Designing a Complaint Management Model in Iranian Hospitals

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ABSTRACT

Introduction: The effectiveness of the complaint management system in hospitals has a significant impact on the quality of healthcare services and improves client satisfaction.

Aim: To develop and validate a patient complaint management model in Iranian hospitals.

Materials and Methods: In the present mixed-methods study, basic information about the complaint management system (executive structure, executive mechanism, and control mechanism) in selected countries (Australia, United States of America (USA), United Kingdom (UK), South Africa, Turkey, and Iran) was reviewed in this study. Scopus, Science Direct, Web of Science, Magiran, Elsevier, Google Scholar search engine, and other databases compiled organisational websites and related and current articles. The Delphi method was utilised to identify the required items, and experts ultimately agreed upon 41 items. During the field study, 215 relevant complaint management experts and managers from across the hospital network responded to the relevant questionnaire. Exploratory Factor Analysis (EFA) and the EQS 6 and Statistical Package for the Social Science (SPSS) version 22.0 software packages were employed to identify and confirm the model's dimensions.

Results: The current state of the complaint management system in Iranian hospitals presents obstacles to enhancing service quality and customer satisfaction. Factors influencing countries' complaint management systems (41 items) were extracted based on expert opinions. The possible relationship between factors and their effectiveness was investigated using heuristic and Confirmatory Factor Analysis (CFA). Finally, four factors were identified and approved for inclusion in the proposed model: structural {Comparative Fit Index (CFI=1.347), managerial (CFI=0.325), executive (CFI=1.132), and compensatory (CFI=0.216)}.

Conclusion: The patient complaint management system in Iranian hospitals can overcome existing challenges by reviewing and formulating structural, managerial, executive, and compensatory measures, as well as by drawing on the experiences of prosperous countries and by fostering coherence, improving service quality, and ensuring patient satisfaction.

Keywords: Patient safety, Patient satisfaction, Quality of healthcare, Service quality

INTRODUCTION

Complaints provide organisations with valuable information used to improve service and program delivery [1]. In recent years, the increase in hospital patient complaints has sparked growing concern among policymakers, academics, and the general public [2]. Establishing a system to deal with hospital patient and companion complaints is unquestionably critically important. The complaints management system improves patient satisfaction by avoiding referrals to competent authorities and allocating resources to more important issues [1].

Patient complaint management is a vital component of the responsibilities of healthcare providers. Hospital administrators use this data to estimate the type and number of recipients' and service providers' expectations and identify the primary and secondary needs of their recipients and service providers, thereby assisting in identifying and resolving root causes of complaints. Complaint management improves customer satisfaction, the quality of services, and the organisation's performance. Therefore, organisations should prioritise complaints and effective management as a critical component of success, as an appropriate response will move the organisation closer to achieving its main goals [1]. Inadequate response to patients' complaints in a timely and principled manner will result in their dissatisfaction with hospital services and a decrease in service quality and patient safety. According to studies, there are four dissatisfied patients for every oral complaint and 100 verbal complaints about every written complaint in hospitals, equating to approximately 400 dissatisfied patients [2].

In a similar study, Jiang Y et al., in China Shanghai region indicate that compliant management must consider factors including complaints and routine visits, negotiations between hospitals and complainants, intermediaries, and intermediary management [3]. Hsieh SY investigated the safety and quality of clinical care in England and healthcare management and staff-patient relationships. This study showed that accurate analysis of patient complaints helps to diagnose problems and patient safety. He demonstrated significant differences in healthcare complaint management systems and mechanisms for implementing a complaint system between countries. Patient complaints are now included in the UK and Australia national quality management systems. This system aims to establish mechanisms that effectively connect the patient complaint management system and the quality management system at the national policy level [4]. Additionally, Friele RD and Sluijs EM assert that patient satisfaction and a sense of justice are contingent upon patients' expectations and experiences [5].

