

## **Review of the Office of Health Review: Report Tabled in Parliament 4 December 2003**

The Office of Health Review was created in 1995 to provide consumers with a formal channel for complaint about health (and since 1999, disability) services in both the public and private sectors, and to allow clinicians and other health and disability service providers to respond in an environment of conciliation, as opposed to litigation.

The former Health Minister announced a review of the Office of Health Review in November 2002. A reference group conducted the review which included extensive community consultation.

Many issues were addressed in the review, including:

- Suitability of the Office's name;
- Adequacy of penalties on providers found to have acted unreasonably;
- Sufficiency of grounds for making a complaint;
- The time limit for making a complaint;
- Receipt of oral complaints;
- Clarity of the process as expressed in the Act;
- Establishment of an advisory group to the office;
- Key performance indicators and performance reporting;
- Communication with providers and complainants during the life of a complaint;
- Staff training.

The Government has accepted 44 of the 47 recommendations contained in the Report (including three with amendments). Those that were accepted with amendments are:

**Recommendation 3** – accepted, however endorsed name change to a less lengthy “Office of Health and Disability Complaints” rather than the suggested name change.

**Recommendation 21**- accepted, however the second part of point (iii) refers to referral by the Internal Complaints Review Committee. This committee is proposed in recommendation 10, which is not accepted.

**Recommendation 29** – accepted, however as Watch on Health no longer exists, the referral will be made to another appropriate body, as per the recommendation.

Those recommendations that were not accepted are:

**Recommendation 10** – an additional tier of appeal would prove inefficient to consumers and providers seeking a timely outcome. The Ombudsman, will remain the source of appeal to those not happy with the OHR's decisions.

**Recommendation 23** – while the intent of the recommendation is accepted, this work will be incorporated into the Director's existing duties

**Recommendation 30** – Watch on Health no longer exists, therefore the recommendation is no longer relevant.

All other recommendations have been accepted in full and implementation is already underway in many cases. Other recommendations require legislative change.

# **REPORT OF THE REVIEW OF THE OFFICE OF HEALTH REVIEW**

**June 2003**





## Review of the Office of Health Review

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Hon Bob Kucera, APM MLA,  
Minister for Health  
Parliament House  
PERTH

Dear Minister

On behalf of the Office of Health Review Review Reference Group, I have pleasure in forwarding a copy of the Report of the Group's deliberations, for your consideration.

A handwritten signature in black ink that reads "Debbie Karasinski".

**Debbie Karasinski**  
**A/Chair**

26 June 2003



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## Terms of Reference and Methodology

In November 2002 the Minister for Health, Hon Bob Kucera MLA, announced a Review of the Office of Health Review<sup>1</sup> in accordance with Section 79 of the *Health Services (Conciliation and Review) Act* 1995, which requires a review of the Office after its first five years of operation.

### Terms of Reference

The Terms of Reference for the Review are as follows:

- 1 Review the operations and the effectiveness of the Office of Health Review having regard to:
  - (a) the desirability of the continuation of the functions of the Office; and
  - (b) such other matters as appear to be relevant to the operations and effectiveness of the Office.
- 2 Make recommendations on any structural, functional or procedural changes, if any, which should be made to the Office arising out of (1).

A Reference Group was convened by the Minister, with Ms June Williams as Chair,<sup>2</sup> to receive and consider submissions from stakeholders and the general public and to report to the Minister under the Terms of Reference by mid 2003. The group was chosen for its collective knowledge and experience as health providers and consumers and its ability to represent the views of various sectors of the community. The Reference Group was provided with executive support by the Western Australian Department of Health.

Members of the Reference Group were:

Ms June Williams, former Commissioner for Equal Opportunity in Western Australia (Chair);  
Ms Debbie Karasinski, Chief Executive Officer, Senses Foundation (Deputy Chair);  
Ms Penny Bird, Director of Services Purchasing, Disability Services Commission;  
Dr Ken Collins, General Practitioner (retired);  
Dr Leela De Mel, Executive Director, Office of Multicultural Interests;  
Ms Maxine Drake, Snr Advocate, Health Consumers' Council of Western Australia;  
Ms Prudence Ford, Senior Health Administrator, Department of Health;  
Ms Pat Kopusar, Aboriginal Health and Community Adviser and advocate;  
Dr Trevor Lee, Independent Consultant on Seniors;  
Emeritus Professor Mark Liveris, former Deputy Vice Chancellor Health Sciences, Curtin University;  
Professor Con Michael, President, Medical Board of Western Australia;  
Ms Irene Mills, former Chair, Western Health Services Board;  
Ms Natasha Owen-Conway, Barrister;  
Dr Lindsay Stewart, Medical Administrator, Sir Charles Gairdner Hospital;  
Ms Ann White, Executive Officer, WA Association for Mental Health;

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<sup>1</sup> In this Report, the Office of Health Review is also referred to as "the Office" and "the OHR".

<sup>2</sup> Ms Debbie Karasinski succeeded Ms Williams as A/Chair in February 2003.

Mr Ben Whitehouse, Social Work student.

Mr Andy Duckworth of the Department of Health was the Executive Officer.

The terms of reference of the Reference Group were as follows:

- 1 Finalise an information paper on the Office of Health Review which will provide useful background information for those wishing to make a submission.
- 2 Receive and review public submissions on the Office of Health Review.
- 3 Conduct a series of public meetings with an emphasis on areas of the State and sections of the community which tend to be under-represented or disadvantaged in terms of access to the services offered by the Office of Health Review.
- 4 Prepare a report for the Minister for Health with recommendations as to the desirability of the continuation of the functions of the Office, as per section 79 of the Act, and/or structural, functional or procedural changes, if any, which should be made if the Office is to continue its operations.

The Reference Group met a total of nine times, beginning in November 2002 and concluding its deliberations in late June 2003.

## **Methodology**

### **Key focus**

In order to address the terms of reference, the Reference Group focused predominantly on the following questions:

- 1 How well does the Office of Health Review carry out its functions as prescribed in Section 10 (1) of the *Health Services (Conciliation and Review) Act 1995*?
- 2 What, if anything, needs to be changed to improve performance of these functions? and/or,
- 3 Should all the section 10(1) functions continue?

### **Call for Submissions**

An advertisement calling for submissions to the Review was placed in "*The West Australian*" on 24 November 2002 with a closing date of 28 February 2003. The Review Group determined, however, that under certain circumstances, for example lodgement of an intention to submit, late submissions would be accepted.

The Executive Officer contacted in writing over 140 organisations, including consumer groups, public and private health services, registration boards, unions, professional organisations and health and disability non-government organisations. All were invited to make a submission to the Review. A total of 50 submissions were received as follows:

Consumers and consumer focused organisations (26);  
Providers and provider focused organisations (19);  
Others with a professional interest in the Complaints System (5).

The great majority of submissions focused their comments on one or more of the core functions of the Office as expressed in section 10(1) of the *Health Services (Conciliation and Review) Act* 1995. Some of the issues raised included the name of the Office, adequacy of penalties on errant providers, sufficiency of grounds for making a complaint, the time limit for making a complaint, receipt of oral complaints, clarity of the process as currently expressed in the Act, the establishment of an advisory group to the Office, key performance indicators (KPIs) and more structured performance reporting, communication with providers and complainants during the life of a complaint, Freedom of Information (FOI) and staff training.

A copy of the Submission Form and associated papers is in Appendix 1.

### **Questionnaires**

In addition to the Submission Form, the Review Group designed a simple, one-page questionnaire, targeting individual consumers who may wish to provide brief feedback without going to the extent of completing a full submission. The questionnaire asked if consumers had ever made a complaint about a health or disability service and whether they had heard of or used the Office of Health Review, and what the outcomes of any contact were.

The questionnaire was sent to over 180 non-government health and disability organisations, with an invitation to place the questionnaire in their next newsletter. Eighty telecentres throughout country WA were similarly contacted and asked to include a copy of the questionnaire in their newsletter. A total of 183 questionnaires were received. Results are summarised in Appendix 2.

### **Consultation with key groups**

The Reference Group decided that rather than hold general community forums, it would focus on consultations with specific sectors of the community, including those most likely to be frequent users of health and disability services and those often regarded as the most vulnerable.

Accordingly a number of meetings were held with:

- Indigenous people;
- Seniors;
- Young people;
- People with mental health issues;
- People from culturally and linguistically diverse backgrounds.

With regard to people with disabilities, a full and detailed consultation process on the role of the OHR in relation to complaints about disability services, has been undertaken within the last 12 months, as part of the Review of the *Disability Services Act* 1993. Substantial information was gathered as a result of that process and this has been taken into account in the context of the present Review.

The main purposes of the consultations were:

- (a) to obtain comment and feedback on their experience from people who have made a complaint about a health or disability service, and whether or not they have heard of the Office of Health Review; and
- (b) to hear what people consider to be the required elements of a good health and disability complaints system.

A total of 17 meetings and forums were held. A summary of comments and issues arising from the meetings is at Appendix 3. In addition one radio interview with a Reference Group member was held, the main purpose of which was to increase awareness of the review and encourage listeners who had dealt with the OHR as consumers or providers to provide feedback to the review.

### **Literature Review**

A brief, relevant and contemporary review of the literature on health and disability complaint systems and mechanisms was undertaken and is in Appendix 4.

### **Presentations by key agencies**

The Acting Director of the Office of Health Review was invited to attend the February meeting of the Reference Group. At the meeting, also attended by two of the staff of the Office, the Acting Director made a presentation on the work of the Office and on what he saw as desirable changes to the legislation, and answered questions put to him by members of the Reference Group.

Representatives of the Medical, Nurses and Dental Registration Boards attended subsequent meetings to present their respective views and respond to questions from the Review Group.

### **Analysis of the Acts**

Although the Review has focused on the Office rather than the Acts, advice was sought on the implications and intent of certain sections of the Acts as required. Ms Natasha Owen-Conway, a barrister and member of the Reference Group and Department of Health Legal and Legislative Services staff assisted in this regard.

### **Other sources of data**

The Reference Group sought and obtained useful written data and comments from a number of relevant organisations including the New South Wales Health Care Complaints Commission, the Victorian Health Complaints Commission, the Western Australian Equal Opportunity Commission and the Western Australian Department of Justice.

## Executive Summary and Recommendations

The cornerstone of the Review is section 10(1) of the *Health Services (Conciliation and Review) Act 1995*, which lists the functions and powers of the Director (and therefore the Office). Primarily, these functions relate to:

- The receipt and management of complaints;
- Public information and reporting;
- Reviewing the causes of complaints and investigating systemic health care issues;
- The provision of information and assistance to users and providers.

The Reference Group reviewing the Office of Health Review (“the Office”) considered the role of the Office as set out in the legislation and the extent to which the Office has fulfilled that role. The Review examined fundamental questions, such as whether the present system of resolving complaints about health and disability services should remain, and whether the current focus on conciliation was desirable. It also looked at the operations of the Office, the information it gathers, and the way in which it reports on that information. A major consideration through the process of the Review was the extent to which the Office is known and accessed by the Western Australian community. The Reference Group has recommended that the Office’s profile be substantially enhanced.

Recommendations made by the Reference Group include the continuation of the Office of Health Review as the principal independent complaints mechanism for health and disability in Western Australia, and the continued operation of the conciliation model of alternative dispute resolution. The Reference Group has recommended that the Office’s name be changed to the Health and Disability Complaints Commission of Western Australia. This name change is in line with virtually every submission to the Review and will help to make the Office more visible and therefore more accessible to consumers, especially those whose special needs make them more vulnerable.

Other recommendations seek to reduce the number of operational inconsistencies brought about by differences between the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993*, in terms of their powers and processes. A number of recommendations are specific to the management of complaints about disability services, and seek to give disability a higher profile at the Office of Health Review.

The Reference Group has recommended changes to the process by which complaints are managed at the Office of Health Review. The purpose of the proposed changes is to streamline and simplify the processes of receipt, acceptance and resolution of complaints, and to make reporting more meaningful.

Other recommendations seek to raise the profile of the OHR in the Western Australian community and improve annual reporting.

A full list of recommendations follows.

## Recommendations

*Office of Health Review to continue as the primary health and disability complaints agency*

### Recommendation 1

**The Office of Health Review continue to have responsibility for the administration of the independent health and disability complaints system, established by the Medicare Agreement of 1993-1998.**

*Conciliation model to remain*

### Recommendation 2

**The Office of Health Review continue to operate within the framework of a conciliation model.**

*Name of the Office to change, to better reflect its functions*

### Recommendation 3

**The name of the Office of Health Review be changed to the Health and Disability Complaints Commission of Western Australia.**

*The Office to establish and promulgate a set of principles and values*

### Recommendation 4

**The Office of Health Review affirm a set of values and principles which underpin its operations and aspirations as a quality complaints agency and guide its process of continuous improvement.**

### Recommendation 5

**These values and principles be published in the Annual Report and promulgated through the Office of Health Review's informational and promotional literature and through other channels as appropriate.**

*Process changes proposed to the current system for receiving and attempting to resolve complaints*

- *Acceptance*
- *Resolution Process*
- *Protection of statements*
- *Independent Complaints Review Committee*

### Recommendation 6

**Within 28 days of a complaint being lodged, the Office of Health Review is to accept the complaint if it cannot be rejected on the basis of section 26 or 28 of the *Health Services (Conciliation and Review) Act 1995* and is not referred on the basis of sections 31 and 32 of the Act, and in the case of a disability complaint, cannot be rejected on the basis of section 38 of the *Disability Services Act 1993*. No attempt to resolve the complaint should occur while this assessment is being made.**

#### **Recommendation 7**

Once a complaint has been accepted by the Office of Health Review, it should move to a process to be known as the Resolution Process, which encompasses a Negotiated Settlement, Conciliation, Investigation and Review.

#### **Recommendation 8**

The Resolution process includes any further preliminary actions that may be necessary to implement a negotiated settlement, a conciliated settlement, an investigation or a review and includes the forwarding of details of the complaint to the provider and any subsequent meetings, discussions or proposals aimed at resolving the complaint.

#### **Recommendation 9**

Section 42 of the *Health Services (Conciliation and Review) Act 1995* ('Protection of Statements Made') and section 39(5) of the *Disability Services Act 1993* apply when the Resolution Process commences; that is, as soon as the complaint has been accepted as per recommendation 6.

#### **Recommendation 10**

*An Independent Complaints Review Committee*, comprising a Chair who is a consumer representative and two other members, one of whom is a legal practitioner with expertise in administrative law and the other a professional with relevant health or disability expertise for the purposes of the particular review, be established. The Independent Complaints Review Committee will provide a further, independent avenue of review to complainants who wish to have the outcome or aspects of their case re-examined.

*Time frame in which complaint can be lodged*

#### **Recommendation 11**

In respect of both health and disability complaints, the Director must reject a complaint the subject matter of which occurred more than 24 months before the complaint is made unless, in the Director's opinion, the complainant has shown good reason for the delay.

*Receipt of Complaints*

- *Complainants to be offered assistance to complete form*
- *Complaints to be accepted via the internet*
- *All complaint forms to be checked for clarity*

#### **Recommendation 12**

- (i) In all cases where an initial determination has been made by the Office of Health Review staff member that the complaint is within the jurisdiction of the Office, an offer of assistance to complete the complaint form be made to the complainant; and
- (ii) As part of this requirement to offer assistance, there be a clearly worded, plain English advice to this effect printed on all complaint forms.

### **Recommendation 13**

Methods of receiving complaints be extended to include submission of complaints via the Internet. The Web site should therefore be modified to advise consumers of this method of lodging a complaint, and carry an explanation that, in cases requiring access to medical records, signed authorisation by the consumer or the consumer's representative will be necessary.

### **Recommendation 14**

- (i) The Office of Health Review routinely check the clarity and quality of written information contained in submitted complaint forms, in order to ensure that the form enables all parties to have a common understanding of the circumstances leading to the complaint and the key issues involved.
- (ii) Where the Officer believes that greater clarity is required, he/she is to contact the complainant and assist with clarification.

#### *Acceptance of Complaints*

- *Deleting a ground for rejecting a complaint which appears unnecessary*
- *Director may accept complaint if complainant has not first tried to resolve complaint with provider*
- *All Providers to come within section 25(1)(b) of the Act*
- *People involved in Workers Compensation or other insurance cases*

### **Recommendation 15**

Delete section 26(1)(b) from the *Health Services (Conciliation and Review) Act 1995*.

### **Recommendation 16**

Amend section 30 of the *Health Services (Conciliation and Review) Act 1995* to provide the Director with the discretion to refer the complaint for resolution, whether or not the complainant, or a person acting on behalf of the complainant, has taken steps to resolve the matter with the provider.

### **Recommendation 17**

Section 25(1)(a) of the *Health Services (Conciliation and Review) Act 1995* be amended to read "a provider" rather than a "public provider" as is presently the case. This would align what may be included in a health complaint with disability complaints (section 33(2) of the *Disability Services Act 1993*).

### **Recommendation 18**

- (i) Further legal opinion be sought in relation to the right of people subject to insurance claims to lodge a complaint to the Office of Health Review based on the provisions of section 25(1)(b) of the *Health Services (Conciliation and Review) Act 1995* and, failing any change in interpretation to include this group,

- (ii) The Act be amended to enable people who are subject to Workers Compensation, and other insurance cases, to lodge a complaint in relation to any clinical interview or intervention received as part of the insurance process, based on section 25(1)(b) of the Act.

*Providers encouraged to respond promptly to complaints*

**Recommendation 19**

- (i) Both the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993* be expanded to include a provision that providers are required to respond to a complaint within 28 days of the Director notifying them of the complaint; and that the Director may, if s/he deems there is good reason, extend the response period further, after which time the Director may advise the provider that s/he may proceed to draw conclusions without a response; and
- (ii) If, without good reason, the provider fails to provide the Director with a response, the Director must report on the provider's failure to respond in the Office of Health Review's subsequent Annual Report.

*Consumers to be given information on advocacy services*

**Recommendation 20**

The Office of Health Review routinely provide a current list of advocacy services to any complainant involved in the resolution process.

*Report to be presented to Director on every conciliation that is ongoing at three months, with options for further action.*

**Recommendation 21**

In every case which has not been concluded within a three-month period, a report be prepared for the Director which recommends on the future conduct of the case. Recommended options include:

- (i) Where there is still a good chance of achieving resolution, continue the conciliation process;
- (ii) Investigation and subsequent recommendations for action; and
- (iii) Where not suitable for investigation and there is little chance of a conciliated settlement:
- Closure of the case with no finding other than that resolution was not achievable;
  - If the complainant wishes, referral for internal review or review by the *Independent Complaints Review Committee*.

