Care Services Quarterly*, 16:41-54.

Goodwin M 1993. Aboriginal aged care. *The Queensland Nurse*, 22-23.

Herzog A & Rodgers W 1988. Interviewing older adults: Mode comparison using data from a face-to-face survey and a telephone resurvey. *Public Opinion Quarterly*, 52:84-99.

- Higginson I, Jefferys P & Hodgson C 1997. Outcome measures for routine use in dementia services: Some practical considerations. *Quality in Health Care*, 6:120-124.
- Home Care Service of NSW 1996. Home care service of NSW service policy guidelines. Sydney: Home Care Service of NSW.
- Jimmieson N & Griffin M 1998. Linking client and employee perceptions of the organization: A study of client satisfaction with health care services. *Journal of Occupational and Organizational Psychology*, 71:81-96.
- Kane R, Caplan A, Urv-Wong E, Freeman I, Aroskar M & Finch M 1997. Everyday matters in the lives of nursing home residents: Wish for and perception of choice and control. *Journal of the American Geriatric Society*, 45:1086-1093.
- Khayat K & Salter B 1994. Patient satisfaction surveys as a market research tool for general practices. *British Journal of General Practice*, 44:215-219.
- Koch T 1998. Evaluation report - RDNS Disabilities Service. Glenside, SA: Royal District Nursing Service of South Australia Inc.
- Kocken PL & Voorham AJ 1998. Interest in participation in a peer-led senior health education program. *Patient Education and Counseling*, 34:5-14.
- Kocken PL & Voorham AJ 1998. Effects of peer-led senior health education program. *Patient Education and Counseling*, 34:15-23.
- Kokocinski L 1998. Western region HACC ethnic services co-ordination project: Six month report. Inner Western Region, North West and Westgate Migrant Resource Centres.
- Kurowski W 1995. Joint survey of aged care services: NESB focus. Canberra: AGPS.
- Lafferriere R 1993. Client satisfaction with home health care nursing. *Journal of Community Health Nursing*, 10:67-76.
- Leveratt M 1997. Aged care reform and low-income older people. *Brotherhood Comment*, Dec 1997:7.
- Llewellyn G, McConnell D & Bye R 1995. Parents with intellectual disability: Support and services required by parents with intellectual disability. Unpublished paper.
- Makkai T & McCallister I 1992. Measuring social indicators in opinion surveys: A method to improve accuracy on sensitive questions. *Social Indicators Research*, 27:169-186.
- Martin L & Kettner P 1996. Measuring the performance of human service programs. Thousand Oaks: SAGE Publications Inc.
- McConnell D, Llewellyn G & Bye R 1997. Providing services for parents with intellectual disability: Parent needs and service constraints. *Journal of Intellectual & Developmental Disability*, 22:5-17.
- McDonnell J 1985. What do consumer surveys tell us about consumers? Paper presented at the Cirt Conference, September, 1985, Vienna.

McGrew K & Quinn C 1997. Examining the effectiveness of telephone assessment and care planning for homecare services. *Generations*, 21:66-67.

McHorney C 1996. Measuring and monitoring general health status in elderly persons: Practical and methodological issues in using the SF-36 Health Survey. *The Gerontologist*, 36:571-583.

Meekers D 1994. Combining ethnographic and survey methods: A study of the nuptiality patterns of the shone of Zimbabwe. *Journal of Comparative Family Studies*, 25:313-328.

Meng Y, Jatulis D, McDonald J & Legorreta A 1997. Satisfaction with access to and quality of health care among medicare enrollees in a health maintenance organization. *Western Journal of Medicine*, 1997:242-247.

Moore P 1995. Carer Support Network Inc. statements and policies.

Moore P 1995. Carer Support Network Inc. evaluation.

Moyle J, Forrest D & Sharpe N 1989. Survey proposal report on client satisfaction survey for Bunbury Elderly and Disabled Support Scheme.

National Community Consultation 1988. Review of the Home and Community Care Program (HACC). Canberra: National Community Consultation.

National Community Consultation 1988. Review of the Home and Community Care Program 1998 - summary statement. Canberra: National Community Consultation.

OECD 1994. Caring for frail and disabled older people. Paris: OECD.

Palframan K 1996. Establishing an older person's consumer advisory group for the HACC quality assurance framework project: An interim discussion paper. South Australia: Office for the Ageing.

Petralia PB, Galante B & Toth-Cohen S 1997. Preliminary outcome evaluation efforts: Utilization review and patient health survey results. *Work: A Journal of Prevention, Assessment & Rehabilitation*, 8:29-36.

Porter J 1994. Royal District Nursing Service of SA client satisfaction survey. Adelaide: RDNS.

Porter J 1998. Report of survey of referral agencies. Adelaide: RDNS.

Porter J 1998. Report of client / carer satisfaction survey. Adelaide: RDNS.

Pot AM, Deeg DJ, Dyck RV & Jonker C 1998. Psychological distress of caregivers: The mediator effect of caregiver appraisal. *Patient Education and Counseling*, 34:43-51.