The ultimate objective of a complaint management system is to enhance and modernise the service delivery system. As a result, simply resolving the issue cannot be regarded as an endpoint. Thus, having an appropriate model for handling complaints can be an extremely effective tool for enhancing service quality. Staff must consider themselves and their "responsibility" to "provide the best service in the shortest amount of time" in order for both the patient and the staff to have a worthwhile and satisfying day; otherwise, nothing but dissatisfaction and a complaint will result [2]. However, even though patient complaints are critical, the majority of healthcare systems do not address them in universities and rarely discuss their rules, principles, and methods.

Due to the lack of comprehensive research on patient complaint management in Iran and its importance, the present study examines patient complaint management in Iran. It compares it to that of selected countries (Australia, USA, UK, South Africa, and Turkey) to identify shortcomings in Iran's hospital complaint management

system and develop a model for its effectiveness. The present study aimed to develop and validate a model of hospital complaint management in Iran to improve patient satisfaction and care quality.

MATERIALS AND METHODS

This mixed-methods study employed a narrative review, qualitative analysis, and EFA to develop and validate a model of complaint management in Iranian hospitals. This study was conducted from February 2020 to March 2021. Electronic databases, and the websites of reputable organisations were searched and academic and hospital experts were interviewed to extract data and conceptualise draft model. Basic concepts such as a variety of complaint redressal procedures, complaint management requirements, complaint management components, and common patterns in hospital complaints management were extracted in this stage. This stage resulted in developing a conceptual model of complaint management for Iranian hospitals.

At every stage of the present study, ethical considerations, including the obligation to interpret and interpret information without any bias, were observed.

Narrative Review

The first stage of the present study was a narrative review designed to present the conceptual framework by examining theoretical foundations and concepts. The data analysis for this step resulted in the identification of three major dimensions and ten sub-dimensions, which included the following: national/state hospital structures, the existence of national/state guidelines, mechanisms for identifying and classifying complaints, time frames for review and response, feedback to the complainant, compensation to the complainant and appeals, the obligation to correct the process, and the obligation to refer unresolved complaints to competent authorities.

The complaint management systems of six selected countries were compared in the present study- Australia, the UK, the USA, Turkey, South Africa, and Iran. These countries were selected for their leadership and extensive experience in patient complaint management, as they serve as an excellent model for managing complaints in Iranian hospitals. Additionally, an attempt was made to select a country from each of the World Health Organisation's six regions. Initially, basic information about the three components of the complaint management system was gathered by consulting the websites of organisations concerned with the three countries' health systems and the World Health Organisation. Questions were posed in each of the three dimensions of the executive structure, executive mechanism, and control mechanism to guide the literature review. Persian terms referring to these three dimensions of the complaint management system and their English equivalents, including executive structure, executive mechanism, and control mechanism, were used to describe the various facets of complaint management in hospitals.

Data collection tools such as the Fish card collected information from reputable sources and published documents from organisations and scientific articles. Tables were utilised to compare the data and extract the factors influencing the development of the complaint management system.

Qualitative Study

The statistical population for the qualitative study phase included 18 experts in various areas of complaint redress, including faculty members, hospital administrators, and other relevant experts, who discussed various aspects of complaint management in hospitals and solicited their opinions. Each panel had the same participants. Participants were recruited through a purposive sampling method. All the meeting contents were taped and verbatim transcribed them in Microsoft Word. Additionally, participant approval of the results and primary data were gained. Two investigators read the transcriptions repeatedly and coded them using standard content analysis procedures. As a result of this iterative process, the investigators

were able to compare their coding to one another. Following that, both authors classified codes and organised them into themes and sub-themes based on their similarities [6].

Quantitative Modelling using the Exploratory Factor Analysis (EFA) Method

The statistical population for this research stage included 215 hospital managers, officials of hospital complaint handling units, and experts. Due to the impossibility of accessing the entire statistical population, the selected sampling method was used to examine the proposed model. To this end, a questionnaire was distributed to 10% of the country's hospitals affiliated to the Ministry of Health (100 hospitals). Approximately two-thirds of them were university hospitals, while a third were non university hospitals. The target group included complaint management experts and hospital administrators.

In this stage, data collection tools included a questionnaire with 41 questions and a 5-point Likert scale for scoring each item.