*Investigation*

- Director must report to the Minister in respect of health and disability complaints if the provider does not remedy situation

#### **Recommendation 22**

**As per section 44 of the *Disability Services Act 1993*, the Director must report to the Minister if his/her recommendations with regard to remedying a situation involving a health complaint are not carried out by a provider.**

#### *Public Information and Reporting*

- *Establishment of Information and Community Liaison Officer position*
- *Provision of information about registration boards*
- *Annual Report*
- *Key Performance Indicators*

#### **Recommendation 23**

**A full-time position of Information and Community Liaison Officer be established to develop and, with the Director, take lead responsibility for a comprehensive information and communications strategy which will:**

- (i) Support the Director's role of increasing the community's awareness of the Office of Health Review and its role and functions;**
- (ii) Improve information about, and access to, the Office of Health Review and its services, with particular reference to groups with special needs including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state;**
- (iii) Ensure that publications and official forms are user friendly and of high quality; and**
- (iv) Work with health and disability service providers to ensure that consumers have access to information about the Office of Health Review, and its role and functions, at points of service, and are informed of their rights with regard to health and disability services.**

#### **Recommendation 24**

**The Office of Health Review ensure, where appropriate, that consumers are provided with relevant information about the role, jurisdiction and activities of registration boards and the relationship between registration boards and the Office of Health Review in the complaints process.**

#### **Recommendation 25**

**As part of the strategic planning process, the Office of Health Review seek information on best practice guidelines in relation to the structure and content of its future Annual Reports and that the 2003-2004 Annual Report incorporate changes which will engender greater clarity and quality of information and presentation.**

#### **Recommendation 26**

**As part of the strategic planning process, the Office of Health Review develop a more comprehensive set of key performance indicators ("KPIs") than is presently the case. Such KPIs should measure the**

extent to which the outcomes sought by the Office of Health Review are being achieved. In the first instance this relates to:

- (i) resolving (rather than finalising) complaints about health and disability services; and
- (ii) improving practices and actions of health and disability services.

*Reviewing the causes of complaints and investigating systemic health care issues*

- Six monthly review of data
- Liaison with 'Watch on Health'
- Strategic approach to management of data
- Transmission of data

#### **Recommendation 27**

The words "and bringing them to the notice of the public" be discarded as an explicit part of function 10(1)(b), but integrated into a broad communication strategy.

#### **Recommendation 28**

The Office of Health Review systematically review complaints data on a six-monthly basis in order to identify any actual or emerging systemic issues of concern.

#### **Recommendation 29**

Where there is evidence of any systemic health or disability issue of concern, based on accurate complaints data and the Office of Health Review is not in a position to investigate the matter, the matter be actively considered for referral to Watch on Health or other appropriate bodies for monitoring and/or investigation.

#### **Recommendation 30**

The Director of the Office of Health Review approach Watch on Health with a view to becoming an ex-officio member of the Watch on Health Council.

#### **Recommendation 31**

Within the Office of Health Review there be an urgent review of management systems, with a view to establishing a strategic approach to the collation, analysis, maintenance, reporting and referral of complaints data.

Amongst other things, such data must enable the Office to assess the extent to which it is reaching and serving the needs of groups with special needs, including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state.

#### **Recommendation 32**

The Office of Health Review establish an effective mechanism for transmitting relevant statistical information on health system issues to stakeholders.

*Providing assistance to providers*

**Recommendation 33**

The present system of regular meetings with customer service officers from metropolitan health services continue and the system be expanded to other groups of like service providers in the health system.

**Recommendation 34**

The Office of Health Review coordinate a forum of complaints officers from disability service providers in order to discuss matters of common interest in relation to complaints handling processes.

*Office to continue functions*

**Recommendation 35**

The present functions of the Office of Health Review as set out in 10(1) of the *Health Services (Conciliation and Review) Act 1995* remain (with the modification to 10(1)(b) proposed in recommendation 26).

*Disability specific recommendations*

**Recommendation 36**

Part 6 of the *Disability Services Act 1993* be amended so that the Office of Health Review has comparable authority and powers with respect to disability and health issues, specifically:

- (i) with the approval of the Minister, the power to inquire into broader issues relating to disability services arising out of complaints received, similar to section 10(1) of the *Health Services (Conciliation and Review) Act 1995*;
- (ii) provisions for directly reporting to Parliament similar to section 56 of the *Health Services (Conciliation and Review) Act 1995*;
- (iii) provisions for the Office of Health Review to take direction for a review from Parliament or the Minister for Disability Services, similar to section 56 and 11 of the *Health Services (Conciliation and Review) Act 1995*.

**Recommendation 37**

The *Disability Services Act 1993* be amended to permit the Minister for Disability Services to have the same powers under the Act as the Minister for Health has in the *Health Services (Conciliation and Review) Act 1995*.

**Recommendation 38**

Grounds for complaints about disability services be extended to include excessive cost, in keeping with the grounds for complaint in section 25(1)(g) of the *Health Services (Conciliation and Review) Act 1995*.

**Recommendation 39**

The *Disability Services Act 1993* be amended, as per section 25(1)(f) of the *Health Services (Conciliation and Review) Act 1995*, to include as a ground for complaint failure by a manager of a service to properly investigate a complaint.

**Recommendation 40**

The Office of Health Review is to ensure that there is equal recognition of the importance of appropriately and continuously addressing disability complaints and associated issues and that sufficient discrete resources are allocated for this purpose.

**Recommendation 41**

The Office of Health Review collect data and statistics on disability complaints, which adequately and appropriately reflect issues relevant to disability, and report separately on these in the Annual Report.

**Recommendation 42**

Disability complaints dealt with by the Office of Health Review must be funded independently of the Disability Services Commission; that is, through an administered fund.

*Training*

- *Internal needs of the agency*
- *External for service providers, consumers and the general community*

**Recommendation 43**

In order to respond to the recommendations of this Report, which propose a significant re-engineering of the processes and procedures of the Office of Health Review, the Director is to formally identify the competencies and skills required by frontline staff and arrange appropriate training.

**Recommendation 44**

The Director is to ensure that the performance management system be enhanced to take account of the changes to process and procedure outlined in this Report.

*Prisons*

**Recommendation 45**

The Director meet formally with the Inspector of Custodial Services, on not less than a six monthly basis, to discuss issues relating to the role of the Office of Health Review in the context of the Prison Health system.

**Recommendation 46**

The Director meet formally, on not less than a six monthly basis or as required, with the Executive Manager of the Prisons Division to discuss operational matters relating to the Office of Health Review's performance of its role in the prison environment.

*Implementation*

**Recommendation 47**

**Not later than 6 months after the Minister has accepted the Report, the Director of the Office of Health Review (or new name) is to provide a progress report to the Minister on the implementation of the recommendations agreed to by the Minister.**

# **The Establishment, Scope and Operations of the Office of Health Review: A Brief Summary**

## **Establishment of the Office of Health Review (OHR)**

The Office of Health Review is an independent statutory authority established under the *Health Services (Conciliation and Review) Act 1995*. The Office commenced operation on 16 September 1996. The first substantive Director, Mr David Kerslake, was appointed on 12 January 1998.

Under Clause 4 of the 1993-1998 Medicare Agreement, all States and Territories agreed to develop a Public Patients' Hospital Charter, as a statement of what consumers should expect from public hospital services. An accessible process for making complaints about health services is part of every Australian charter of patients' rights. A summary of the Western Australian Public Patients' Hospital Charter is to be found at Appendix 6.

Schedule D of the current Australian Health Care Agreement between the Western Australian Government and the Commonwealth also stipulates that the State agrees to maintain an independent complaints body. The Agreement requires that the complaints body must have powers to investigate, conciliate and/or adjudicate on complaints received by it, and the complaints body must be given the power to recommend systemic and specific improvements to the delivery of public hospital services.

The Office of Health Review was created to provide consumers with a formal channel for complaint about health (and since 1999, disability) services in both the public and the private sectors, and to allow clinicians and other health and disability service providers to respond in an environment of conciliation. Its creation was intended to provide an alternative to litigation.

The Office of Health Review is an agent of the Crown and the Director is appointed by the Governor. Whilst the Director and the Office of Health Review are responsible to the Parliament, rather than to the Minister for Health, the Minister can direct them in respect of the Director's performance, either generally or in respect of a particular matter. However, the Minister cannot give directions to the Director or the Office in respect of a particular person, complaint or matter pertaining to a particular complaint.

On 18 November 1999, Parliament transferred responsibility for the management of complaints about the provision of disability services to the Office of Health Review. The authority for the Office to deal with disability complaints is set out in Part 6 of the *Disability Services Act 1993*.

From the perspective of health consumer groups, the establishment of the Office of Health Review was the culmination of many years of lobbying for such a body, to receive and independently assess complaints.<sup>3</sup> Apart from South Australia, where

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<sup>3</sup> A useful summary, by Duncan Boldy and Linda Grenade, of the background to the Office's establishment has been provided in Thomas, David (ed) *Medicine Called to Account: Health Complaints Mechanisms in Australasia*, School of Public Health and Community Medicine, University of New South

the Ombudsman deals with health care complaints, Western Australia was the last State in Australia to establish a statutory body for the express purpose of receiving and investigating complaints about health and disability services.

A brief inter-State comparison of the legislation governing health and disability complaints mechanisms and the scope and powers of the respective agencies is included in this Report in Appendix 5

Based largely on the model of the Office of the Health Services Commissioner in Victoria – (the titles of the governing Acts are the same) - the Office of Health Review came into existence eight years after the Victorian legislation. Like Victoria, the model of operation of the Office has always been conciliation, with an emphasis on processes that were as informal as possible. Ideally, conciliation would lead to the restoration of a workable relationship between the complainant and the provider of the health service that was the subject of complaint.

The Second Reading Speech of 31 August 1995 in the Western Australian Parliament made clear that the Office of Health Review was to operate essentially within a conciliation framework. It also spelled out what it termed the educational role of the Office: “The Director will assist provider organisations to establish structures to assist users and to train staff to handle complaints”.<sup>4</sup>

## **Scope of Complaints dealt with by the Office of Health Review**

### **(a) Health**

Section 25 of the *Health Services (Conciliation and Review) Act 1995* stipulates that a complaint about a health service must allege that one or more of the following has occurred:

- a public provider has acted unreasonably by not providing a health service for the user;
- a provider has acted unreasonably in the manner of providing a health service for the user;
- a provider has acted unreasonably in providing a health service for the user;
- a provider has acted unreasonably by denying or restricting the user’s access to records kept by the provider and relating to the user;
- a provider has acted unreasonably in disclosing or using the user’s health records or confidential information about the user;

a manager has acted unreasonably in respect of a complaint made to an institution by a user about a provider’s action, by:

- not properly investigating the complaint or causing it to be properly investigated; or

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Wales (Sydney) 2002, which provides an overview of the health care complaints mechanisms in all the Australian States and Territories, as well as New Zealand.

<sup>4</sup> *Hansard Thursday, 31 August 1995, 7545*

- not taking, or causing to be taken, proper action on the complaint.

a provider has acted unreasonably by charging the user an excessive fee or otherwise acted unreasonably with respect to a fee.

**(b) Disability**

Similarly, in relation to a disability service, Part 6, section 33 of the *Disability Services Act* 1993 defines the scope of complaints dealt with.

A complaint may only be about:

- a service provider who or which, at the time the subject matter of the complaint arose, was providing a disability service, whether or not with funds granted under Part 4;
- a service provider which is a public authority, other than the Health Department, and which, at the time the subject matter of the complaint arose, was providing a disability service, whether or not with funds granted under Part 4; or
- the Commission.

A complaint must allege that after the date on which this Act comes into operation, a service provider or the Commission:

- acted unreasonably by not providing a disability service to the complainant;
- acted unreasonably by providing a disability service to the complainant;
- acted unreasonably in the manner of providing a disability service to the complainant;
- acted unreasonably by denying or restricting the complainant's access to records relating to the complainant kept by the service provider or the Commission;
- acted unreasonably by disclosing records or confidential information relating to the complainant,
- or that the Commission acted unreasonably in making or not making a grant to the complainant under Part 4.

## **The Office of Health Review as One Element of the Complaints System**

It should be noted that the Office of Health Review is one element, albeit an important one, in a broad complaints system which includes formal complaints mechanisms in the public and private hospitals and other elements of the public health system, the professional registration boards and peak consumer bodies, such as the Health Consumers' Council.

Most complaints are dealt with at points of service such as hospitals or general practitioners' surgeries. For example, the Metropolitan health system reported that 4,161 complaints were received in 2001-2002.

Table 1 below shows the number of complaints that the OHR has received over the past six years, together with some measures of efficiency.

	<b>96/97</b>	<b>97/98</b>	<b>98/99</b>	<b>99/2000</b>	<b>2000/01</b>	<b>2001/02</b>
<b>No. of complaints</b>	672	1016	1238	1427	1496	1383
<b>Cost per finalised complaint</b>	\$1480	\$655	\$682	\$565	\$646	\$697
<b>No. of days taken to finalise complaint</b>	52 days	62 days	85 days	103 days	118 days	118 days
<b>Percentage of complaints finalised</b>	83%	91%	91%	98%	99%	104%*

*\* More cases closed than open due to carry over from previous year*

## Findings and Recommendations of the Review

### The Administration of an Independent Health and Disability Complaints System

Within the Australian states there are different models for the administration of the independent health complaints bodies established in the 1990s through the Commonwealth State Agreements. In most states the system is administered through a separate Health Complaints Commission (in WA titled the Office of Health Review). As referred to earlier, in South Australia the Ombudsman is currently responsible for Health complaints, (though the state government is now in the process of legislating to establish a dedicated Health Complaints Commission) and in the Northern Territory, one person occupies the two positions of Ombudsman and Health Complaints Commissioner.

A small number of submissions to the Review posed the question as to whether health and disability complaints should continue to be administered by the Office of Health Review or whether they should in future come under the jurisdiction of the State Ombudsman. The Reference Group gave this matter some consideration but could find no compelling reason to change the present situation. Firstly, the transfer of jurisdiction of health and disability complaints to the Ombudsman would entail complex legislative changes, given that the Ombudsman is currently only empowered to receive complaints from the public sector. Secondly, it was felt that there is merit in retaining a specialist agency like the OHR. It is therefore recommended that:

#### Recommendation 1

**The Office of Health Review continue to have responsibility for the administration of the independent health and disability complaints system, established by the Medicare Agreement of 1993-1998.**

### The Conciliation Model

In all Australasian jurisdictions the bodies responsible for the administration of health and/or disability complaints emphasise conciliation as the major method of complaint resolution. In New South Wales and New Zealand, however, the Commissions also possess strong prosecutorial powers which are used from time to time. Some submissions suggested the adoption of prosecutorial powers for the OHR similar to those operating in New South Wales, as a means of addressing the perceptions of some that the OHR is a 'toothless tiger'.

The Reference Group does not share this view and would rather see the Office develop a reputation for excellence as the primary alternative dispute resolution agency for health and disability complaints, within a broad conciliation framework.

It seems evident from the second reading speech which preceded the establishment of the *Health Services (Conciliation and Review) Act 1995*, that the Office of Health Review, like its Victorian equivalent, was always intended to operate within the framework of a conciliation model.

Notwithstanding these comments, there are inevitably some cases where conciliation fails to achieve an outcome that the complainant regards as satisfactory and this is

probably the source of many of the ‘toothless tiger’ claims. This issue is addressed to some extent in Recommendation 10 of this Report.

In summary, the Reference Group is of the view that the OHR should continue to operate within the conciliation framework outlined in the second reading speech. It is thus recommended that:

### **Recommendation 2**

**The Office of Health Review continue to operate within the framework of a conciliation model.**

## **Name of the Agency**

Almost every submission to the Review commented on the inadequacy of the Office’s name to convey its role. A number of submissions also expressed the view that the present name is the major reason why the Office and its activities are so little known in the community. Accordingly, many believe that it is imperative that the name be changed to better reflect its role as principal health and disability services complaints agency in Western Australia. The Reference Group agreed with these submissions and with the Office of Health Review’s own view on this matter. It is thus recommended that:

### **Recommendation 3**

**The name of the Office of Health Review be changed to the Health and Disability Complaints Commission of Western Australia.**

## **Principles Underpinning Quality Complaints Systems and Complaint Agencies**

In the review of the literature, reference is made to the essential components of a quality complaints system. Indeed, members of the Reference Group took some time to discuss what attributes a quality system should contain, both in order to establish a means of evaluating the performance and adequacy of the OHR and as a template against which to frame recommendations that may assist the Office to achieve a status of excellence. Both the literature and many of the comments received in submissions and discussion forums, suggest that a quality health and disability complaints mechanism should include at least the following operational principles and values:

A good complaints system should be:

- Accessible and user friendly to all members of the community
- Fair and impartial in its processes
- Timely and efficient in achieving outcomes
- Committed to achieving fair remedies and promoting systemic improvements
- Accountable and transparent in its operations
- Committed to best practice and continuous improvement
- Cost effective
- Subject to periodic review.

The Commonwealth Ombudsman's *Good Practice Guide for Effective Complaints Handling* adds a specific quality to this list, which was felt by the Reference Group to be important for the OHR:

- It should be easily accessible and well publicised for all people, *including those with special needs*.

Health and disability complaints systems should also be genuinely independent in their operations and have adequate funding, the source of which is independent of any service provider.

The Reference Group endorses these principles. In relation to disability complaints specifically, the Reference Group endorses the principles enunciated by the Steering Committee reviewing the Disability Services Act. These are outlined in a later section of the report entitled 'Specific Issues Relating to Disability'.

It is noticeable that in both the Annual Report and in the informational literature of the OHR, there is no statement about the principles and values which the Office believes should underpin its work, nor indeed any reference or discussion of what quality complaint systems should contain or strive for. A vision statement and set of values is, however, articulated on the OHR web site within a section entitled "Corporate Plan 1999-2001", signed off by the previous Director. This is to be commended, but it is difficult to see why these statements are not included in printed informational material, which is still the preferred medium for many, certainly those who do not have ready access to personal computers.

By way of contrast, the NSW Health Care Complaints Commission includes a section in its Annual Report entitled "Vision, Charter, Aims and Stakeholders". It also publishes a booklet containing their strategic plan, which clearly states the values and principles that should underpin the work of the Health Care Complaints Commission and outlines how as an organisation it plans to achieve excellence in relation to each.

The Reference Group believes that the open approach taken by NSW Health Care Complaints Commission is a positive basis for engaging the community and instilling confidence in the operations of the Commission. It also implies a listening culture dedicated to continuous improvement.

Like New South Wales, the OHR should promote its values and principles more prominently as a means of ensuring that the community and potential users of OHR services in particular, are clear about what the organisation stands for and the principles and values which underpin its operations. It is therefore recommended that:

#### **Recommendation 4**

**The Office of Health Review affirm a set of values and principles which underpin its operations and aspirations as a quality complaints agency and guide its process of continuous improvement.**

#### **Recommendation 5**

**These values and principles be published in the Annual Report and promulgated through the Office of Health Review's informational and promotional literature and through other channels as appropriate.**

## **Functions of the Office of Health Review (section 10(1) of the *Health Services (Conciliation and Review) Act 1995*)**

Having considered the broad context in which the OHR operates, the Reference Group took the view that the logical starting point for an assessment of the 'operations and effectiveness' of the Office is section 10(1) of the *Health Services (Conciliation and Review) Act 1995*, which sets out that the core functions of the Office as follows:

### *Functions and Powers of Director*

10. (1) *The functions of the Director are:*
- (a) *to undertake the receipt, conciliation and investigation of complaints under Part 3 and to perform any other function vested in the Director by this Act or another written law;*
  - (b) *to review and identify the causes of complaints, and to suggest ways of removing and minimising those causes and bringing them to the notice of the public;*
  - (c) *to take steps to bring to the notice of users and providers details of complaints procedures under this Act;*
  - (d) *to assist providers in developing and improving complaints procedures and the training of staff in handling complaints;*
  - (e) *with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;*
  - (f) *subject to subsection (4), to cause information about the work of the Office to be published from time to time; and*
  - (g) *to provide advice generally on any matter relating to complaints under this Act, and in particular –*
    - (i) *advice to users on the making of complaints to registration boards; and*
    - (ii) *advice to users as to other avenues available for dealing with complaints*

Because some of these listed functions cover similar or overlapping issues, for the purpose of discussion, they are grouped under the following thematic headings:

- Receiving and dealing with complaints - 10(1)(a)
- Public information and reporting - 10(1)(c),(f) &(g)
- Investigating the causes of complaints and systemic health care issues – 10(1)(b) & (e)

- Providing assistance to providers to improve complaints procedures and the training of staff in complaints handling – 10(1)(d ).