Quality Improvement Council 1998. Community & health services core infrastructure standards. Brisbane: Quality Improvement Council.

Reed M & Solomon S 1992. Improving Australia's rural health and aged care services. Canberra: National Health Strategy.

Reynolds M 1995. Approaches for improving service quality and equity for people using home care services. Williamstown: Carers' Association.

Roberts H & Philp I 1996. Prioritizing performance measures for geriatric medical services: What do the purchasers and providers think? *Age and Ageing*, 25:326.

- Royal District Nursing Service of SA 1996. Client / carer survey. Adelaide: RDNS.
- Russell C 1989. Good news about aging. New York: John Wiley & Sons.
- Sanderson L 1995. Consumers, questionnaires and quality. *Health Forum*, 34:12-14.
- Sanson-Fisher R & Foot G 1996. How to collect information from patients...The development of a needs-based questionnaire. Canberra: AIHW.
- Savelkoul M, Commissaris K & Kok G 1998. Behaviour and behavioural determinants in the management of demented people in residential homes. *Patient Education and Counseling*, 34:33-42.
- Sawyer M, Miller L, Pearson C, Marino B & Homer C 1996. Health outcomes at a children's hospital: Parent satisfaction with services. Canberra: AIHW.
- Schron E, Wassertheil-Smoller S & Pressel S 1997. Clinical trial participant satisfaction: Survey of SHEP enrollees. *Journal of the American Geriatrics Society*, 45:934-938.
- Schultz R & Palframann K 1996. Towards a quality assurance framework for Home and Community Care funded services in South Australia. Adelaide: Home Care Service.
- Smith P 1996. Measuring outcome in the public sector. York: Taylor & Francis.
- Smith R 1997. Report of survey of referral agencies. Adelaide: SA Home Care Service.
- Smith R 1997. Report of discharged client satisfaction telephone survey. Adelaide: SA Home Care Service.
- Social Policy Research Unit, University of York 1995. Older people having a say in community care. York: University of York.
- Sofaer S 1998. Satisfaction and quality in managed care for older people. *Generations*, 22:25-30.
- Speedling E, Nizza A, Eichhorn S, Rosenberg G & Schnepf P 1993. The consumer survey review process: A pathway to quality. *Mount Sinai Journal of Medicine*, 60:399-404.
- Srebnik D, Hendryx M, Stevenson J, Caverly S, Dyck D & Cauce AM 1997. Development of outcome indicators for monitoring the quality of public mental health care. *Psychiatric Services*, 48:903-909.
- Stallard P & Hutchison T 1995. Development and satisfaction with individual programme planning in a disability service. *Archives of Disease in Childhood*, 73:43-47.
- Stedman T, Mellsop G, Yellowlees P & Clarke R 1996. Field testing of selected measures of consumer outcomes in mental health. Canberra: AIHW.
- Steele JG, Walls AW & Murray JJ 1995. Methodological issues involved in sampling a population of the elderly for a dental survey. *Community Dental Health*, 12:77-82.
- Steinberg MA, Bischoff NG & Clark MJ 1996. Coping and service needs across the hospital / home interface: Patient, carer and health practitioner perspectives.

Report to the Quality and Outcomes Section, Health Service Outcomes Branch of the Commonwealth Department of Human Services and Health.

Street P 1995. Post-acute community services study. A study conducted for the Department of Human Services and Health by the Centre for Applied Gerontology at Bundoora Extended Care Centre in conjunction with Preston and Northcote Community Hospital. Bundoora: Centre for Applied Gerontology.

Tanzman B 1993. An overview of surveys of mental health consumers' preferences for housing and support services. *Hospital and Community Psychiatry*, 44:450-455.

Tasmanian Department of Community and Health Services 1993. The Tasmanian HACC review / evaluation process. Hobart: Tasmanian Department of Community and Health Services / Australian Community Health Association.

Thornton P & Tozer R 1994. Involving older people in planning and evaluating community care: A review of initiatives. York: University of York.

Thorson J & Powell FC 1992. Rural and urban elderly construe health differently. *Journal of Psychology*, 126:251-260.

Tozer R & Thornton P 1995. A meeting of minds: Older people as research advisers. York: Social Policy Research Unit, University of York.

Ursic M & Helgeson J 1994. Variability in survey questionnaire completion strategies: A protocol analysis. *Journal of the Market Research Society*, 31:225-240.

Wehmeyer M & Metzler C 1995. How self-determined are people with mental retardation? The national consumer survey. *Mental Retardation*, 33:111-119.

Wilding P 1994. Maintaining quality in human services. *Social Policy & Administration*, 28:57-72.

Willis G & Gonzalez A 1998. Methodological issues in the use of survey questionnaires to assess the health effects of torture. *Journal of Nervous and Mental Disease*, 186:283-289.

Wood G 1996. Consumer / patient satisfaction: The SA experience. Canberra: AIHW.