The fitness of the conceptual measurement model was evaluated using Structural Equation Modeling (SEM) [7]. The goodness of fit indices was used to assess the model's fitness. RMSEA values less than 0.08 and Tucker-Lewis Index (TLI) and Comparative Fit Index (CFI) values greater than 0.90 confirmed the model's fitness. The Kaiser-Meyer-Olkin (KMO) index was used to ensure the sample size was adequate and determine whether the available data was suitable for factor analysis. KMO equaled 0.932. Due to the high level of categorisation capability of this data.

STATISTICAL ANALYSIS

Bartlett test was performed, demonstrating the data's competence and adequacy for factor analysis. The p-values of less than 0.05 were deemed statistically significant. The IBM Statistical Package for the Social Sciences (SPSS) software for Windows (version 22.0, IBM Corp., Armonk, NY, USA) and the EQS 6 structural equations program were employed to analyse the data.

RESULTS

Findings of the present study were divided into two phases: The comparative study phase and the exploratory and CFA phase.

Comparative Study Phase

Countries were compared on three dimensions to establish a comparison framework for the study community, including executive structure, executive mechanism, and patient complaint management control system. The comparative tables present the findings from each country separately [Table/Fig-1] [8-24].

Second Stage of Exploratory and Confirmatory Factor Analysis (CFA) Findings

Descriptive data: In this section, the respondents' job positions, work experience, level of education, and place of employment were examined. Recognising the sample's demographic characteristics sheds light on the community's overall characteristics and aids other researchers in comprehending and extrapolating the findings to other communities to formulate future research questions [Table/Fig-2].

Inferential data: The validity of research hypothesis is investigated in this section using appropriate statistical methods such as factor analysis. To this end, EQS 6 and SPSS 22.0 statistical software packages were used.

Findings and Results of Exploratory Factor Analysis (EFA)

The number of factors was determined by plotting the factor analysis scree plot for each of the 41 available items. This diagram suggests any number of components with an eigenvalue greater than one (hidden factor or variable) for the same number of factors. This diagram suggested 11 factors that reduce complexity; modeling was began by considering the first six values, then the first four values (there are very few changes from four upwards), and the items (observed items or

Country	Hospital complaints management system	State complaints management system	Complaint identification	Complaint classification	The duration of the proceeding	Feedback to the plaintiff	Hospital compensation	Publish reporting
Australia [8,9]	Yes	Yes	Both active and inactive	Yes	Yes	Yes	Yes	Yes
United Kingdom [10-14]	Yes	Yes	Both active and inactive	Yes	Yes	Yes	Yes	Yes
United States of America [15-18]	Yes	Yes	Both active and inactive	Yes	Yes	Yes	Yes	Yes
South Africa [19,20]	Yes	Yes	Both active and inactive	Yes	Yes	Yes	Yes	Yes
Turkey [21,22]	Yes	Yes	Both active and inactive	Yes	Yes	Yes	Yes	-
Iran [23,24]	Yes	Yes	Both active and inactive	Yes	No	No	No	No

[Table/Fig-1]: Comparison of the structure of Iran's patient complaint management system with other countries [8-24].

Variables	Values
Frequency distribution of respondents	
Chairman and manager	18%
Relevant experts	79%
Others	3%
Work experience of the respondents (years)	
<5	3%
5-10	26%
>10-20	81%
>20-30	54%
>30	4%
Education level	
Bachelor	56%
Master	39%
Professional doctor	3%
Specialised doctor, PhD	2%
Employment location	
University hospitals	63%
Non university hospitals	34%
Others	3%

[Table/Fig-2]: Descriptive data of respondents.

variables) to four. Then these factors (hidden variables) were separated. In the EFA, none of the research variables were excluded.

The four dimensions of the EFA model are:

1. First factor (executive measures): The variables included were having a complaint office at the level of medical universities, having a hospital technical committee for complaint redress, having a complaint redressal office within the hospital, having an active complaint identification system, having a passive complaint identification system, having a national complaint system, and having an initial review feedback system. Complainant, provide final feedback to the complainant, timely file complaints and code definitions, categorise and prioritise complaints, establish timeframes for complaint redress, ensure proper filing and documentation of resolved complaints, conduct ongoing monitoring and evaluation of the Ministry of Health's complaint management system for universities and hospitals, and publish reporting services provided by hospitals, universities, and the Ministry of Health.