### **Receiving and dealing with complaints - section 10(1)(a)**

In the view of the Reference Group, this is the central function of the OHR. Most of the comments and views obtained in submissions and through discussions with both users and providers relate to this function.

Predictably perhaps, there are some differences of opinion as to the effectiveness of the Office in relation to this function between users and providers of health and disability services. Many of the registration boards and professional medical and disability service bodies express general satisfaction with the current way in which the OHR receives complaints and conciliates or investigates them. However, this is not to say that provider groups do not have specific reservations or criticisms, for example about the Office's communication in relation to the progress of particular cases and the sometimes lengthy periods of time taken to reach a final outcome.

In general, consumers are more critical of the Office's performance of this function. Issues frequently raised included the need for OHR to receive oral complaints and to assist people to lodge complaints. Aspects of the conciliation and investigation process, including clarity of procedures, perception of power imbalance between parties, the existing time limits of the process and, in some cases, outcomes of conciliation events were also raised in submissions.

In considering the performance of the OHR in this centrally important function, the Reference Group took into account not only data it had received through submissions, questionnaires, presentations and discussions, but also information and literature on other comparable bodies in similar jurisdictions.

### ***The Present System***

The present system allows for the resolution of complaints by 'informal inquiry', conciliation or investigation, the latter carrying with it the powers to require attendance or provide documents and records. In addition, the Office may refer matters to registration boards or receive referrals from registration boards. Complaints are referred elsewhere if they are clearly not within the jurisdiction of the Office. All contacts are nevertheless recorded.

Figure 1 on page 27 illustrates in outline the present process employed by the OHR for receiving and resolving complaints. In the majority of cases the present system has provided fair and adequate scope for resolving health and disability complaints. However, a number of improvements to process can be made.

Most of the complaints received by OHR are resolved informally, with very few cases involving formal conciliation or investigation. In 2001-2002 for example, there was only one conciliation and one investigation. In this financial year to date there have been 24 conciliations and 9 investigations for more than 1600 complaints.

The common practice of the Office is to use the extendable period of time permitted by section 34 of the *Health Services (Conciliation and Review) Act 1995* (s37 of the *Disability Services Act 1993*), to pursue informal resolutions to complaints, known in

the Office as 'informal inquiries'<sup>5</sup>. In other words, as well as using this section of the Act to gather preliminary information necessary to assess whether or not the complaint should be accepted - which the wording implies is the prime purpose of the section - staff also use it to informally resolve complaints, notwithstanding that there is no explicit reference in the section to a more informal resolution approach.

Judging by some of the views expressed in submissions, the use by the Office of section 34 to informally resolve a complaint, whilst there is no reference in that section to informal resolution, has generated confusion, and in some cases concern, that the Office is operating at an unofficial level. Both the Reference Group and the OHR<sup>6</sup> believe that this concern should be addressed and the Reference Group believes that overall, the present process should be made simpler, clearer and more understandable. In particular the process used to determine whether or not to *accept* a complaint should precede and be distinct from subsequent attempts to *resolve* it. At the present time the two stages of the process are not clearly delineated and it is this that is causing some confusion.

### ***Recommended changes to the current process for receiving and resolving complaints***

A remodelled approach to the process currently employed by the OHR is recommended. Conceptually the system encompasses four stages – Contact/inquiry, Lodging a complaint, Acceptance of a complaint and the Resolution process. A brief diagrammatic summary of the proposed system is shown at Figure 2 on page 28.

The criteria for accepting a complaint are primarily expressed in sections 25, 26, 28, 31 and 32 of the *Health Services (Conciliation and Review) Act* 1995 and sections 33, 33A, 34 and 38 of the *Disability Services Act* 1993. These criteria can be summed up as follows:

- Is lodgement of the complaint within the stipulated time limit? (s24 HSC & R Act, s34 DSA)
- Does the complaint comply with the Act? That is, is it within jurisdiction?(ss25, 26c & 28 HSC & R Act, s33 DSA)
- Are there grounds at this stage for regarding it as 'vexatious, trivial or without substance'? (s26 HSC & R Act, s 38 DSA)
- Has it been dealt with elsewhere? (s26 (2) HSC & R Act, s 38 (2) DSA)
- Should it, in the first instance, be referred straight to another body such as a registration board or another agency? (ss31, 32 HSC& R Act, s38 (4) DSA)

These criteria should be used to confirm acceptance of a complaint, with section 34 (1-3) of the *Health Services (Conciliation and Review) Act* 1995 and section 37 of the *Disability Services Act* 1993, being used solely to provide the time period within which to make any brief inquiries that may be necessary to arrive at a decision. The decision should be made as expeditiously as possible and no attempt to resolve the complaint should be made until the acceptance process has been finalised. The

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<sup>5</sup> Source: Office of Health Review: Guidelines for Dealing with Disability and Health Complaints, page 3.

<sup>6</sup> 'Office of Health Review Submission on the Review of the Office of Health Review', page 5

complainant should receive written confirmation that the complaint has been *accepted*.

#### **Recommendation 6**

**Within 28 days of a complaint being lodged, the Office of Health Review is to accept the complaint if it cannot be rejected on the basis of section 26 or 28 of the *Health Services (Conciliation and Review) Act 1995* and is not referred on the basis of sections 31 and 32 of the Act, and in the case of a disability complaint, cannot be rejected on the basis of section 38 of the *Disability Services Act 1993*. No attempt to resolve the complaint should occur while this assessment is being made.**

Once a complaint has been accepted according to these criteria, it should move straight to a separate phase known as the 'Resolution Process', which includes Negotiated Settlement, Conciliation, Investigation and Review as the major methods of achieving resolution of the complaint. The resolution phase includes any actions that may be necessary to implement an agreed settlement, a conciliated settlement, an investigation or a review, such as the forwarding of details of the complaint to the provider and any subsequent meetings, discussions or proposals aimed at resolving the complaint. Section 34 (4) of the *Health Services (Conciliation and Review) Act 1995* should be amended to reflect that after accepting a complaint, the Director may refer it for *negotiated settlement*, conciliation or investigation.

A 'negotiated settlement' refers to the present situation of 'informal inquiry' where, for example, after a preliminary approach by the OHR a provider agrees to give a refund to a complainant, without any formal conciliation having taken place. Given the feedback in the course of the Review, that some people equate the word 'informal' with 'unsatisfactory', the term 'negotiated settlement' is suggested to describe this means of resolution. Conciliation refers to the accepted meaning of the term as referred to in both the *Health Services (Conciliation and Review) Act 1995* and part 6 of the *Disability Services Act 1993*. It entails the conciliator working formally with the parties to the complaint to assist them to reach a mutually agreeable outcome.

Investigation is the process as currently described in both the relevant Acts and is used in cases where the Director wishes to ascertain whether unreasonable conduct has occurred.

It is proposed that the entire resolution process be covered by the terms of the present section 42 (1) of the *Health Services (Conciliation and Review) Act 1995* and section 39 (5) of the *Disability Services Act 1993*. The protection against anything said by parties to the complaint being used in a court or tribunal is an important safeguard of the integrity of the alternative dispute resolution process and a deterrent to those whose real interest lies in litigation. It is therefore recommended that:

#### **Recommendation 7**

**Once a complaint has been accepted by the Office of Health Review, it should move to a process to be known as the Resolution Process, which encompasses a Negotiated Settlement, Conciliation, Investigation and Review.**

#### **Recommendation 8**

**The Resolution process includes any further preliminary actions that may be necessary to implement a negotiated settlement, a conciliated**

settlement, an investigation or a review and includes the forwarding of details of the complaint to the provider and any subsequent meetings, discussions or proposals aimed at resolving the complaint.

#### **Recommendation 9**

**Section 42 of the *Health Services (Conciliation and Review) Act 1995* ('Protection of Statements Made') and section 39(5) of the *Disability Services Act 1993* apply when the Resolution process commences; that is, as soon as the complaint has been accepted as per recommendation 6.**

#### ***Review***

Opportunity for review is an important part of any complaints or dispute resolution process. The Office currently has the capacity to offer complainants an internal review of their case, using personnel not previously involved in the resolution process. If complainants are still not satisfied, they may seek a review by the Ombudsman of OHR process, in relation to their case.

In New South Wales there is an additional avenue for review. If the complainant is still not satisfied following an internal review, there is also the capacity to have a case reviewed by a body known as the *Independent Complaints Review Committee*. This is administered by the Health Care Complaints Commission and is composed of three members, a consumer representative, a lawyer and a person with clinical expertise in a relevant field. The consumer representative is the chair. Given the importance of achieving a satisfactory resolution in as many cases as possible, members of the Reference Group believe that a similar independent review mechanism is worthwhile and should be established in Western Australia. It is therefore recommended that:

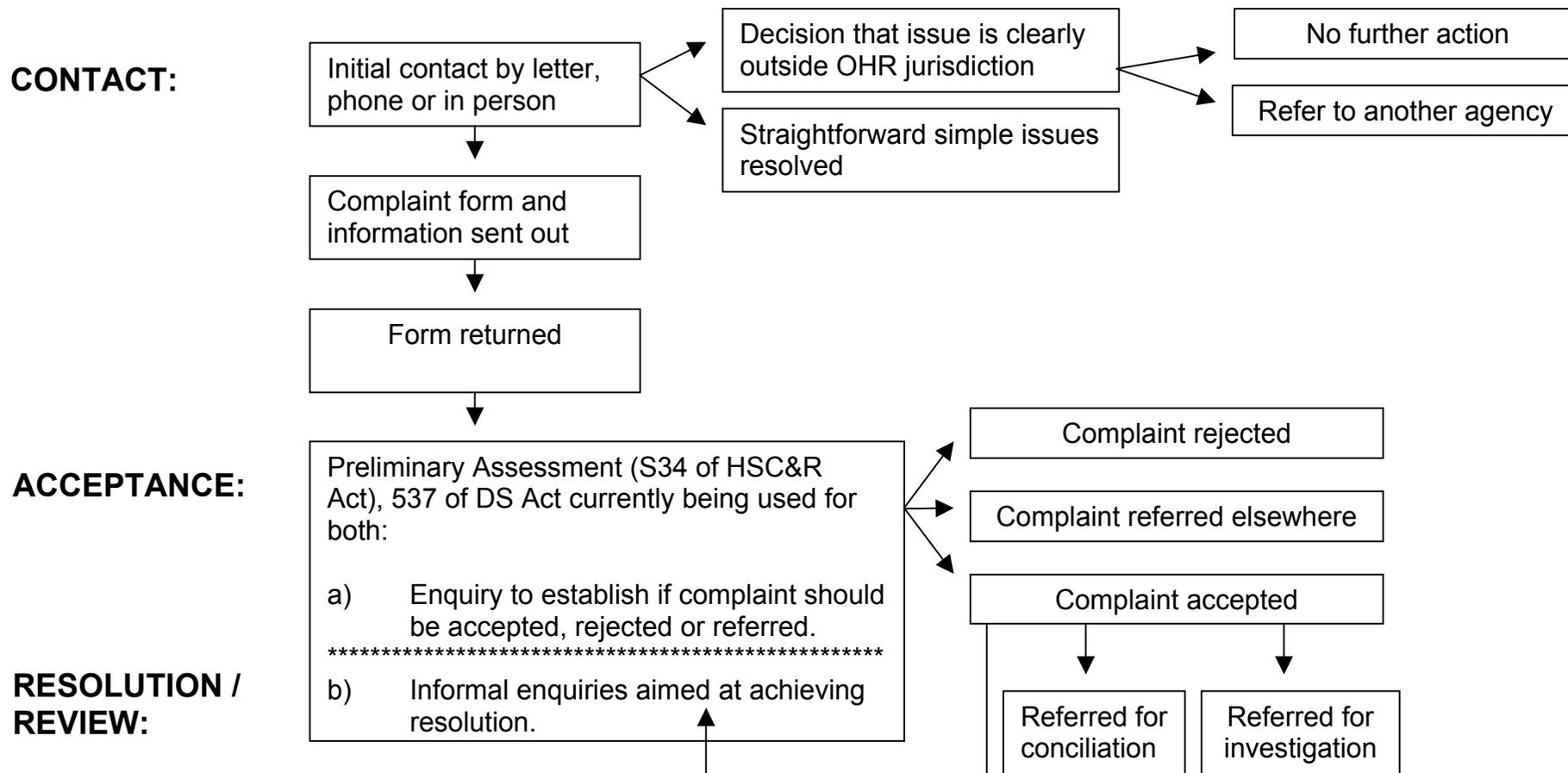
#### **Recommendation 10**

**An *Independent Complaints Review Committee*, comprising a Chair who is a consumer representative and two other members, one of whom is a legal practitioner with expertise in administrative law, and the other a professional with relevant health or disability expertise for the purposes of the particular review, be established. The *Independent Complaints Review Committee* will provide a further, independent avenue of review to complainants who wish to have the outcome or aspects of their case re-examined.**

#### ***Time limits to lodge a complaint***

The *Health Services (Conciliation and Review) Act 1995* stipulates that a complaint must be made not more than one year after the event that constitutes the content of the complaint, unless there is good reason for the delay. The Act gives the Director the discretion to accept complaints that are about events older than one year if, for instance, the consequences of the treatment that is the subject of the complaint did not become apparent until later. If consumers are unaware of the existence of the OHR and their right to complain, the Director may also exercise discretion and accept a complaint about a matter that is older than one year.

## The Current Process for Lodgement, Acceptance and Resolution of Complaints by OHR (in outline)

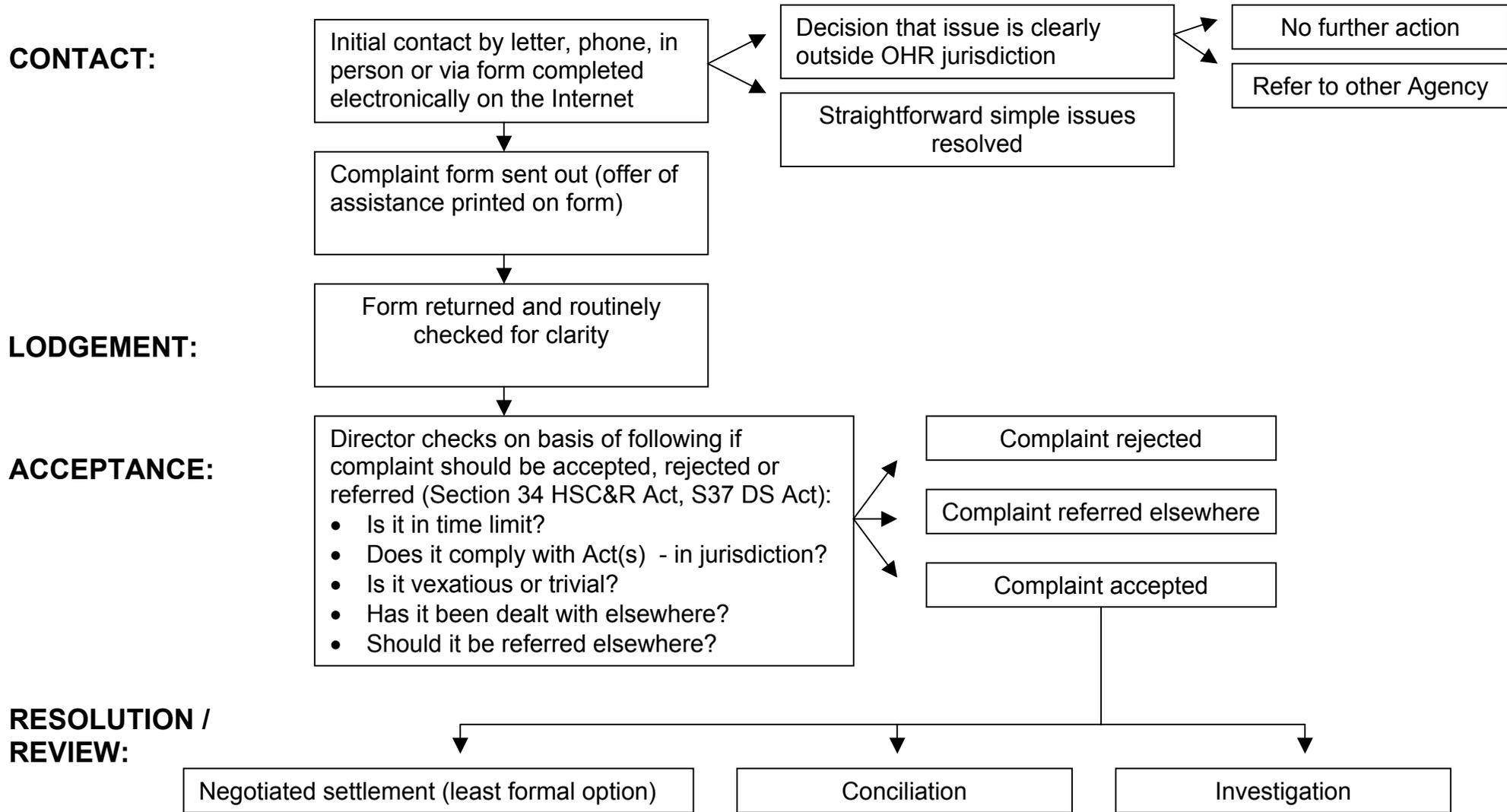


- Statements made in conciliation are protected (S42 of HSC&R Act) but statements made in “Informal Enquiries” are not protected.
- Complaints dealt with initially by informal enquiries may be referred for conciliation or investigation.
- Complaints dealt with by conciliation may be referred to investigation.
- Parties dissatisfied with outcome of conciliation or investigation may request internal review.
- Parties dissatisfied with internal review may request review of process by the Ombudsman.

TIME LIMIT: Disability complaints must be received within two (2) years and health complaints within one (1) year of incident complained of.

**FIGURE 1**

## Proposed process for Lodgement, Acceptance and Resolution of Complaints by the OHR (in outline)



- Resolution includes all further enquiries and negotiations necessary to achieve resolution.
- Negotiated settlement (least formal option) to be recognised in both Acts.
- All enquires and activities associated with resolution process protected as per S42 of HSC&R Act.
- Parties dissatisfied with outcome of conciliation or investigation may seek internal review, if dissatisfied with internal review – for the review by Independent Complaints Review Committee and /or process review by Ombudsman.

**FIGURE 2**

The Reference Group recognised that it is in the interests of consumers if the period of time between an adverse event, or a matter giving rise to a complaint, and the complaint being made, is greater rather than less. This is because consumers may be traumatised or otherwise unable to contemplate making a complaint in the first twelve months, or more, after an adverse experience. This is especially the case where the experience has resulted in a major disability, or in cases where a complaint is being made about treatment that resulted in the death of the consumer.

The Reference Group took into account the fact that complaints about disability services may be about events that are two years old, and considered that at the least, the time limits for health and disability complaints should be consistent.

#### **Recommendation 11**

**In respect of both health and disability complaints, the Director must reject a complaint the subject matter of which occurred more than 24 months before the complaint is made unless, in the Director's opinion, the complainant has shown good reason for the delay.**

#### ***Initial contact with the OHR and the lodging of a complaint***

When a complainant first contacts the Office, the opportunity arises not only to provide useful information, advice and assistance, but on a more general level, to instil confidence in the professionalism of the staff. At this stage of the process it is important, as discussed, to screen out any complaints that clearly do not fall within the scope of the Office and redirect the complainant to relevant assistance. There may also be the opportunity for simple advocacy, for example perhaps making a telephone call on the complainant's behalf to obtain their medical record if the 'system' has inadvertently or otherwise defeated their first attempts. Currently OHR staff do carry out a considerable amount of this type of straightforward assistance and this should continue. However, if a matter is unable to be resolved at this preliminary level, it should be formally lodged and accepted as a complaint and proceed to the resolution phase as speedily as possible.