2. Second factor (functional measures): The variables included were hospital managers' knowledge and information, human resource motivation, the existence of rules and instructions relating to timely service, the extent to which they exist, the quality of hospital services, service integration and coherence, review and response to criticism, continuous monitoring and evaluation of management system complaints at the hospital level, and intervention by the hospital executive management team.

3. Third factor (structural): The variables included centralised care at the Ministry of Health level, hospital-level care, hospital managers' attitudes, proper hospital preparation, the presence of rules and regulations, organisation, a positive approach by the Ministry of Health and upstream organisations, citizens' demands, a systematic structure in the country, the existence of a complaints policy committee in the Ministry of Health, and the existence of an executive office of complaints in the Ministry of Health, referral of unresolved complaints to competent authorities at the hospital level, continuous monitoring, and evaluation of universities and hospitals' complaint management systems by the Ministry of Health.

4. Fourth factor (compensatory measures): Includes variables relating to hospital managers' knowledge and information, human resource allocation, managers' commitment to responding to complaints, dealing with incompetent staff, appeasing the plaintiff, and compensation.

The proposed model's Confirmatory Factor Analysis (CFA) results: According to the factor analysis, the following factors contribute to the final model (complaint management): [Table/Fig-3]

CFA results and the overall Comparative Fit Index (CFI) indicate that the fitted pattern is relatively "good" (CFI=0.70) [Table/Fig-4].

Examining the results of each factor affecting the final model (complaint management), it is clear that all factors had a significant effect on the final model's measurement (p-value <0.0001). As a result, no factors or sub-factors associated with complaint management were eliminated from the final model. Furthermore, the results indicate that the first and third factors were the most significant, while the fourth factor played a minor role in determining the final pattern.

DISCUSSION

The study findings validate a model of complaint management systems in four dimensions: structural, functional, executive, and compensatory measures. This was completed to emphasise the critical role of these factors in developing the complaint management system.