A number of submissions to the Review indicated that the OHR should receive complaints orally. It is a common misconception that the OHR does not receive oral complaints - section 27 of the Act provides for the receipt of complaints orally, by telephone or in writing. However, section 27(2) then goes on to add that all oral complaints must be confirmed in writing. Clearly this section of the Act has caused some confusion in the community and it is therefore incumbent on the OHR to provide clear information, advice and practical assistance to people who may wish to lodge a complaint, either orally or in writing.

One practical way to address this seemingly confusing situation would be to routinely offer to assist complainants to complete the written form used by the Office to record the complaint. It is therefore recommended:

#### **Recommendation 12**

- (i) In all cases where an initial determination has been made by the Office of Health Review staff member that the complaint is within the jurisdiction of the Office, an offer of assistance to complete the complaint form be made to the complainant; and**

- (ii) **As part of this requirement to offer assistance, there be a clearly worded, plain English advice to this effect printed on all complaint forms.**

In recognition of the wide use of the Internet in the Western Australian community, the Reference Group explored the idea of the Internet as a means of lodging health and disability complaints. In Victoria, use of the Internet by the Health Services Commission is limited to the same degree as applies in Western Australia. That is, consumers can down-load a Complaint Form from the Web site, but the form must be signed and sent by post or facsimile to the Commission before any action can take place.

In Tasmania, however, initial lodgement of a complaint may be via the Internet. The receptionist makes a hard copy of the e-mail and makes up a hard file. The Commission then follows up in writing and, where access to a consumer's medical records is necessary, obtains a signed authorisation before proceeding further.

It is therefore recommended that:

#### **Recommendation 13**

**Methods of receiving complaints be extended to include submission of complaints via the Internet. The Web site should therefore be modified to advise consumers of this method of lodging a complaint, and carry an explanation that, in cases requiring access to medical records, signed authorisation by the consumer or the consumer's representative will be necessary.**

Where individuals do not require or accept assistance from the OHR to complete complaint forms, there may nevertheless be cases where the adequacy and standard of clarity of the submitted form leaves much to be desired. It is in the interests of all parties that the essence of the complaint is clearly expressed and understood. From discussions with the OHR there are some indications that such checking does occur from time to time. However, it is important that this is done as a matter of routine. It is therefore recommended:

#### **Recommendation 14**

- (i) **The Office of Health Review routinely check the clarity and quality of written information contained in submitted complaint forms, in order to ensure that the form enables all parties to have a common understanding of the circumstances leading to the complaint and the key issues involved.**
- (ii) **Where the Officer believes that greater clarity is required, he/she is to contact the complainant and assist with clarification.**

#### ***Acceptance of complaints***

Recommendation 7 has already dealt with the criteria that should be employed by the Director to accept or reject a complaint. Sections 26, 28, 31 and 32 of the *Health Services (Conciliation and Review) Act 1995* and sections 33 and 33A of the *Disability Services Act 1993* are pivotal to this.

In most respects the Acts would appear to be clear as to the criteria for acceptance or rejection of complaints. However, the Reference Group believes that some changes are nevertheless necessary, in the interest of clarity and procedural fairness.

Section 26 of the *Health Services (Conciliation and Review) Act 1995* “Complaints that must be rejected” states that:

1. The Director must reject a complaint that in the Director’s opinion:
  - a) is vexatious, trivial or without substance;
  - b) does not warrant any further action; or
  - c) does not comply with this Act.

The Reference Group is concerned that 26(1)(b) is both unnecessary and unclear as to its intent. Furthermore, it could enable the Director of the day to arbitrarily and possibly unfairly reject a complaint using this particular clause. In the view of the Reference Group clauses (a) and (c) adequately cover sound reasons for rejecting a complaint and in both cases, unlike (b), the reasons for the rejection is evident. It is felt that the removal of (b) not only has merit for the reasons outlined but would also help to dispel any concerns or perceptions, however inaccurate, that the Office may act arbitrarily and without sound reason to reject a complaint. It is therefore recommended:

**Recommendation 15**

**Delete section 26(1)(b) from the *Health Services (Conciliation and Review) Act 1995*.**

***The requirement that individuals approaching the Office of Health review must have attempted to resolve the matter with the provider***

Section 30 of the Act - “User must try to resolve the matter” - states:

*“The Director must not refer a complaint for conciliation or investigate a complaint unless the Director is satisfied that:*

- a) The user has taken reasonable steps to resolve the matter with the provider;  
or
- b) If the complaint was made on the user’s behalf, all reasonable steps to resolve the matter have been taken on the user’s behalf.”

Whilst the intent of this section is clear and has some merit, (i.e: that ideally complainants should attempt to resolve their complaint with the disability or health service provider before approaching the OHR), there may nevertheless be some cases where this is neither practicable nor desirable. Examples could include situations where a complainant alleges issues such as sexual impropriety or threatening behaviour and where further contact with the provider may be traumatic, stressful or otherwise deleterious to the person’s wellbeing.

Whilst the Reference Group believes that the intent of Section 30 should be retained, account should nevertheless be taken of these types of circumstances. Accordingly the phrase “the Director must not refer...” should be reworded to provide the Director with discretion. The Reference Group therefore recommends as follows:

**Recommendation 16**

**Amend section 30 of the *Health Services (Conciliation and Review) Act 1995*, to provide the Director with the discretion to refer the complaint for resolution, whether or not the complainant, or a person acting on**

**behalf of the complainant, has taken steps to resolve the matter with the provider.**

***Private providers' right to refuse a service***

Section 25 of the Act makes it clear by omission that, unlike the public sector situation, [25(1)(a)], it is not a ground for a complaint to allege that a private provider has acted unreasonably by not providing a health service for the user.

Where ample choice of providers exists this may not be a serious issue for health consumers. However, in rural or remote areas of the State, where choice of providers may be extremely limited, including a choice of one, the issue of refusal of service becomes more serious.

There are undoubtedly many good and valid reasons for refusal of service, for example threatening or unseemly behaviour by a client. However, there is no comparable exclusion of the right to complain against a private provider for refusing to provide a disability service. It would therefore appear inequitable to impose this distinction in the health sphere. It is therefore recommended:

**Recommendation 17**

**Section 25(1)(a) of the *Health Services (Conciliation and Review) Act 1995* be amended to read "a provider" rather than a "public provider" as is presently the case. This would align what may be included in a health complaint with disability complaints (section 33(2) of the *Disability Services Act 1993*).**

***The current exclusion of cases involving Workers Compensation or other insurance claims***

Currently the OHR does not accept any complaints from people involved in Workers Compensation or other insurance claims. This follows Crown Solicitor's Office opinion received by the Office in January 1997. The opinion is based on the premise that the provider in these cases is providing a service to the insurance companies rather than to the individual who is subject of the insurance claim and the consequential clinical assessments.

The Reference Group finds difficulty with the consequence of this decision, which apparently excludes this group of people from making a complaint to the OHR under the terms of Section 25(1)(b) of the Act, namely:

"A provider has acted unreasonably in the manner of providing a health service".

The exclusion of all people involved in insurance cases from making a complaint about the manner in which an insurance-related clinical interview or examination is delivered, essentially takes away a right of redress granted to all others, on a technical classificatory basis rather than on the basis of natural justice. Thus, someone who felt that they were subjected to undue rudeness, roughness, or offhandedness would currently be refused access to the services of the OHR. The Reference Group is of the view that the early Crown Solicitor's Office decision (or the OHR's interpretation of that decision) should be revisited with a view to re-examining the access of this group of people to OHR complaint procedures.

In making this recommendation the Reference Group recognises that the workload of the Office may well increase, with implications for resources. A view was also expressed that the Insurance Industry should perhaps contribute to the costs associated with the management of complaints arising from these individuals.

Despite these considerations however, the Reference Group took the view that these individuals should not be disenfranchised on the basis of a legal technicality.

It is therefore recommended that:

**Recommendation 18**

- (i) **Further legal opinion be sought in relation to the right of people subject to insurance claims to lodge a complaint to the Office of Health Review based on the provisions of section 25(1)(b) of the *Health Services (Conciliation and Review) Act 1995* and that, failing any change in interpretation to include this group,**
- (ii) **The Act be amended to enable people who are subject to Workers Compensation, and other insurance cases, to lodge a complaint in relation to any clinical interview or intervention received as part of the insurance process based on section 25(1)(b) of the Act.**

***The timely provision of information by the provider***

One of the perennial complaints about complaint resolution systems anywhere is that the process takes too long. A number of submissions, mainly from individuals, make this assertion about the OHR. These criticisms are not always easy to interpret because of the nature of complaints resolution, which can be stressful to parties involved, many of whom are seeking a rapid resolution of their problem and who want to ‘get it over with’ as soon as possible and move on.

The reality is not so simple. A publicly accountable complaints authority must ensure that its processes are thorough, scrupulously fair and impartial and that all relevant information is taken into account as part of the resolution process.

Despite some allegations of tardiness, many cases - especially those involving relatively simple and straightforward issues - are dealt with expeditiously by the Office. In those cases where a reasonable amount of time to achieve an outcome is required, everything possible should be done to keep to reasonable time lines for the various stages of the process. From communications with the OHR and a perusal of their draft procedures manual entitled “Office of Health Review: Guidelines for Dealing with Disability and Health Complaints”, it clear that the OHR is aware of this and is taking steps to ensure that reasonable time limits apply. Presently time limits stipulated in the early part of the process are as follows:

<b>Step</b>	<b>Time Frame</b>
Decision by Director to accept or refuse a complaint	Within 28 days of receipt of the complaint with possible extension of a further 28 days.
Notification to provider of complaint	14 days after accepting the complaint
Time given to the provider to respond	Not stipulated in the Act. Currently OHR allows 21 days, after which there is a follow-up and extension of a further 14 days. Following this, a letter from the Director is sent to the provider explaining reasons for the need for a timely response. After a further 14 days the Director writes indicating options for further action, i.e: powers of investigation.

Whilst most providers respond in a timely manner, from discussions with the OHR it appears that there are some providers who only respond after an extended time period and many prompts. This is one of the main reasons why some cases take an extended period to resolve.

The Reference Group takes the view that there may be a greater encouragement to resolve complaints in a more timely manner if the Act stipulates reasonable time periods for the providers to respond to complaints. It is therefore recommended:

**Recommendation 19**

- (i) **Both the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993* be expanded to include a provision that providers are required to respond to a complaint within 28 days of the Director notifying them of the complaint; and that the Director may, if s/he deems there is good reason, extend the response period further, after which time the Director may advise the provider that s/he may proceed to draw conclusions without a response; and**
- (ii) **If, without good reason, the provider fails to provide the Director with a response, the Director must report on the provider's failure to respond in the Office of Health Review's subsequent Annual Report.**

***Conciliation: recommended amendments to process***

There are two process amendments that the Reference Group believes will improve and strengthen the operation of the conciliation process.

The first matter relates to the perception of even-handedness in discussions that are held as part of the resolution process.

Section 39(1) of the Health Services (Conciliation and Review) Act, although at first implying that neither party may be represented by another person during the conciliation process, then enables the Director to determine otherwise. Section 39(2) strengthens the options of including others 'who may ... help in the conciliation'. The Reference Group strongly supports the apparent intent of the Act to prevent the alternative dispute resolution model from becoming 'legalistic'.

Nevertheless, where monetary or other compensation forms part of the subject matter of the conciliation proceedings, providers frequently – and with good reason – involve their insurance legal representatives. In some cases this helps to facilitate speedy and mutually agreeable outcomes. From discussions with the OHR it appears complainants are also permitted to have a lawyer or advocate assisting them.

Not all complainants have easy access to advocacy and some comments were received in the course of the Review to the effect that complainants may feel disadvantaged or intimidated if the provider has a lawyer present and they do not. The OHR does make an effort to rectify the situation in such cases, by referring the complainant to the Health Consumers' Council for advocacy assistance.

The Reference Group believes that this service could be strengthened and extended if the OHR routinely provided a current list of advocacy services to any complainant involved in the resolution process. This would be particularly relevant to those consumers who might otherwise not have access to an advocate and who feel that they would benefit from some support and advice, or who might feel overwhelmed in situations where the provider does have such representation.

This would constitute a worthwhile practical service and also help combat any perceptions that the consumer may be disadvantaged in relation to the provider. The recommendation which follows is, however, made with the strong proviso that the Reference Group does not wish to see the Conciliation process become 'legalistic' or any more formal than is required.

It is recommended that:

#### **Recommendation 20**

**The Office of Health Review routinely provide a current list of advocacy services to any complainant involved in the resolution process**

#### ***Timeliness in the conciliation process***

The second matter relates to time limits. Currently, the conciliation process has no time limit. The Health Services (Conciliation and Review) Act merely states in section 40 that:

“40(1) The conciliator –

May make reports to the Director on the progress of the conciliation; and

Must make a final report on the result of that process”.

It is suggested that the OHR adopt a procedure which ensures that in every case which has not been finalised within a three-month period (either by 'agreed settlement' or conciliation) a report be prepared for the Director, with recommendations on the future conduct of the case. It is therefore recommended that:

#### **Recommendation 21**

**In every case which has not been concluded within a three-month period, a report be prepared for the Director which recommends on the future conduct of the case. Recommended options include:**

- (i) Where there is still a good chance of achieving resolution, continue the conciliation process;**
- (ii) Investigation and subsequent recommendations for action; and**
- (iii) Where not suitable for investigation and there is little chance of a conciliated settlement:**
  - Closure of the case with no finding other than that resolution was not achievable;**
  - If the complainant wishes, referral for internal review or review by the *Independent Complaints Review Committee*.**

#### ***Failure of a provider to respond to or remedy a situation when asked to by the Director following an Investigation***

Under the *Health Services (Conciliation and Review) Act 1995*, if the Director finds after an Investigation that “unreasonable conduct....has occurred” (section 50), the

provider must provide the Director with a report within 45 days on what action has been taken to remedy the situation. There is, however, no compulsion on the provider to actually undertake any remedial action.

*The Disability Services Act 1993* is somewhat more powerful in this respect, in that section 44(2) requires the Director to “ give the Minister a copy of the decision and a written report about the refusal or failure of the respondent to take the remedial action.” Subsequently the Minister “*may* table [the report] before each House of Parliament” (section 44(4)).

Ultimately, neither Act can compel the remedial action. However, the Disability Services Act carries considerably more incentive for the provider to do so. The Reference Group believes that both health and disability complaints procedures should carry the stronger provision outlined in the *Disability Services Act 1993*. It is therefore recommended:

#### **Recommendation 22**

**As per section 44 of the *Disability Services Act 1993*, the Director must report to the Minister if his/her recommendations with regard to remedying a situation involving a health complaint are not carried out by a provider.**

#### **Public information and reporting – 10(1)(c),(f) & (g)**

One of the most frequently raised issues emerging from the submissions was the very low visibility of the OHR. Many comments were received from agencies, advocacy groups, users and providers to the effect that the existence of the OHR, let alone its function, is very little known in the community. It would be fair to assume that the majority of the population has never heard of the Office of Health Review. Comments to this effect in the submissions are reinforced by the fact that of 183 completed questionnaires received by the Review, only 17% were aware of the OHR.

A related problem is the name of the Office itself. Many submissions argued that the title ‘Office of Health Review’ is misleading and does not clearly link the agency to the business of receiving and managing complaints. Thus, even if people are aware of the Office, they may not know from its title what it does. Recommendation 3 is designed to address this problem.

The Reference Group strongly believes that there is a need for a dedicated, full-time position to take the lead responsibility, in consultation with the Director, for raising the community’s awareness about the agency’s functions. The incumbent of the position should make a special effort to reach disadvantaged groups and those people in the community who may not be fully aware of their right to have their complaint heard.

This position would also have responsibility for publications, including the Annual Report, and for making sure that information about the agency is up to date, user-friendly and disseminated to providers and consumers. In this regard, greater use of the Internet as a vehicle to reach some groups, especially young people, could be explored.

The position needs to be quarantined from complaints handling and investigation and be a full-time information and liaison role. If, as in the past, it is combined with other duties, such as investigation or conciliation, it is likely that these other duties will overtake the information, community awareness and liaison functions.

It is envisaged by the Reference Group that the position would include a requirement to work with others to ensure that meaningful, relevant data is collected and reported on, both in relation to the agency's Annual Report and for the benefit of providers, consumers and relevant organisations such as Watch on Health and the Department of Health's Office of Quality and Safety.

These functions, performed by a dedicated staff member, have the potential to optimise the Office's role in improving the overall health system in Western Australia. It is therefore recommended that:

#### **Recommendation 23**

**A full-time position of Information and Community Liaison Officer be established to develop and, with the Director, take lead responsibility for a comprehensive information and communications strategy which will:**

- (i) Support the Director's role of increasing the community's awareness of the Office of Health Review and its role and functions;**
- (ii) Improve information about and access to the Office of Health Review and its services, with particular reference to groups with special needs including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state;**
- (iii) Ensure that publications and official forms are user friendly and of high quality; and**
- (iv) Work with health and disability service providers to ensure that consumers have access to information about the Office of Health Review, and its role and functions, at points of service, and are informed of their rights with regard to health and disability services.**

#### ***Provision of information to consumers about registration boards***

As is now the case, the Office should continue to provide consumers with relevant information about the role of Registration Boards and their relationship to the OHR.

#### **Recommendation 24**

**The Office of Health Review ensure, where appropriate, that consumers are provided with relevant information about the role, jurisdiction and activities of registration boards and the relationship between registration boards and the OHR in the complaints process.**

#### ***Annual Reporting***

The Annual Report is the pre-eminent official vehicle for an agency's statement of accountability and the provision of clear information about its purpose and performance. A good Annual Report is written in plain English, is clearly and logically constructed and enables the reader to quickly and easily access key information.

Particularly in cases where agencies may not be well known, the Annual Report can act as a high-impact vehicle for the transmission of key messages about the agency

and perhaps, if linked to an interesting media release about trends, improvements or issues over the year, may generate some publicity about the activity of the agency. Conversely, an Annual Report that is unclear and poorly structured misses the opportunity to present information to the community.

In the view of the Reference Group the 2001-2002 Annual Report of the Office of Health Review lacks logical structure and focus. Information is not presented in a clear sequential or informative way and it is noticeable that in the main body of the latest Report there are no graphs and almost no tables or diagrams. By contrast, the New South Wales Health Care Complaints Commission's Annual Report 2001-2002 make copious use of clear, informative and well-presented tables and graphs, including a section entitled "The Year at a Glance" in the Executive Summary immediately following the Table of Contents. On this page, six important indicators are clearly presented in bar graph form, enabling the reader to have an "at a glance" summary of the year's activities.

The OHR Annual Report also lacks any information about the strategic overview of the Office's objectives in the short to medium period and the extent to which the Office's objectives are being achieved. The many 'case studies' though interesting, are not used to strategic effect. Such case studies should be included for a purpose - for example, to exemplify emerging trends that the Office is confronting, or as an example of effective or ineffective management of a complaint.