In a study conducted in China, Jiang Y et al., discovered that hospitals bear the greatest responsibility for managing patient complaints and identified barriers to effective complaint management, including low staff awareness of rules and processes in the first instance, insufficient capacity and skills of healthcare providers, incompetence and inability of complaint managers, conflicts between relevant factors and unfounded complaints made by patients during the resolution process, as well as lax enforcement of regulations, a lack of information to manage patient complaints, and hospitals' unwillingness to handle complaints, and the exchange of non transparent information during the complaint process dictated the next step. Additionally, the study demonstrated that appropriate mechanisms should be established to link patient complaints to improved care quality. The study's findings are consistent with those of the current study [3].
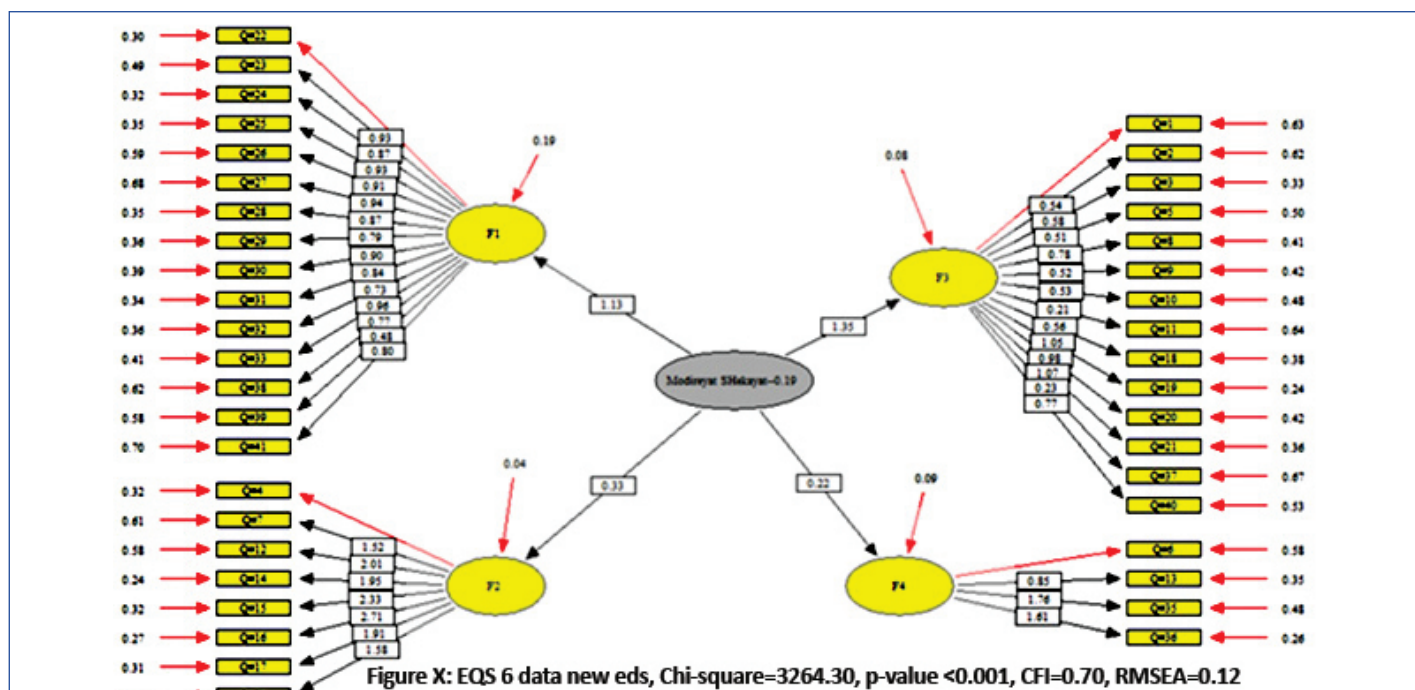
Figure X: EQS 6 data new eds, Chi-square=3264.30, p-value <0.001, CFI=0.70, RMSEA=0.12

[Table/Fig-3]: Fit pattern diagram based on standard values of the complaint management model in Iranian hospitals.

Factor	Impact factor	Standard error	Enter statistics	p-value
F1	1.132	0.000	1.600	<0.0001
F2	0.325	0.076	4.472	<0.0001
F3	1.347	0.233	5.770	<0.0001
F4	0.216	0.082	2.627	<0.0001

[Table/Fig-4]: Importance of factors related to the final model (complaint management).

Hsieh SY discovered that the primary difference between healthcare complaint management systems in the United Kingdom (UK), Australia, and Taiwan was the complaint mechanism system implemented. The UK and Australia have made a concerted effort to incorporate patient complaints into their national quality management systems. Their objective was to establish mechanisms at the national policy level that would effectively connect the patient complaint management system and the quality management system. Due to their excellent coherence, the UK and Australia have integrated patient complaints into their national quality systems. In comparison, the findings of this study in Iran indicate that national quality systems, particularly in healthcare, remain influential. Moreover, according to this study's comparative analysis findings, most selected countries, including Australia, the United States of America (USA), the UK, and South Africa, have an integrated structure for handling complaints. While in Iran, there is low coherence to handle complaints due to structural weaknesses, and multiple Institutions and organisations may play a role concurrently [4].

Nord Lund and Edgren's (1999) comparison of the Netherlands' and Sweden's patient complaint management systems, similar to the current study, revealed that the Netherlands has a more effective decentralised patient complaint system than Sweden. Nonetheless, the Swedish complaint system is in greater demand. Patient law is different in the two countries, and the Netherlands has distinct patient rights laws, which are not present in Sweden. In both countries, it appears that more than just the law is required to protect the patient. Furthermore, measures enhancing the autonomy of certain rules within the complaint system and facilitating the use of all functions within patient complaint systems appear to be necessary.