In short, many members of the Reference Group feel that the Annual Report as currently written represents a missed opportunity to clearly inform the public about the work of the Office, its plans and objectives for the future and the extent to which it is realising its key objectives. There is a strong view that the Office must improve the overall quality of its Annual Report as a matter of priority. It should be noted that there are a number of best practice guidelines and organisations that can provide assistance and advice in relation to best practice in annual reporting. The Reference Group therefore recommends as follows:

#### **Recommendation 25**

**As part of the strategic planning process, the Office of Health Review seek information on best practice guidelines in relation to the structure and content of its future Annual Reports and that the 2003-2004 Annual Report incorporate changes which will engender greater clarity and quality of information and presentation.**

#### ***Key Performance Indicators***

The Reference Group is of the view that the OHR needs to improve the quality and clarity of its key performance indicators (KPIs), which currently do not focus enough on outcomes. It is felt that the emphasis should be on resolving complaints rather than finalising them and that this should be reflected in newly developed KPIs. There is, for example, no explanation of what 'finalised' entails; that is, how many 'finalised' complaints are unable to be resolved satisfactorily or are simply administratively closed because the complainant is no longer in contact with the agency. In other words, the efficiency and effectiveness indicators as presently written provide no basis for assessing the efficiency, effectiveness or quality of work undertaken by the OHR.

Similarly, the "number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations" gives little indication of

what is entailed in practice. At the least, it might be expected that there is an explanatory table that clearly lists kinds of improvements that the indicator refers to.

In summary, the present indicators do not comprehensively or effectively provide the reader with an assessment on the extent to which the stated outcome -

“To resolve complaints about health and disability services by providing systems for dealing with complaints and improving practices and actions of health and disability service providers” - is achieved.

The Reference Group therefore recommends as follows:

#### **Recommendation 26**

**As part of the strategic planning process, the Office of Health Review develop a more comprehensive set of key performance indicators (“KPIs”) than is presently the case. Such KPIs should measure the extent to which the outcomes sought by the Office are being achieved. In the first instance this relates to:**

- (i) resolving (rather than finalising) complaints about health and disability services; and**
- (ii) improving practices and actions of health and disability services.**

#### **Reviewing the causes of complaints and investigating systemic health care issues – 10(1)(b) & (e)**

Complaints are a form of feedback on the effectiveness or otherwise of organisations and systems. A careful analysis of complaints can provide vital information on why the activity causing the complaint occurs and how the situation at both an individual and systemic level can be rectified. Increasingly organisations are using complaints and aggregate complaints data as indicators of where organisational and systems improvements can and should be made. This is more and more the case in the health industry, where safety and quality issues have become a major priority in recent years.

Although the OHR collects some aggregated data as part of its Management Report Process, by its own admission it has not been in a position to rigorously or comprehensively pursue investigations of systemic health issues. Nor has it been able to thoroughly review and identify the causes of complaints, based on such data or other information at the disposal of the Office.

This point was raised in the course of a presentation to the Reference Group by the Acting Director of the Office, who expressed the view that the primacy of the function of “undertaking the receipt, conciliation and investigation of complaints” left little time for the pursuit of broader system issues. The Reference Group has some sympathy with this position. However, it begs the question of whether these functions should be continued if they cannot be satisfactorily carried out.

The Reference Group is strongly of the view that these are important functions. The value of aggregated complaints data is lost if it cannot be used effectively to further investigate and address causes of complaints and systemic issues. We are therefore of the opinion that functions 10(1)(b) – with a slight amendment – and 10(1)(e)

should continue to be carried out by the OHR, subject to resource issues and the more effective management and use of data.

Notwithstanding the importance of function 10(1)(b), the Reference Group is of the view that the wording “*and bringing them to the notice of the public*” should be removed and simply dealt with as part of a broad public information strategy. The Reference Group therefore recommends as follows:

#### **Recommendation 27**

**The words “and bringing them to the notice of the public” be discarded as an explicit part of function 10(1)(b), but integrated into a broad communication strategy.**

#### ***Closer liaison with Watch on Health***

With respect to 10(1)(e), the opportunity for this important function to be more adequately fulfilled has been enhanced by the establishment of the newly created body ‘Watch on Health’. The terms of reference for Watch on Health specify that it may “consider any of the following matters:

1. Emerging areas of concern in which trends in one or more identified conditions (e.g: diseases or injuries) *or factors in the health system*, the general environment or *human behaviour*, which have the potential to:
  - a) Act to the detriment of the health of the population of Western Australia or the quality of health services; or
  - b) Cause or worsen inequality in health status or access to health services across population sub-groups.
2. Existing areas of concern in which one or more *factors in the health system*, the general environment or *human behaviour* are presently:
  - a) Acting to the detriment of the health of the population of Western Australia or the quality of health services; or
  - b) Causing or worsening inequality in health status or access to health services across population sub-groups.

Preliminary informal discussions with Watch on Health have identified the fact that that organisation sees a role for the OHR in referring potential systemic problems to them for further monitoring and/or investigation, based on reasonable evidence gleaned from complaints data. The Reference Group believes that there should be a strengthening of links between the OHR and Watch on Health, and that the referral of actual or potential systemic health issues to Watch on Health will strengthen the performance of the OHR in relation to Function 10(1)(e).

The Reference Group therefore makes the following recommendations:

#### **Recommendation 28**

**The Office of Health Review systematically review complaints data on a six-monthly basis in order to identify any actual or emerging systemic issues of concern.**

#### **Recommendation 29**

**Where there is evidence of any systemic health or disability issue of concern, based on accurate complaints data, and the Office of Health Review is not in a position to investigate the matter, the matter be actively considered for referral to Watch on Health or other appropriate bodies for monitoring and/or investigation.**

#### **Recommendation 30**

**The Director of the Office of Health Review approach Watch on Health with a view to becoming an ex-officio member of the Watch on Health Council.**

#### ***Management and dissemination of data***

The Reference Group has a general concern that the collection, analysis, maintenance and reporting of key data within the OHR lack rigour and make the communication and referral of relevant information to key stakeholders more difficult and less satisfactory than should be the case. Reference has already been made to the very limited data on the activity of the Office presented in its Annual Reports and the inadequacy of the present key performance indicators.

In terms of day-to-day management and operations, there would also appear to be a need for a more rigorous and strategic approach to information and data management. This is as a matter of importance in its own right, as an essential precursor to the provision of relevant and useful information to stakeholders, and as an indicator of how well the Office is serving particular sectors of the community. For this reason the Reference Group recommends as follows:

#### **Recommendation 31**

**Within the Office of Health Review there be an urgent review of management systems, with a view to establishing a strategic approach to the collation, analysis, maintenance, reporting and referral of complaints data.**

**Amongst other things, such data must enable the Office to assess the extent to which it is reaching and serving the needs of groups with special needs, including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state.**

In parallel with a more efficient data management system, there needs to be an effective mechanism for transmitting relevant information on system issues to stakeholders on either a regular or issue-by-issue basis.

#### **Recommendation 32**

**The Office of Health Review establish an effective mechanism for transmitting relevant statistical information on health system issues to stakeholders.**

#### **Providing assistance to providers to improve complaints procedures and the training of staff in complaints handling– 10(1)(d)**

On the face of it this is a worthwhile function for the Office which, if pursued vigorously, has the potential to increase the number of complaints dealt with

satisfactorily at the point of service. It could also encourage best practice and consistency of standards across the health and disability sphere.

In practice, like other 10(1) functions, which are outside the core business of 'the receipt, conciliation and investigation of complaints', the OHR can only achieve so much with its present establishment and resources. It should also be recognised, however, that service organisations and providers themselves must take prime responsibility for ensuring that there is an adequate complaints system at their point of service, which includes the provision of quality training for staff. In the case of individual providers this sometimes presents difficulties. However, there is an expanding role here for umbrella organisations such as professional associations (for example, the Royal Colleges and the Divisions of General Practice).

At present, the OHR attempts to fulfil this training function in at least two ways. First, there is the provision of feedback to providers, which may include suggestions of how the situation might have been better handled and/or could be if a similar situation were to arise again. Secondly, the Office currently holds regular meetings with the customer service officers of Metropolitan public hospitals. These meetings provide the opportunity to raise common problems and raise issues of interest related to complaint resolution and the role of the OHR.

The Reference Group is of the view that this process of meeting with key stakeholders should continue and be expanded to include other service organisations, including the establishment of a separate group of key disability service providers.

#### **Recommendation 33**

**The present system of regular meetings with customer service officers from metropolitan health services continue and the system be expanded to other groups of like service providers in the health system.**

#### **Recommendation 34**

**The Office of Health Review coordinate a forum of complaints officers from disability service providers in order to discuss matters of common interest in relation to complaints handling processes.**

The question of whether OHR should do more than this is dependent, to a significant extent, on available resources. Were additional resources to become available, the establishment of a full-time training officer position should be considered. The incumbent could be responsible for both in-house training for OHR staff and some training activities with health and disability providers.

## **Continuation of Functions of the Office of Health Review**

After considering each of the section 10(1) functions, the Reference Group believes that they should all remain, even though to this point in time, it has been difficult for the Office to fulfil all of them to the extent that staff and the community might wish. The Acts lay down the blueprint for what the Office should strive to attain in its role as the principal alternative dispute resolution agency for health and disability complaints in Western Australia. This Review, through its recommendations, is intended to assist the Office to further improve its effectiveness in relation to its performance of these functions. Accordingly it is recommended that:

### **Recommendation 35**

**The present functions of the Office of Health Review as set out in 10(1) of the *Health Services (Conciliation and Review) Act 1995* remain (with the modification to 10(1)(b) proposed in recommendation 26).**

## **Specific Issues Relating to Disability Services**

Although this Report is in general designed to refer equally to health and disability complaints, there are issues specific to disability which, in the view of the Reference Group, require separate and specific mention. This section of the Report deals with those specific issues, and also includes reference to the work of the Steering Committee which oversaw the 2001-2002 Review of the *Disability Services Act 1993*.

The Reference Group was sensitive to the fact that many people in the disability community see disability complaints as the 'poor relation' at the Office of Health Review. In part, this is because disability complaints were not dealt with by the OHR until late in 1999, and because referrals of disability complaints to the OHR are still comparatively few. In 2001-2002, the OHR received only 24 disability complaints, compared with 1,359 complaints about health services. This disparity partly reflects the smaller population base for potential disability complainants. It is also partly reflective of the general lack of visibility of the OHR, and the fact that its name does not readily identify its role and functions in resolving complaints generally, and specifically does not include the word "disability".

The Reference Group was keen to re-brand the organisation as the major independent complaints resolution mechanism for both disability and health.

The Steering Committee of the Review of the *Disability Services Act 1993* noted that the review by the Minister for Health of the Office of Health Review was a useful means of strengthening the complaints mechanism for people with disabilities, through the adoption of recommendations aimed at increasing the jurisdiction of the OHR. It also noted that it was appropriate to reconsider the discussion and recommendations of the Review of the Disability Services Act (DSA) in reviewing the OHR.

### **Statement of Principles**

The Steering Committee agreed on a set of principles that should be fundamental to any complaints mechanism. These are:

- People with disabilities should have access to services and supports in the same way as other members of the community;
- The complaints mechanism must be accessible and approachable for people with disabilities. It must be sensitive to and address the range of specific communication and support needs that may be experienced by people wishing to make complaints;
- The complaints mechanism must be maintained within the Disability Services Act. This ensures that the people with disabilities are consulted about, can comment on, and can recommend changes to the external complaints mechanism as part of the requirement to review the Act every five years. This is highly valued by the disability community;
- The complaints mechanism must be administered independently of the Disability Services Commission;

- The complaints mechanism must include the authority for systemic review. The authority for systemic review ensures that, should issues emerge which are common to a number of service providers, these issues can be investigated jointly;
- The complaints mechanism must be able to be responsive to issues raised by the Minister for Disability Services;
- The complaints mechanism must include the authority for initiating investigations and reviews;
- The complaints mechanism must be able to report to the Parliament (and therefore to the community); and
- The complaints mechanism must include provisions for communication with the Disability Services Commission on significant issues or types of complaints.

Like the Reference Group (see Recommendation 1), the Steering Committee determined that the external complaints mechanism for disability should remain with the OHR and the Disability Services Act be amended to give a stronger mandate to the OHR in its dealings with complaints from people with disabilities.

In addition, the Steering Committee recommended that:

“The complaint mechanism be clearly identifiable and labelled as a service for people with disabilities”. This recommendation is reflected in Recommendation 3 of this Report. The Steering Group also recommended changes to the *Disability Services Act 1993* which would provide powers in respect of disability complaints comparable to those in the *Health Services (Conciliation and Review) Act 1995* which apply to health complaints.

The general approach taken by the Reference Group in relation to the two pieces of legislation is to make them more consistent with respect to their powers and processes. This is reflected in many of the recommendations of this report, including those which follow. Whilst some persuasive arguments for a single Act were made in a number of submissions, the Reference Group is mindful of the strongly held feelings within the disability community that the two Acts should remain separate. Accordingly there is no recommendation to change this situation.

Specific legislative changes recommended by the Steering Committee reviewing the Disability Services Act were as follows:

“That Part 6 of the DSA be amended so that the Office of Health Review has comparable authority and powers with respect to disability and health issues.

Specifically these are

- the power to initiate an investigation of serious public interest issues of its “own motion”;
- provisions for directly reporting to Parliament; and
- provisions for the OHR to take direction for a review from Parliament or the Minister for Disability Services.”

and

“The *Health Services (Conciliation and Review) Act 1995* be amended, to permit the Minister for Disability Services to have the same power under the Act as the Minister for Health”.

With respect to “the power to initiate an investigation of serious public interest,” the Reference Group considered that there should be an equivalent power to section 10 (1)(e) of the *Health Services (Conciliation and Review) Act 1995* in the *Disability Services Act 1993*. That is, “with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received”. Equally, the Reference Group is of the view that the *Disability Services Act 1993* should carry the power for the Director to report directly to Parliament, or take direction for an investigation or review from either House of Parliament, in similar fashion to the powers stated in section 56 of the *Health Services (Conciliation and Review) Act 1995*.

In relation to the respective powers of Ministers, both Acts allow the Minister to refer matters for investigation by the Office of Health Review (s 45 of the *Health Services (Conciliation and Review) Act 1995*, s 46 of the *Disability Services Act 1993*). However in section 11, the *Health Services (Conciliation and Review) Act 1995* also empowers the Minister to “give directions in writing to the Director with respect to the performance of the functions of the Director” and in section 12, to have access to and request information in the possession of, the Director (with the exception of personal identifying information). The Reference Group believes that the Minister for Disability Services should have similar powers expressed in the *Disability Services Act 1993*.

Recommendations 35 and 36 essentially support the recommendations of the Steering Committee. Recommendations 37 and 38 aim to further reduce the disparities between the two pieces of legislation.

#### **Recommendation 36**

**Part 6 of the *Disability Services Act 1993* be amended so that the Office of Health Review has comparable authority and powers with respect to disability and health issues, specifically:**

- (i) **with the approval of the Minister, the power to inquire into broader issues relating to disability services arising out of complaints received, similar to section 10(1) of the *Health Services (Conciliation and Review) Act 1995*;**
- (ii) **provisions for directly reporting to Parliament similar to section 56 of the *Health Services (Conciliation and Review) Act 1995*;**
- (iii) **provisions for the Office of Health Review to take direction for a review from Parliament or the Minister for Disability Services, similar to sections 56 and 11 of the *Health Services (Conciliation and Review) Act 1995*.**

#### **Recommendation 37**

**The *Disability Services Act 1993* be amended to permit the Minister for Disability Services to have the same powers under the Act as the Minister for Health has in the *Health Services (Conciliation and Review) Act 1995*.**

#### **Recommendation 38**

**Grounds for complaints about disability services be extended to include excessive cost, in keeping with the grounds for complaint in section 25(1)(g) of the *Health Services (Conciliation and Review) Act 1995*.**

### **Recommendation 39**

**The *Disability Services Act 1993* be amended, as per section 25(1)(f) of the *Health Services (Conciliation and Review) Act 1995*, to include as a ground for complaint failure by a manager of a service to properly investigate a complaint.**

Within the OHR, there is one FTE dedicated to disability matters, although in reality this officer spends a considerable amount of time on health complaints. If the Office is to provide a good standard of service to the disability community, it is essential that there are resources specifically dedicated to disability complaints and issues. It is also essential that substantial effort is made to raise awareness of the Office's role in conciliating and investigating disability complaints, among the 355,500 people with a disability in Western Australia and the almost 200,000 people who are carers.<sup>1</sup>

Further, the Reference Group believes that, just as it is essential to have staff with specialist skills and knowledge dealing with disability complaints, it is important that the OHR establishes and maintains data and statistics appropriate to disability complaints, and that these statistics are presented separately in the Annual Report. Finally, independence of funding must be both a perception and a reality.

### **Recommendation 40**

**The Office of Health Review is to ensure that there is equal recognition of the importance of appropriately and continuously addressing disability complaints and associated issues and that sufficient discrete resources are allocated for this purpose.**

### **Recommendation 41**

**The Office of Health Review collect data and statistics on disability complaints, which adequately and appropriately reflect issues relevant to disability, and report separately on these in the Annual Report.**

### **Recommendation 42**

**Disability complaints dealt with by Office of Health Review must be funded independently of the Disability Services Commission; that is, through an administered fund.**

## **Other Matters**

### **Staff Training**

It is acknowledged that staff at the Office of Health Review are committed, work hard and have developed a measure of expertise in the investigation, conciliation and resolution of complaints. It appears on the basis of discussions with the Office, however, that there has been relatively little formal training offered to staff over the years of the Office's existence.

Additionally, because of the small number of staff and the flat management structure of the Office in recent times, there has been a lack of systematic professional development opportunities within the organisation. Staff who are given acting opportunities at higher levels tend merely to be allocated a heavier workload than they already carry.

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<sup>1</sup> Disability Services Commission, Annual Report 2001-2002

This Review and its recommendations provide the opportunity for the agency to take stock of its role and the way in which it fulfils its functions. It is also an opportunity to re-think to some extent, the skills and competencies which staff will require to implement the changes outlined, particularly in relation to handling complaints from groups with special needs. If the recommendations of the Report are to lead to improvements to the profile and performance of the Office, appropriate staff training and performance management are essential.

It is therefore recommended:

**Recommendation 43**

**In order to respond to the recommendations of this Report, which propose a significant re-engineering of the processes and procedures of the Office of Health Review, the Director is to formally identify the competencies and skills required by frontline staff and arrange appropriate training.**

**Recommendation 44**

**The Director is to ensure that the performance management system be enhanced to take account of the changes to process and procedure outlined in this Report.**

## **Prisons**

A small number of submissions were received which were critical of the Office's relationship with prisons and the prison health system. Certainly the institutional and cultural environment of the prisons presents some unique challenges, particularly for people who are unfamiliar with that environment. It is important therefore that a closer working relationship be established between OHR and both the Department of Justice and the Inspector of Custodial Services, in order to foster a greater appreciation of the problems and circumstances peculiar to prisoners, prison health staff and the prison health system. It is therefore recommended that:

**Recommendation 45**

**The Director meet formally with the Inspector of Custodial Services, on not less than a six monthly basis, to discuss issues relating to the role of the Office of Health Review in the context of the Prison Health system.**

**Recommendation 46**

**The Director meet formally, on not less than a six monthly basis, or as required, with the Executive Manager of the Prisons Division to discuss operational matters relating to the Office of Health Review's performance of its role in the prison environment.**

## **Advisory Group**

The issue of an Advisory Group to the OHR was raised in some submissions and considered by the Reference Group. In Victoria, a Council of eleven people – made up of providers, users and independents – is chosen by the Minister. The Council provides advice to the Minister and the Commissioner, presents its own Annual Report within the Commission's Annual Report and undertakes its own program of

work. For example, it recently held a seminar on privacy legislation. Based on personal communications from both the Commissioner, Beth Wilson, and the President of the Health Services Review Council, Russell Kennedy, the Council works well and is seen as an important element in the health complaint system in that state. Both emphasise that to work successfully an advisory council requires adequate funding.

Whilst there is some support within the Reference Group for the idea of an Advisory Group, the general view is that at this time, any new resources should be channelled into agency staff and other in-house resources. Accordingly no recommendation on this matter is made. The establishment of an advisory council may nevertheless be considered appropriate at some time in the future.

## **The Issue of “Own Motion” Power**

Several submissions to the Review of the Office of Health Review made reference to the power of “own motion” and stated that it was desirable the Act was amended to give the Office this power.

The Reference Group first considered what is meant by this power, and then looked at whether, as claimed, the Office’s lack of own motion power affected its ability to do its job properly.

The power of “own motion” was considered by the Reference Group to mean, in the context of the Office, that, without requiring a direction from the Minister for Health, or an individual complaint, or any other authority, the Office could take up any issue that, in the Director’s opinion, was an issue of serious public interest, and investigate and make recommendations to Parliament on that issue.

It was noted by the Reference Group that section 10(1)(b), section 10(1)(e) and section 56(1) of the Act currently give the Director quite extensive powers, to look behind the circumstances of an individual complaint (including an oral complaint) for evidence of systemic problems or other serious public interest issues. It was not felt that, on the face of it, there was a compelling case for expanding these powers. The Reference Group considered, for instance, that there was likely to have been some prior notice of an issue held to be of such serious public interest that the Director might want to investigate it. Crucially, a single complaint could serve as the trigger for such an investigation. This situation did not seem to point to any deficiency in the present powers. It was thought there could be more benefit in leaving the Act as it stands on this issue.

Of more practical weight was the consideration that the OHR is a small Office and its personnel do not include staff with professional health and disability qualifications. In the event of a serious public interest inquiry, such as investigation of major problems at a large teaching hospital, what role could the Office, as presently constituted, fill? What power would it have in such a circumstance that would make it, rather than a specially convened expert panel or investigative body, the best or most logical body to carry out the inquiry?

Another practical consideration is that the recently formed Watch on Health has a designated role to take up systemic inquiries and, as a precaution against unnecessary inquiries, has a rigorous screening process to which it submits potential investigations. Watch on Health undertakes a preliminary investigation of the

issue(s) to determine whether it should proceed to a formal inquiry in the public interest.

Those people in the Western Australian community who know about the Office of Health Review (and almost 9,000 of them have taken complaints to the Office) have an expectation that the OHR will deal with their individual complaints. There is an acceptance that the prime business of the OHR is the investigation and conciliation of people's individual complaints about health and disability services. Unless the OHR is resourced to the same level as the New South Wales and New Zealand commissions, it is unlikely that it will be able to take up public interest issues in the same way as these two commissions. Indeed, as former commissioner Liza Newby has pointed out, most commissions are able to do one thing well. Most carry out one major function somewhat at the expense of the other. The extent to which they are resourced has a profound impact on their ability to carry out the two major functions of individual complaints conciliation and systemic review and standard-setting.

Taking into account all these factors, the Reference Group believes it has not been demonstrated that the OHR Director needs any power additional to those already conferred by the Act.

## **The Position of Carers and Proposed Legislation**

The Reference Group is aware that consideration is currently being given by the State Government, to the provision of greater recognition and support for Carers, through the development of a *Carers Recognition Bill* and associated policies and practice.

The OHR is a particularly important agency in so far as meeting the needs of Carers is concerned. Sections 19 and 20 of the *Health Services (Conciliation and Review) Act 1995* and section 32 of the *Disability Services Act 1993* provide for 'users representatives' and 'advocates for a person with a disability' to lodge a complaint on behalf of a person. In addition to this legislative authority it is important that the Office continues to take account of the needs of Carers and responds fully to any further whole-of-government policy or legislative changes currently being developed.

## **Implementation**

It is important that following approval by the Minister of some or all of the recommendations in this Report, an implementation schedule is established by the Office and a report on progress provided to the Minister within six months.

### **Recommendation 47**

**Not later than 6 months after the Minister has accepted the Report, the Director of the Office of Health Review (or new name) is to provide a progress report to the Minister on the implementation of the recommendations agreed to by the Minister.**



# **APPENDIX 1**

## **SUBMISSION DOCUMENTS**

## Letter to organisations inviting a submission

Dear

As you may be aware, the Minister for Health, Hon Bob Kucera MLA, has commissioned a Review of the Office of Health Review (OHR), in accordance with Section 79 of the *Health Services (Conciliation and Review) Act 1995*, which requires that the OHR be reviewed after five years of operation.

I enclose information on the Review process, should your organisation wish to make a submission.

Submissions can also be made electronically by accessing either the Web site at [www.ohr-review.health.wa.gov.au](http://www.ohr-review.health.wa.gov.au)

Or by e-mailing the following address and requesting a submission form

**E-mail:** [ohr.review@health.wa.gov.au](mailto:ohr.review@health.wa.gov.au)

Yours sincerely

Andy Duckworth  
Executive Officer  
OHR Review Reference Group

Ph 9222 4111

## REVIEW OF THE OFFICE OF HEALTH REVIEW: SUBMISSION FORM

This form has been designed to assist you in your submission to the Review of the Office of Health Review. Using this format will also assist the Review in the information gathering process.

### Your Details

Name of person completing submission: \_\_\_\_\_

Name of Organisation (if applicable): \_\_\_\_\_

Position in Organisation (if applicable): \_\_\_\_\_

Postal Address: \_\_\_\_\_

\_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact No: \_\_\_\_\_

e-mail address: \_\_\_\_\_

### Confidentiality

We are concerned about your confidentiality, so please indicate which of the following applied to this submission:

- This submission is to remain strictly confidential and is not to be shared/distributed to anyone outside of the Review.
- This submission may be shared/distributed to any other party, if my personal details are removed and kept confidential.
- This submission is public information and may be freely shared/distributed to anyone interested.
- Other, please specify:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Closing date

The closing date for submission is **Friday 28 February 2003**. Please send your submission to:

The Executive Officer  
Review of the Office of Health Review  
PO Box 8172  
Perth Business Centre  
Western Australia 6849

or

Facsimile: 9222 4009 or  
E-mail: ohr.review@health.wa.gov.au

## Terms of Reference of the Review

The terms of reference for the Review of the Office of Health Review are as follows:

1. Review the operations and the effectiveness of the Office of Health Review having regard to:
  - (a) the desirability of the continuation of the functions of the Office; and
  - (b) such other matters as appear to be relevant to the operations and effectiveness of the Office.
2. Make recommendations on any structural, functional or procedural changes, if any, which should be made to the Office arising out of (1).

## Making Your Submission

The Review is about the operation and effectiveness of the Office of Health Review and the desirability of the continuation of the functions of the Office. It is not about **resolving** individual cases (although you can quote your own experiences as an example), nor is it about issues which are outside the legal or operational scope of the Office.

In order to assist your submission, the principal functions of the Office – taken from section 10 (1) of the Health Services (Conciliation and Review) Act 1995, are listed on the pages which follow. These functions and the way in which they are carried out are at the core of the Review. Using the headings might help you to organise your submission.

You may wish to focus your submission on one or more of the functions listed on the pages following. If you do not wish to use this format you are free to present your submission in any way you choose.

The enclosed 'Information Paper' is intended as a reference source, which you may find useful.

If you are able to provide an electronic copy of your submission, that would be appreciated – but is certainly not required.

This sheet is available on the Internet at [www.ohr-review.health.wa.gov.au](http://www.ohr-review.health.wa.gov.au) or by contacting the Executive Officer on (ph) 9222 4111, e-mail address [ohr.review@health.wa.gov.au](mailto:ohr.review@health.wa.gov.au) .





**9. To provide advice to users as to other avenues available for dealing with complaints**

**10. The desirability of the continuation of the functions of the Office**

**OTHER COMMENTS**

**What do you think the Office of Health Review does well?**

**Where do you think there is room for improvement?**



## **APPENDIX 2**

### **THE QUESTIONNAIRE**

## Letter to Organisations

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As well as inviting formal submissions from organisations, the Reference Group carrying out the Review would also like to hear the views and experiences of individuals who may have made a complaint about a health or disability service, and who may or may not have accessed the Office of Health Review.

Accordingly the Reference Group invites you to include a copy of the enclosed questionnaire as a page in your next newsletter, with encouragement to your members to respond.

For any other information about the Review, including how to make a formal submission, please access the Web site at [www.ohr-review.health.wa.gov.au](http://www.ohr-review.health.wa.gov.au)  
E-mail [ohr.review@health.wa.gov.au](mailto:ohr.review@health.wa.gov.au) or write to

The Executive Officer  
Review of the Office of Health Review  
PO Box 8172  
Perth Business Centre  
WA 6849

Yours sincerely

Andy Duckworth  
Executive Officer



## Review of the Office of Health Review

PO Box 8172

**Perth Business Centre**

**Western Australia 6849**

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<http://www.ohr-review.health.wa.gov.au>

### To the Telecentre Management Committee

#### REVIEW OF THE OFFICE OF HEALTH REVIEW

The Office of Health Review is an independent statutory body established to deal with complaints about the provision of health or disability services

As you may be aware, the Minister for Health has commissioned a Review of the Office of Health Review (OHR), in accordance with Section 79 of the Health Services (Conciliation and Review) Act 1995, which requires that the OHR be reviewed after five years of operation.

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Address: The Executive Officer  
PO Box 8172  
Perth Business Centre  
Western Australia 6849

Telephone: 9222 4111

Yours sincerely

**Andy Duckworth**

## QUESTIONNAIRE AND SUMMARY OF RESPONSES (N -183 )

1. *Have you ever felt so dissatisfied with a health or disability service that you felt you would like to make a complaint? (tick or circle appropriate response)*

**Yes 119**

**No 59**

2. If yes, did you proceed with this complaint?

**Yes 37**

**No 74**

2a If yes, who did you complain to?

(i) The person or organisation providing the service **32**

(ii) A professional organisation (eg the AMA) **5**

(iii) The Office of Health Review **12**

(iv) The WA Department of Health **8**

(v) Other (please state) **1** (Human Rights & E O Commission) \_\_\_\_\_

2b If no, why did you not go ahead with your complaint?

Did not know who to complain to **44**

I had no faith that it would be dealt with properly **45**

I lost interest/changed my mind **10**

The process was too difficult/stressful **25**

Other (please state) \_\_\_\_\_

3. Have you ever heard of the Office of Health Review for dealing with health and disability complaints?

**Yes 29**

**No 140**

4. Have you ever contacted the Office of Health Review about your concerns or complaints?

**Yes 13**

**No 148**

5. Did they deal with your complaint?

**Yes 11**

**No 65**

6. If yes, were you pleased with the way they dealt with the complaint? (The process)

**Yes 7**

**No 18**

7. Were you pleased with the outcome?

**Yes 3**

**No 19**

## NOTES

The data have some reliability problems in parts, for example:

- Beyond question 4, many respondents wrote 'no' responses to questions 5-7, where N/A would have been more appropriate;
- A small number of people answered both 2a and 2b;
- Not all respondents answered all questions.

The data are thus perhaps most useful in relation to 1 – 4.

A total of 183 questionnaires were received. They represent

- 87 as a general response to our requests through newsletters,
- 72 as a result of discussions with indigenous groups,
- 24 as a result of discussions with young people.



## **APPENDIX 3**

# **REPORT ON ISSUES RAISED IN FORUMS AND IN QUESTIONNAIRES**

As part of the Review a series of meetings and forums were held with community groups as follows: The report summarises some of the comments made and issues raised.

Group	Meetings	Number of people attending
CALD	2	30
Young People	7	58
Mental Health	1	6
Seniors	1	50
Indigenous	10	72
TOTAL	21	216

A reflection of the general social disadvantage of indigenous people is that many of those surveyed did not know that they have the right to receive health and disability services that respect their dignity and affirm their worth. Despite the Office of Health Review's outreach to a number of remote Aboriginal communities in 2000 (Ngallagunda, Kupingurri, Imintji, Warmun and Bidadanga amongst others), the Reference Group found there was a low rate of knowledge of the Office among indigenous people.

Aboriginal people in the Kimberley, Pilbara and Murchison regions of the state are among those most disadvantaged when trying to make a complaint, because of the barriers posed by inadequate levels of spoken English and formal education, and by different viewpoints and values in these communities. Whilst the indigenous community in remote areas reflects a considerable diversity of educational and economic backgrounds, it is true to say that the disadvantage of Aboriginal people generally is very evident in their access to and experience of health and disability services.

In some cases, indigenous people in remote areas needed to discuss what could and should be expected during a visit to a health agency. That is, their experience of health services was sufficiently limited to make the concept of complaint more difficult. Other indigenous people had had such negative experiences of mainstream Australia that they did not expect that providers of health and disability services would treat them with respect or invite them to be critical of services.

Among other culturally and linguistically diverse groups<sup>1</sup> approximately 50% of people responding to questionnaires and forums were unaware of the OHR and its role. Length of residence in Western Australia did not impact on a person's knowledge about the OHR. Community Settlement Scheme (CSS) workers were also unaware of the OHR. The majority of respondents in this group felt they did not know enough about the Office to comment on its operations and effectiveness. However, there was a consensus that there is considerable scope for improvement in making the Office, and its services, sufficiently well known that members of ethnic communities will approach it with confidence.

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<sup>1</sup> The ethnic backgrounds represented, apart from indigenous people, included Anglo-Burmese, Bosnian, Croatian, Hungarian, Indian, Iranian, Iraqi, Irish, Italian, Moldovan, Polish, Portuguese, Punjabi, Romanian, Singaporean Indian, Somali, Sri Lankan, Vietnamese and Yugoslav. One respondent was from Sierra Leone and one was from Uganda.

One suggestion was that the OHR consider providing in-service training or seminars to community workers (including CSS workers) to equip them with relevant knowledge to assist those of their clients who wish to complain. Another suggestion was for the OHR to consider working in partnership with umbrella agencies such as the Ethnic Communities Council of WA and the Migrant Resource Centres, so that these agencies can provide their clients with up-to-date information about the OHR.

Many migrants come from countries where there is no comparable system for complaints about health and disability services. The concept of making a complaint to a body such as the OHR is therefore unfamiliar. The process of making a complaint was, in addition, daunting to most people. There was an overall sense that priority should be given to making the OHR more visible, and that the Office should promote itself as offering simple, accessible and transparent resolution of complaints.

It was suggested that the Office could make itself better known and raise awareness of its services through means such as ethnic radio, community access television and community organisations such as the migrant resource centres. There was acknowledgment that the OHR may already be doing some of these things, but the participants did not know if that were the case.

For both indigenous people and migrants, there is a major need to inform consumers of the rights they have to high quality services that are delivered with respect, and to complain if they do not receive such service. However, it is not the sole responsibility of the Office of Health Review to inform consumers of their rights. Providers, both public and private, have a clear responsibility in this regard.

Some participants in forums expressed an interest in knowing whether staff at the OHR were doctors or lawyers, and the view was endorsed that the Office should investigate systemic complaints, as well as personal complaints about the health and disability sectors.

Two main views were expressed with regard to time frames. The first was that complaints needed to be dealt with promptly if people were to have confidence in the system. The second was that complaints should not be dealt with too quickly, to ensure they are properly investigated.

Participants expressed interest in knowing how far they could pursue a complaint through the OHR, whether the Office could award compensation, and whether they would be disadvantaged in their future dealings with a doctor against whom they had complained.

In one focus group, a participant had an OHR complaint form with her, but said she had found it too hard to fill in. She said she would need help to complete the form, and would be interested in an initial assessment of the relevance of her complaint before going ahead.

The OHR reports that very few people under the age of twenty-four years complain to the Office about health and disability services. (Many complaints about services received by young people under the age of eighteen are made by parents or guardians.) Seven Youth Advisory Councils from within the Perth metropolitan area were approached to discuss possible improvements to the current health and disability complaints processes which, if enacted, would make those processes more "youth friendly". "Respondents" to the survey of young people include both professional youth workers and young people. All respondents in this survey said that anonymity in the initial stage of the complaint was essential and that anonymity

would best be achieved by the ability to lodge complaints by e-mail (95.5%) or telephone (77.9%)

Respondents said the Office needed to be located close to all forms of public transport – buses and trains – or access would be a problem for young people. Approachable, friendly staff who are respectful of young persons and their opinions were also regarded as essential, and these qualities were seen as more important than age, gender or ethnicity.

Of the 58 young people consulted, who were not professional youth workers, only one person knew of the Office's existence and its role. Most respondents (92.6%) believed having OHR guest speakers in schools would be the most effective means of informing young people about the Office and about their right to complain. An even bigger proportion of respondents believed that a youth-friendly Web site was of great importance.

Other ideas on how to make the Office more likely to attract complaints about services from young people, including a recommendation that there be a Youth Worker in the Office, were circulated to the Reference Group for consideration.

The needs of mental health patients and people with a mental disability were also considered by the Reference Group, which looked at a set of recommendations from the Western Australian Association for Mental Health (WAAMH). Almost all these recommendations have been endorsed by the Reference Group and are represented in this Report's recommendations. There was a specific recommendation from WAAMH that there should be funding and resources for education and training of OHR staff, about the effects of mental illness on individuals, in order to better facilitate the acceptance of people with mental illness as clients of the OHR.

Most participants in forums did not know of the Office's existence, but among those who did, there were very positive experiences, as well as complaints that the process of resolving the complaint had taken too long, and that the Office was without real power to compel improvements.

One submission to the Review claimed there was a lack of independence at the OHR:

"This is a government organisation and tends to side with and believe fellow government public servants".

The same respondent claimed the Office took information "on hearsay", there was "no effective follow-up" of information provided by complainants and said "professionals involved in (the) complaint process are always more convincing to believe than (the) complainant."

In the same vein, another submission to the Review said the OHR had not investigated a complaint properly, or independently, and had made "totally inappropriate judgements about medical matters" while failing to consult with the medical staff who had encouraged the complainant to complain about a particular provider.

Four respondents to the questionnaire accused the OHR of being dismissive of their complaint. Other respondents criticised the Office for "wasting their time" and claimed they were "kept in the dark" about the progress of their case.

By far the greatest number of respondents (including seniors) said they did not know about the OHR, and would have complained to it if they had known.



## **APPENDIX 4**

### **REVIEW OF THE LITERATURE**

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## Origins of health care complaints systems in Australasia

A former Health Care Complaints Commissioner, Ms Liza Newby, has written of health care complaints systems in Australia and New Zealand that they set out to provide “a model of independent community accountability for failures in standards of health care.”<sup>1</sup> Apart from Sweden and a few States in the USA, there are no comparable examples of “independent health ombudsmen” such as exist in Australia and New Zealand.<sup>2</sup>

Most of the health care complaints systems in place in Australasia today have evolved over the past decade. The oldest of these mechanisms, the New South Wales Health Care Complaints Commission, did not come into existence, in its present form, until 1993, almost a full decade after its earlier incarnation as the Complaints Unit of the New South Wales Department of Health.<sup>3</sup>

That Complaints Unit, established in 1984, was itself a ground-breaking development, “the first body of its kind anywhere in the world” (Thomas, *ibid*, 2002); yet it was not formed in the same considered way as the quite different model established in Victoria in 1988. The original New South Wales model was a response and a reaction to particular issues and notable scandals in the health system. The establishment of the Victorian Health Services Commissioner office, on the other hand, was the result of “a coalition of interests determined to establish a central health complaints mechanism”<sup>4</sup>. It came about at a time when consumer consciousness had developed to a point where independence from government and service providers was seen as essential.