According to the current study, the patient complaint management system in hospitals in Iran and most selected countries is semi-centralised. Management and resolution of patient complaints in Iranian hospitals and hospitals themselves, at the national (Ministry of Health) and provincial (Universities of Medical Sciences) levels

and the organisation of the medical system and competent judicial authorities, can also be handled. Additionally, according to the studies in this paper, complaint redressal in the UK in the form of National Health Service (NHS) and in the USA in the form of medical and Medicare services, as well as in the event of dissatisfaction with the redress process, should be directed to the appropriate authorities listed in the relevant instructions and regulations. In Australia, each state has its own mechanism, is decentralised at the state and local levels, and operates according to state guidelines.

National guidelines govern provincial proceedings in South Africa, and unresolved hospital-level complaints are referred to the Provincial Health Centre, the Ministry of National Health, and professional councils and committees. Turkey's system for resolving patient complaints is also semi-centralised. Following hospitalisation, if the patient is dissatisfied with the process, the case is referred to the Ministry of Health's Patient Rights Committee and the court.

Moreover, the current study found that in most of the countries studied (Australia, UK, and South Africa), a national guide to complaint management has been developed and communicated, serving as the criterion for action for a comprehensive dealing of patient complaints. At the same time, this is still the first step in Iran. Furthermore, the study's findings indicate that the presence of regulations and the existence of an executive office for handling complaints within the Ministry of Health are critical indicators of the structural factor.

As mentioned previously, according to Hsieh SY (2011) findings, which are comparable to those of this study, the primary distinction between countries' healthcare complaint management systems is the mechanism by which the complaint system is implemented. The hospital generally receives complaints and conducts surveys of patients using semi-structured questionnaires whose validity and reliability are questionable and vary by hospital. In comparison, active identification is conducted in selected countries under national guidelines, and the results can be cited [4]. In contrast to other countries studied, passive identification in Iranian hospitals occurs through various portals, is generally "in person," and is accomplished by completing the appropriate form. In the majority of countries, complaints are classified and graded similarly. Moreover, in Iranian hospitals, according to the Annex to National Accreditation Standards (Fourth Edition), classification as Immediate: Immediately upon receipt of the complaint and without interruption; immediate: within six hours of receipt of the complaint; non urgent with priority:

within 24 hours of receipt of the complaint; Normal non emergency: prompt treatment is recommended [25].

According to Kent A, (2008) findings from a study conducted in French University hospitals, patients who complain about their care are interested in redressing moral harm and establishing trust. Patients' expectations regarding the maintenance of ethical standards in healthcare are disregarded, and they believe that they act as a deterrent to physicians reporting adverse events honestly. The study's findings are consistent with those of the current study [26].

Lister G developed a comprehensive complaint redressal system for the UK based on the plans of Northern Ireland, Scotland, and Wales, as well as Australia, Canada, Denmark, Germany, New Zealand, and the Netherlands. According to the study, a complaint or statement opinions based on an accurate understanding of service quality should be expected. Employees must apologise and resolve issues quickly on the spot, re-establish relationships, and take lessons to improve systems. The study's findings align with the current study [23].

According to the developed model, the dimensions associated with executive actions and the structure proposed in this study can ultimately increase patient satisfaction by instilling a sense of justice in customers. Friele RD and Sluijs EM demonstrated that the perception of whether or not justice was served was influenced by the complaint committee's decision (good or bad) and the committee's behaviour, hospital management, and professional problems [5].

Limitation(s)

Due to a lack of sufficient research on complaint management systems in most countries, it was impossible to compare the results of the present study to similar work to identify the study's weaknesses, which was one of the study's limitations. On the other hand, access to accurate information about complaint management systems was impossible in some countries.

CONCLUSION(S)

The fitted and saturated models in this study indicated that all four dimensions of the complaint management system in Iranian hospitals significantly impact the integrity of patient complaint management in the country. The final model presented in the present study has the potential to improve the integrity of Iran's patient complaint management systems by establishing a single department under the Ministry of Health, establishing a decentralised and multi-sectoral structure, focusing on customised staff education for each hospital, and designing information and statistical data management systems that are efficient in their handling, organisation, and availability.

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