Queensland’s Health Rights Commission was established in 1992 and its origins “lie in the notorious Ward 10B of the Townsville General Hospital during the 1980s”.<sup>5</sup> The Australian Capital Territory’s independent health care complaints body was first proposed in 1983, by the Health Care Consumers’ Association of the ACT. It came into existence in 1994. In the same year, the New Zealand Health and Disability Commissioner was established. This also was principally the result of reaction to the scandal of experimental treatment of women with cervical cancer at Auckland’s National Women’s Hospital, beginning in 1966, and exposed in a popular magazine in 1987.<sup>6</sup>

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<sup>1</sup> Newby, Liza, *Concluding Commentary* in Thomas, David, ed., **Medicine Called to Account: Health Complaints Mechanisms in Australasia**, Australian Studies in Health Administration, No. 93. University of New South Wales School of Public Health and Community Medicine, 2002, pp 111-118.)

<sup>2</sup> *idem*

<sup>3</sup> Thomas, *op. cit*, p 15

<sup>4</sup> Barraclough, Simon, *Victoria: The Office of the Health Services Commissioner* in Thomas, *op. cit*, p 34

<sup>5</sup> Hovenga, Evelyn J.S., *Queensland: The Health Rights Commission* in Thomas, *op.cit*. p 55

<sup>6</sup> K Dew and M Roorda have written, in **Institutional innovation and the handling of health complaints in New Zealand: an assessment** in *Health Policy 57 (2001)*: “The major impetus for the Health and Disability Commissioner Act 1994 was provided by the recommendations of Judge Cartwright in the Report of the Cervical Cancer Inquiry, 1988. The inquiry followed allegations of unethical treatment of women with cervical cancer...These experiments involved the withholding of treatment ...from women diagnosed as having carcinoma-in-situ in order to prove that carcinoma-in-situ was not pre-malignant. For Associate Professor Herbert Green, the leader of the research, the possible reduced fertility following the treatment of carcinoma-in-situ was not acceptable. His research, which commenced in 1966 and was never formally terminated, was to study the natural history of the untreated disease. The women were not informed of Green’s failure to treat the cancer. By the late 1970s concerns over the research led to patients no longer being referred for inclusion in the experiment, and about 40 of these women developed invasive cancer due to the withholding of treatment. The discovery of this experiment has had a major effect on goodwill shown to the medical profession in New Zealand.” (pp 33-34)

The Commonwealth's 1993-1998 Medicare Agreement with the States required State Governments to devise a Charter of patients' rights in public hospitals. One of the rights enshrined in the Public Patients' Hospital Charter of each State was the right to an accessible means of making a complaint.

Western Australia's independent statutory complaints body, the Office of Health Review, opened its doors in September 1996, a year after the release of the State's Public Patients' Hospital Charter. The Office's enabling legislation drew on the example of the Victorian legislation, with some important differences, and – apart from the date - had the same name: the *Health Services (Conciliation and Review) Act 1995*.

Tasmania's independent health complaints unit was established in 1997, the Northern Territory's in 1998. Both these jurisdictions have, like Queensland and Western Australia, based their legislation on the Victorian model. South Australia is in the process (May 2003) of establishing an independent complaints body. The *Health and Community Services Complaints Bill* was tabled in the South Australian Parliament in July 2002; but at present health care complaints continue to be received and investigated by the State Ombudsman.

The impetus for establishing these bodies has been different in every jurisdiction. However, in each case there has been a consumer advocacy body with a strong interest in the outcome. There have been major differences in whether the push for an independent complaints mechanism came from circumstances that brought the system into disrepute and under fire, or whether it came from a concerned and active group of consumers, intent on empowering all consumers to exercise their right of complaint, or from governments required to deliver an independent complaints body as part of their funding agreement with the Commonwealth.

The various bodies differ in relative size and resources, with New South Wales and New Zealand noticeably better off than their counterparts, as the table below shows.

Jurisdiction	Population served (000)	FTEs	Budget 2001-2002
New Zealand	4,000.0	48.2	NZ \$6.14 million
New South Wales	6,657.4	69.3	A\$7.90 million
Victoria	4,888.2	24	A\$1.74 million
Queensland	3,729.0	27.2	A\$2.23 million
Western Australia	1,934.5	12	A\$0.98 million

## Health care complaints mechanisms outside Australasia

In 1973, the Office of the Health Service Commissioner (more generally known as the Ombudsman) was created in the United Kingdom. This office, which is independent of the NHS and the government, investigates complaints about the National Health Service and – until 1996 - had no jurisdiction over the private sector.

The Health Service Commissioner investigates alleged breaches of the Patient's Charter, essentially the rights of public patients and patients in public hospitals and health services. The Office also publishes de-identified accounts of cases it has investigated, with the aim of improving practices across the public health sector.

Complaints management in the United Kingdom is concentrated at local area level. Complaints that are not resolved satisfactorily may proceed to an Independent Review Panel, again at the local level. The Ombudsman investigates complaints about the National Health Service that have not been resolved locally. "In law, there are three separate Health Service Ombudsmen for England, Scotland and Wales but all three posts are held by the same person, currently Mr Michael Buckley, who has offices in London, Edinburgh and Cardiff.

The Ombudsman receives around 3,000 complaints a year covering all sectors of the NHS. This figure...implies that the vast majority of complaints are dealt with at the Local Resolution stage."<sup>7</sup>

The UK Ombudsman can investigate a complaint only if it is made in writing. Oral complaints cannot be investigated and there is no power to initiate an investigation without a written complaint. Once an investigation has begun, the Ombudsman has the same powers as the courts to obtain papers necessary to the investigation. The role of the Ombudsman in the United Kingdom is notably similar to that of the Director of the Office of Health Review in Western Australia. The current UK complaints procedure, enabling the Ombudsman to investigate health care complaints about primary care (GP) practices, as well as in the NHS, and extending jurisdiction to cover matters arising from clinical judgement, was implemented in April 1996.<sup>8</sup>

An important difference in the duties of the two bodies is that the UK Ombudsman, in addition to sending a report of his findings to the complainant and the provider, *must* send a report to the relevant Secretary of State for Health, at the end of an investigation. (Gunn, *ibid*, p 39)

Accountability of the individual health body or local authority is emphasised. In cases where the Ombudsman's investigation finds the health provider at fault, the Ombudsman's report will contain recommendations aimed at ensuring the problem does not recur. Failure of the provider to act on the recommendations may result in a report from the Ombudsman to the Parliamentary Select Committee on Public Administration, which may invite senior officers of the provider body to public proceedings, to give reasons for their inaction. (*ibid*, p 40)

The two year review of the "new" (1996) NHS Complaints procedure, conducted in England between 1999 and 2001, examined responses to the introduction of a new independent complaints support service. The review reported widespread dissatisfaction (77% of complainants) with the length of time that an Independent Review Panel took to deal with complaints; and 75% of complainants who requested an independent review thought that the system was biased.<sup>9</sup> Also, there "seemed to be no real system to learn from experiences and make improvements – this sentiment was clearly echoed by front-line NHS staff."*(idem)*

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<sup>7</sup> Gunn, Chris, **A Practical Guide to Complaints Handling in the Context of Clinical Governance**, Churchill Livingstone, (Edinburgh) 2001, p 39

<sup>8</sup> Limerick, Sylvia, **The NHS Complaints Procedure: Perceptions of a recent convener** in *Journal of the Royal College of Physicians of London*, Vol 34, number 3, May-June 2000

<sup>9</sup> National Health Service, Government of the United Kingdom, *Reforming the NHS Complaints Procedure: a listening document*, p 5

The government response to the National Evaluation of the NHS Complaints Procedure has yet to be fully articulated and implemented. However, it has stated a commitment to change and to “make it easier to hear, and strengthen, the voice of patients, their carers and the public; and make it easier and quicker to solve problems for individual patients” (*ibid*, p 2). *Involving Patients and the Public in Health Care – a discussion document* “summarises the Government’s proposals to create a patient-centred NHS.” It builds on the provisions of the *Health and Social Care Act 2001*, the introduction of an independent complaints support/advocacy service, and new Patient Advocacy and Liaison Services (PALS) which aim to resolve patient concerns and complaints quickly and informally. The need for a better system of formal complaint resolution is acknowledged in the discussion document (*ibid*, p5); while the principles endorsed for an effective complaints procedure are that it should:

- be easy for patients to access;
- resolve complaints quickly;
- be an open process, which is independent where appropriate; and
- be responsive to the outcome of complaints so effective improvements are made as a result. (*ibid*, p6)

In the United States, the approach in the private sector dominated health system has been to link “patient ombudsmen” and complaint handling with total quality management (TQM). Hundreds of patient ombudsmen work in US hospital corporations and long term and aged care institutions, and have done so for over twenty years.<sup>10</sup> Increasingly, these authors say, the traditional Quality Assurance approach to assessing and monitoring standards and consumer satisfaction, and responding to complaints, is being replaced by that of continuous quality improvement (CQI) in the private health care sector. “The newer approach – CQI through TQM aimed at prevention – is a system of assessment, improvement and management of every aspect of the health care organization.”

In the United States public health system, the Department of Health and Human Services administers the Health Care Financing Administration (HCFA). The HCFA has two separate external review systems for handling complaints from Medicare consumers. One system deals with issues of health plan coverage, such as eligibility for services and the costs of care, through a contract agency. The other system deals with consumer complaints about the quality and manner of health care. Traditionally, these complaints have been examined by Peer Review Organizations (PROs).

The HCFA has recently moved from sole reliance on the PROs to assess these complaints, to trialling a new system of complaints handling.

In their study entitled “Study of Medicare Beneficiary Complaint Procedures” (*Quality Management in Health Care*, 2001) Harrington, Hanawi, Ramirez *et al* compared “new procedures for reviewing a sample of Medicare beneficiary complaints about quality of care...with traditional procedures at a peer review organization (PRO) for 1998-1999.

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<sup>10</sup> Ziegenfuss, James T and O'Rourke, Patrick, **Ombudsmen, Patient Complaints, and Total Quality Management: An Examination of Fit** in the *Joint Commission Journal on Quality Improvement*, Vol 21, Number 3, March 1995, p 133

The new procedures included:

- 1) expanded communications with complainants and providers,
- 2) changed data collection methods,
- 3) integrated concurrent review findings from other agencies,
- 4) expedited review procedures, and
- 5) changed medical review (i.e; complaint processing) procedures.

The findings showed improved beneficiary satisfaction with the new procedures over the traditional procedures and shorter time periods for processing the reviews. Even with the new procedures, beneficiaries continued to be concerned that the review time frames were too lengthy, the reviews generally failed to confirm their complaints, and the PROs generally did not disclose their findings to the beneficiaries.” (*ibid*, p 65)

The Study found that standard time frames for review of complaints amounted to an average 165 days for the entire process. The new procedures (using a case management approach) proposed a cumulative 107 days for the whole process. (*ibid*, p 72) But complainants interviewed afterwards judged both time frames as being too lengthy. (*ibid*, p 76) Complaints in the sample study were chiefly about treatment (56.9 percent) and about other quality issues such as communication (13.8 percent). The authors noted that the “general level of dissatisfaction with the providers in cases where complaints were filed was extremely high”. (*ibid*, p 81)

The United States experience with consumer complaints in the public domain offers little that is useful to reviewers of the health care complaints system in Australasia. However, some of the points made by the Study authors are worth noting in relation to that task. In no particular order, they are:

- “Responsiveness to Medicare beneficiary complaints about quality should be considered a basic component of consumer protection.” (*ibid*, p 66)
- Problems, from the (consumer) perspective, include lack of substantive responses, lengthy processes, and failure to confirm (i.e; substantiate) the complaints.” (*idem*)
- Only 12.9 percent of complaints were confirmed as having a quality problem.
- In the cases where the complaint was confirmed about poor physician services, all of the physicians refused to release the findings (Physician consent to release findings is required under current HCFA regulations).
- None of these cases had sanctions applied or recommended.” (*ibid*, p 67)

Differences between the openness of the UK Ombudsman system and the US system, whereby the findings of peer review investigations of complaints are not released to complainants, are particularly marked. The investigation/peer review process itself also differs, with the US Peer Review system entirely reliant on examination of the medical records relevant to a case.

As elsewhere, the *rate* of complaint reported in this American study is very low. The authors note that they surveyed a population that is more vulnerable and “generally with higher needs for health care services and more frequent contact with the health system than other groups” (*ibid*, p 66). A study of complaints filed with the California PRO in 1995-1996 showed that just 248 complaints were filed about quality of care in

an eighteen-month period. This was for a Medicare population of 3.7 million people (*idem*).

## Scope and powers of independent complaints bodies

The various bodies established in Australian States and Territories and in New Zealand for receiving and investigating health care complaints – called “Commissions” here, for the sake of brevity – differ from each other in the scope of what they may deal with and the powers they may exercise. In general, though, they have the following features in common: They “are empowered, firstly, to receive complaints from consumers about adverse incidents they have suffered in the course of treatment either at the hands of individual practitioners or of institutions. Secondly, they attempt to satisfy complainants either through a process of mediation or conciliation between them and the responsible providers, or in some cases by taking direct legal action against the latter”. (Thomas, *op. cit.*, p 1) The Commissions are also, to varying degrees, empowered to investigate “systemic” issues. The New Zealand Health and Disability Commissioner is among those offices which have a wider brief, with the ability to investigate private and public sectors, orthodox and alternative therapists, and, most importantly, to initiate investigations of his or her own volition. (Dew and Roorda, 2001, p 37).

In addition to their differences of scope and powers, the Commissions have all developed differing modes of operation. “In all jurisdictions except New South Wales, the legislation makes provision for ‘point of service’ resolution.”<sup>11</sup> Most Commissions have been set up to take a conciliation approach to complaint resolution. The New South Wales and New Zealand Commissions use conciliation but also have a prosecutorial approach. The implications and effects of these differences will be discussed later.

Thomas (2002) writes of the Commissions as having “a dual function”:

“On the one hand, they act as mechanisms designed to sharpen and enforce the accountability of medical professionals, but they can also be seen as organisations which have the improvement of the quality of health services as their major *raison d’être*. Of course, these are simply different sides of the same coin and it would be a mistake to decry one aspect at the expense of the other. In her study of complaints mechanisms in Australasia, the Victorian Health Services Commissioner Beth Wilson (1998) emphasised the quality improvement aspect...” It can be said that “an important point which emerges from the kaleidoscope of experience and action in Australasian States and Territories is that although there has been broad agreement on the need for increased medical accountability, there has been much less agreement on how such accountability should be effected” (*ibid*, p 5).

The differences between individual Australasian commissions can be seen firstly as symptomatic of a debate about “the relationship between law and the notion of trust”. The conciliation approach aims to restore trust. ‘That contrasts with the prosecutorial approach, which is based on the argument that the perceived failure of the profession to justify the trusted reposed in it, demands that law should not be a last, but a routine resort in order to enforce medical discipline. Thus legal investigation and

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<sup>11</sup> Wilson, Beth, **Health Disputes: A “Window of Opportunity” to Improve Health Services** in Freckleton, Ian and Petersen, Kerry, eds, Controversies in Health Law, Sydney, The Federation Press (1999) p 185

prosecution are seen to be central to the activities of any health complaints body. Moreover,...proponents of this view argue that by ensuring that justice is seen to be done, the due process of law highlights shortcomings in the medical system which need to be rectified. In other words, they believe that the improvement of quality in health services is crucially dependent on the invocation of law to highlight shortcomings that need to be rectified” (*idem*).

The legislation establishing the commissions generally provides for the following functions and powers, as summarised by Meg Wallace<sup>12</sup>:

- investigation of complaints, including those that are not amenable to conciliation, are serious, or are referred by the Minister;
- publication of information and education concerning the operation of the legislation;
- inquiries into issues in relation to provision of health services and the causes of complaints;
- provision of advice to the Minister responsible on matters relating to health services;
- powers to examine witnesses; and
- powers to obtain warrants for search and seizure, for the production of information and documents and to impose penalties for non-compliance with directions relating to providing information, or for providing false information.

They also provide for:

- protection from reprisals against those involved in a complaint (for example, threats, bribery, refusal to provide services); and
- immunity from legal action for making a complaint, statement, or report or for the performance of a function under the Act.

Wallace notes, “The first priority of these bodies is to provide a means whereby conciliation is possible. This means encouragement of the parties themselves to come to an agreement, which may result in some compensation. Where conciliation is not a viable option, their function is to determine the facts of the situation complained about, and to bring about a more satisfactory standard of health care through influencing the establishment of more effective procedures and practices by the health provider involved. They are also a means for referral of matters to disciplinary bodies, the Ombudsman, the Director of Public Prosecutions or other appropriate body, for further action where referral is indicated (*ibid*, p 599).

In New Zealand, where the first task of the Health and Disability Services Commissioner was the development of a Code of Health and Disability Consumers’ Rights, the first Commissioner signalled her independence of the Government early on. The Commissioner, Robyn Stent, announced that she would carry out an inquiry into a number of deaths in the Emergency Department of the Christchurch Hospital, shortly after the announcement of an inquiry into the same matter by the Minister for Health. The Commissioner’s right to conduct such an inquiry was challenged in the courts by the Association of Salaried Medical Specialists, and was upheld. The Commissioner’s report of her findings, released shortly after the Minister for Health published his report, was highly critical of the management style of the hospital, and of the government’s under-funding of the hospital. (Dew and Roorda, *op. cit*, p 38) This case confirmed the Commissioner’s jurisdiction to investigate an issue without

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<sup>12</sup>Wallace, Meg, **Health Care and the Law**, Third Edition, Lawbook Co. (2001) pp 598-599

reliance on an individual complaint. It also established the Commissioner's independence of the Government. However, both in this and a subsequent early case, involving a midwife who was de-registered by the Nursing Council amid claims of trial by media, there was considerable controversy around the Commissioner's role. Dew and Roorda note that the "subsequent commissioner has kept a much lower public profile" (*ibid*, p 41).

## **Are health and disability complaints commissions able to fulfil all their mandated functions?**

Some interesting observations on this question are provided by a former Commissioner, Liza Newby. Writing in 2002, she notes that "two major policy objectives fuelled the 'push' in Australasia for Health Complaints Commissioners' offices. These were:

- a) accountability for standards of health care (the 'public watchdog' role), and
- b) as a solution to the perceived 'blowout' of resources required to meet costs (in litigation or public insurance) of compensating patients injured in the course of treatment, by acting as an alternative dispute resolution agency. (In Australia, patients had to legally sue for compensation for avoidable injuries in health care; in New Zealand they had to apply to the Accident Compensation Commission.) (Newby, *op. cit*, p 113)

Newby argues "[i]t is in the dichotomy between these two objectives, that the seeds of the major deficiencies in the models as they actually were established and developed in each jurisdiction, are to be found.

Health Complaints Commissioners' offices were established to function independently of the health professions, industry associations or public health provision by governments...However, governments, particularly in the last few years (when notions of the 'common good' as sufficient reason for provision of public services have been steadily rolled back), have traditionally found it difficult to deal with true independence in any agency funded from the public purse, whatever its legal mandate.

I would argue that therein lies the source of the other major failure to meet initial expectations. Most of the Health Complaints Commissioners' offices have been so starved of funds to operate according to their legal mandate, and so beholden to major stakeholders (government, health industry, etc), that significant components of their functions have been curtailed altogether or if extant, are pale shadows of what they could be." (*idem*)

According to Liza Newby, the problem of health and disability complaints commissions in fulfilling their charters is seen in all jurisdictions. The two major activities mandated for these bodies – resolution of individual complaints and improvement of the overall health system – are seen as competing for resources to such an extent that both cannot be done well, and one activity usually suffers at the expense of the other. "In Victoria...reasonable funding levels to allow for the community and provider education aspects of the statutory role have never been forthcoming on an ongoing basis, despite numerous submissions. Nor have funds to mount a major investigation or to obtain legal advice if such an investigation were to go ahead. In the 14-year history of the Health Services Commissioner, there have only been a handful of such investigations. Perhaps this is not surprising when we

consider that the Health Department in Victoria both funds the office of the Commissioner and is the major agency which would be investigated if such an inquiry were to go ahead.” (*ibid*, pp 114 -115)

Newby argues that “the jurisdictions with the greatest leanings towards the ‘alternative dispute resolution’ (ADR) method of dealing with health complaints are those with least resources to do anything else. It is no coincidence that the best resourced Offices in Australasia, (on a per capita basis) New Zealand and New South Wales, are the only two which have routinely carried out major public investigations into systemic health care standards issues, and have a political mandate to take their ‘public watchdog’ role more seriously.” (*ibid*, p 115)

The legislation in all jurisdictions intends the Health and Disability Complaints Commissioner to “act at an individual level to protect and enhance the rights of the consumer to high quality care, through conciliating complaints when that care fails, but also to operate systemically on behalf of the community to encourage high standards by investigating and holding...providers accountable for inadequate care.” (*idem*) Newby says these two objectives have “entirely different operational requirements” which have obliged Commissioners to emphasise one of their roles and effectively sacrifice the other.

The confidentiality of the conciliation process adopted in most jurisdictions prevents detailed information and issues about standards of care, which would be of interest to the general public, from becoming known. “The only time that both functions sit easily side by side is when....a complaint referred to a professional Registration Board for investigation can also at the request of the complainant, be referred back to the Commission for conciliation.” (*ibid*, p 116)

New South Wales, by contrast, has taken an approach to complaints which “focuses primarily on investigation and prosecution for breach of health care standards.” Newby concludes that, in this approach “what is important about a complaint is not so much its resolution and ‘doing justice’ to the complainant, but rather the way in which it signals poor practice. Often the two aims can coincide, but when they do not, the public accountability aspect of the original NSW model has taken precedence over the needs of complainants. However, in establishing the Conciliation Registry, NSW has probably gone further than any other Office in resolving the incompatibilities between the two objectives.” (*ibid*, p 117)

## Conciliation

*The Australian Standard – Guide to the prevention, handling and resolution of disputes – AS 4608 – 1999*, defines conciliation by reference to the National Alternative Dispute Resolution Advisory Council definition. That is,

“A process in which the parties to a dispute, with the assistance of a neutral third party (the conciliator) identify the disputed issues, develop options, consider alternatives and endeavour to reach an agreement. The conciliator may have an advisory role on the content of the dispute or the outcome of the resolution, and may have a determinative role. The conciliator may advise on or determine the process of conciliation whereby resolution is attempted, and may make suggestions for terms of settlement, give expert advice on likely settlement terms, and may actively encourage the participants to reach an agreement.”

The Financial Industry Complaints Service (FICS) employs conciliation processes but defines them merely as a process in which “an officer of the Service tries to resolve the complaint by talking to the complainant and the (provider) concerned” (Rule 3, FICS Rules).

In practice, the assisted negotiation or “shuttle negotiation” that is most often practised by FICS is very like the informal conciliation process used in a number of Health Complaints Commissions, including the Office of Health Review:

“The case manager liaises by unilateral phone calls and letters with the parties to determine the areas of agreement or disagreement. In addition, this process may result in the exchange of information that may enable parties to reconsider their interests and their positions.”<sup>13</sup>

Victorian Health Services Commissioner Beth Wilson has neatly summarised the essential elements of the formal conciliation process, in her jurisdiction and others, and how it works:

“Conciliation proceedings are quarantined from the other work of the office; they are confidential and privileged. Information that is produced in conciliation cannot be used in later court proceedings. Not all cases in which medical negligence is alleged, or where damage has occurred as a result of medical procedures, are suitable for conciliation. Most complaints are resolved much earlier in the process and the willingness of the parties to come to the table is an important consideration. Just under 10 percent of complaints received by the HSC in Victoria proceed to conciliation. In New South Wales conciliation is handled by a registry which is separate from the Commission.” (Wilson, *op. cit.*, p 185)

In Western Australia, the great majority of complaints received are resolved “earlier in the process” and at the time of writing, just 8 complaints out of approximately 1600 received in 2002-2003 had proceeded to formal conciliation. That is .6 of a percent. (Source: Office of Health Review personal communication.)

Beth Wilson writes of the Australasian experience:

“Because conciliation is voluntary the Commissioner will not refer cases unless the parties agree. They can, however, withdraw at any time, but this rarely happens in practice. One reason for the high rate of success of conciliation is that the alternative, litigation, is costly, inaccessible and risky, or, as the Tito Report put it, ‘the current system of compensation for injury arising from health care...from the patient’s point of view...is a lottery.’<sup>14</sup> Sometimes health service providers, whether they be doctors or hospital administrators, are reluctant to conciliate, because they feel they have not erred (or perhaps because they have made mistakes). However, their defence organisation or insurers will successfully encourage them to participate in the conciliation process. The provider sometimes refuses to discuss the complaint with the patient unless those discussions take place in

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<sup>13</sup> Community Solutions, La Trobe University, University of Western Sydney, **Review of the Financial Industry Complaints Service 2002 – What are the Issues?** p 28

<sup>14</sup> Commonwealth of Australia, Department of Human Services and Health, *Review of Professional Indemnity Arrangements for Health Care Professionals: Compensation and Professional Indemnity in Health Care: Final Report*, AGPS, Canberra, 1995

a conciliation meeting. Indeed, their medical indemnity or insurers often advise them to take this course of action because of the protection afforded by the legislation....

The conciliators are neutral and cannot direct either party how to proceed, other than to explain the rules of conciliation and to conduct the conciliation process. The options open to the parties are explained and solutions suggested. Information is provided about the law of negligence, the legal process, the role of lawyers and the courts. **The parties may not be represented during the conciliation proceedings unless the Commissioner considers it to be necessary for the process to work effectively** (emphasis added). However, there is nothing to prevent the parties seeking legal advice outside the meetings. The parties bear their own legal costs except where a settlement expressly includes a component for the complainant's costs.

In practice this means that the parties, other than minors, the disabled, the incompetent or a deceased person, are not represented at conciliation meetings. Many consumers, however, choose to bring family members or other support persons with them. When a claim for compensation is settled in conciliation, release or other relevant documents are prepared, usually by the solicitors acting for the provider's defence organisation or insurer. The legislation allows negotiations in conciliation to continue up until a court has commenced hearing the matter. However, the very few complainants who decide to go to court usually withdraw completely from conciliation and begin the legal process afresh." (*ibid*, pp 185-186)

One point of contention arising from the process described above is the question of whether *both* parties should be allowed to have legal representatives present, if *one* is so represented?

At the Office of Health Review, it is not usual for face to face conciliation meetings to take place.<sup>15</sup> Usually, conciliations are conducted by way of an exchange of submissions, where both the complainant and the provider can obtain legal advice on their submissions or responses. The Office can then correspond with the legal representatives of both parties and/or the parties themselves, to ensure each party has all relevant information.<sup>16</sup> While consumers often do not want a face to face meeting with the provider they have complained about, some face to face meetings have occurred, with the provider attending unrepresented. If a meeting was to take place, and a provider was represented, the OHR would expect the provider, as well as their representative, to attend in person. The consumer would also attend in person, with their support person and legal representative. Consumers/complainants are always advised by OHR staff to obtain their own legal advice on a settlement, particularly one that has a financial aspect.<sup>17</sup> There is a difficulty, of course, in the present system, if a provider has expert legal representation or advice through their insurer, and the consumer in the case is unable to afford legal advice. Consumer advocates such as the Health Consumers' Council have argued that this practice effectively reinforces the power imbalance between the parties.

In considering the merits of conciliation and litigation, Beth Wilson writes:

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<sup>15</sup> Office of Health Review, personal communication, 15 May 2003.

<sup>16</sup> *idem*

<sup>17</sup> *idem*

“While in many cases conciliation offers a better alternative to litigation, it is not always appropriate in all cases in which medical negligence is alleged, or where damage has occurred as a result of medical procedures. It is most important that the right cases are selected and that the parties are willing to cooperate.” Observing that the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists supported the conciliation model as applied by the Victorian Health Services Commissioner, Wilson notes that the “adversarial system does not always produce winners and losers. In some cases all the parties lose out. An example of this has been documented by Professor Harold Luntz in an article on the 1992 High Court case, *Rogers v Whitaker*.”<sup>18</sup>

While the decision in this case succeeded in setting the standard of care expected of a medical practitioner in relation to disclosure of risks - by placing the patient's informed consent at the centre of consideration - Professor Luntz's article examined what happened to the patient *outside* the legal significance of the decision. He found that, in addition to losing her sight, Mrs Whitaker was some \$214,000 out of pocket at the end of the case. There was also the emotional cost of the protracted court case. “The delays and anxieties associated with the adversarial system would have been significant for all parties.” (Wilson, *ibid*, p 187)

“*Rogers v Whitaker* is a decision generally applauded by those who see patient autonomy as being more important than medical paternalism. Professor Luntz, however, questions the extent of what was achieved and whether protracted and expensive litigation was the only way the public interest could have been served.”

## What do people complain about?

Information from the (now closed) National Health Complaints Information Project (NHCIP) showed, in December 2000, that complaints about the quality of treatment, including diagnosis, treatment and medication, were by far the most numerous. Complaints in this category amounted to 35% of all complaints, and the predominance of this issue applied over a period of ten years for which data had been collected. (Thomas, *op. cit*, p 11)

The Office of Health Review Annual Report for 2000-2001 recorded that 53% of complaints it had received that year were about treatment. The previous year's figure was 47.5%. In 2001-2002, the Office of Health Review reported that 50% of complaints it had closed concerned treatment.

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<sup>18</sup> The article referred to is Luntz, H “Mrs Whitaker's Gothic Cathedral. Editorial Comment” (1996) *A Torts Law Journal*, p 195

## The NHCIP Report

Nationally, the NHCIP reported other categories of complaints as follows:

'Issue'	%
Access	13
Communication	12
Professional conduct	11
Privacy/discrimination	9
Cost	9
Consent	6
Corporate services	5
Grievances	1

'The issues which were found to be giving rise to complaints against institutions broadly followed the pattern of those against individual practitioners, complaints about treatment in hospitals ranking highest at 41%. As far as service providers are concerned, the Report confirmed the observation made by Complaint Commissioners that 'in general, complaints tend to be evenly divided between individual and organisational providers'. Medical practitioners formed the great majority of individual providers complained against (74%) although other specialists such as dentists (16%) and optometrists (1%) and even naturopaths (1%) were included in this category. The Report comments that because Medicare statistics show that general practitioners provide approximately 45% of services 'therefore it could be expected that this group would attract more complaints than other specialties' (p 10 of Report). However, nurses, who comprise by far the largest sector of the health workforce, attracted only 1% of complaints against individual providers." (Thomas, *op. cit.*, p 11)

Office of Health Review statistics show that, in 2000-2001, 35% of all complaints were about individual medical practitioners – a decrease of almost 19% from the previous year – and of those complaints, over 76% were against General Practitioners. (Calculation from *Annual Report, 2000-2001*, p 6). In 2001-2002, 30% of complaints to the Office of Health Review were about services provided by individual medical practitioners, and of those, 61% were against General Practitioners. (OHR, *Annual Report 2001-2002*, p 6.)

As documented in the *Report to the Review Committee of the Office of Health Review* by the Office of Safety and Quality in Health Care, there is a metropolitan-wide Complaints Management Policy for public hospitals. (*Report*, p 3) As has been the experience in other places (see: Wilson and others), the majority of complaints about public hospital services are resolved by the hospital complaints officers at the local level. The aim of the overarching policy, established towards the end of 1998, was to put in place a "consistent method of management, monitoring and reporting of complaints, actions and outcomes to improve the quality of health services." (*Report*, p 4) Those complaints that cannot be resolved by the hospital complaints officer or patient liaison officer are referred to the Office of Health Review.

In 2001-2002, in metropolitan hospitals and health services in Western Australia, the number of complaints rose 19.2% on the previous year.<sup>19</sup> "Three categories continue to make up the majority of complaints with 71% of the total between them

<sup>19</sup> Office of Safety and Quality, Department of Health, *Annual Complaints Report*, p 1

for 2001-2002. These are **Privacy & Consideration** at 28% overall (up 30.73%), **Access** at 23% overall (up 27.56%), and **Quality of Care** at 20% (up 12.93%). **Communication** is the 4<sup>th</sup> major area of dissatisfaction at 16% (up 28.17%).” (*Report*, p1)

Analysis of complaints by the Office of Safety and Quality “continues to highlight the following issues for hospitals and health services in the metropolitan area.

- Courtesy and lack of service for consumers
- Admission processes and delay in treatment
- Quality of care and treatment processes
- Misinformation and failure to communicate with patients/clients” (*Report*, p 3)

According to the same report, “Fifty percent of hospitals and health services resolved more than 55% of complainant issues within two weeks.” “A further 30% were resolved within six weeks, leaving a minor proportion taking longer than six weeks to resolution.

“...Overall, referral to another agency (such as the Office of Health Review) of complainants’ issues for resolution occurred infrequently at only four sites in 2001-2002. Most complainants’ issues were investigated and resolved at the hospitals and health services where they originated.” (*idem*)

## Registration boards

People who are unaware of the existence of the Office of Health Review and who have an unresolved complaint or serious allegation against a medical or other health service provider, may take their complaint or allegation direct to the provider’s Registration Board. These complaints may be noted or recorded by the Boards but are generally, and properly, referred (with the complainant’s permission) to the Office of Health Review. The exception to this is any complaint that alleges criminal behaviour. This type of complaint should be referred immediately to the Police. The Office of Health Review and the Medical Board will not investigate the same complaint concurrently (Office of Safety and Quality, *op. cit*, p 8). The Board will take referrals from the Office of Health Review if, for example, the OHR finds on investigation that a doctor has behaved improperly towards a patient or has provided incompetent treatment. The *Health Services (Conciliation and Review) Act* 1995 stipulates that a Board, having received a referral from the OHR, must report to the Office on its determination in the matter.

## Communication as an issue of complaints

Several writers have highlighted the issue of communication in complaints. In her thesis, *Doctor and Patient Communication, Communication in Health Service Complaints and Complaint Resolution*, (University of Melbourne 1998) Lynn Griffin reveals that “communication is a feature in almost all complaints”. The current Victorian Health Services Commissioner, in her article “Health Disputes: A Window of Opportunity to Improve Health Services”, writes:

“The experience of the commissioners is that most consumers do not seek revenge and money. More often they require explanations about what went wrong and why, and they want to ensure that services are improved so that the same mistakes are not repeated. Poor communication features

prominently in complaints, particularly against medical practitioners in private practice.”

And – “The most common communication complaint relates to a perceived absence of caring. Failures to gain informed consent, failures to warn about risks, wrong or conflicting information from different members of a treating team, breaches of confidentiality, rudeness or avoiding patients when an adverse outcome has occurred are also prominent. The experience of the commissioners is that good communication becomes extremely important where an adverse event has occurred. This is also reflected in a 1994 study published in *The Lancet* where patients and relatives who had taken legal action against doctors indicated that failures to provide explanations or apologies were a strong motivating factor for proceeding with legal action.”<sup>20</sup>(Wilson, *op. cit*, p 188)

As noted above, the *Annual Complaints Report* for Metropolitan Hospitals and Health Services in 2001-2002, published by the Office of Safety and Quality, reports that “Communication is the 4<sup>th</sup> major area of dissatisfaction at 16% (up 28.17%)” on the previous year. (*Report*, p 1)

In the article referred to by Wilson and published in *The Lancet* in 1994, researchers from a London hospital Department of Psychiatry and a solicitor reported their findings on why people sue doctors.<sup>21</sup> They recorded the responses of 227 people in the UK, who had sued their doctors on their own or another’s (usually a child’s) behalf. They found that: “Even when compensation is vital, the motivation for litigation may not be exclusively financial but determined by the way the original incident was handled by the staff concerned. Did a senior doctor give an apology, an explanation, and begin immediate reparative treatment? Or did the staff simply keep quiet and hope nothing would come of it?” (*ibid*, p 1609). They concluded, “Communication assumes a special importance when things have gone wrong. Patients often blame doctors not so much for the original mistakes, as for a lack of openness or willingness to explain. A valued feature of the civil system, much appreciated by patients, is that if they successfully proceed beyond the initial stages of litigation, their case is reviewed by an independent expert instructed by their solicitor. Unlike the complaints procedures, the patient sees the clinical report, has access to the notes, and may be able to discuss their case with the expert.” (*ibid*, p 1613)

In relation to the incident that had given rise to the litigation, the researchers reported that “feelings of anger were expressed by 90%, bitterness by 88%, betrayal by 55%, and strong feelings of humiliation by 40%” (*ibid*, p 1611). A staggering 85 of the 227 respondents said that they *never* received an explanation of what had happened, and 15 people said they had waited over a year before receiving an explanation. (*ibid*, p 1611) Explanations were viewed by the respondents as being given sympathetically in under 40% of cases and in only 30 cases, (13% of the total sample) was responsibility for what had happened fully or partly accepted. (*idem*)

It is acknowledged by the researchers that “a person who decides to take legal action for negligence must be extremely determined and prepared to endure a long and often frustrating legal process” (*ibid*, p 1609). However, they also could claim, in 1994, that complaints procedures “in spite of attempts to make them more accessible

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<sup>20</sup> Vincent, C, Young, M and Phillips, A, “Why do people sue doctors? A Study of Patients and Relatives Taking Legal Action” (1994) 343 *The Lancet*, p 1609.

<sup>21</sup> *Ibid*, pp 1609-1613

for the patients, are still slow, complex, and often frustrating and bewildering and they seldom lead to any real assurance that changes to clinical practice have been made.” (*ibid*, p 1613)

Interestingly, there is extreme consistency in what consumers complain about - across health systems that are vastly different and in different countries. For instance, in the USA, researchers Hickson, Federspiel, Pichert *et al* looked at how a small number of physicians experienced a “disproportionate share of malpractice claims and expenses” between 1992 and 1998.<sup>22</sup> Using a retrospective longitudinal study of 645 general and specialist physicians, they analysed the complaints made against individuals and compared those complaints with each physician’s risk management records for the same period. The research found that risk “seems not to be predicted by patient characteristics, illness complexity, or even physicians’ technical skills. Instead, risk appears related to patients’ dissatisfaction with their physicians’ ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively.”<sup>23</sup> The researchers also reported that, “Within complaint categories, surgeons more frequently than (others) were associated with complaints related to care and treatment, billing, communication, access and availability and humaneness.”<sup>24</sup>

Dr Mark O’Brien, at an Australian Resource Centre for Hospital Innovations (ARCHI) seminar in Fremantle, in May 2002, quoted Vincent’s 1994 research finding that patients are motivated to sue to correct deficient standards of care; to find out what happened and why; to enforce accountability; and to obtain compensation for accrued and future costs. He also advised seminar participants that:

- Patients have difficulty assessing clinical competence.
- (The) quality of the interaction (between clinician and patient) becomes “*de facto*” the standard of clinical competence.
- If the quality of the interaction is low, patients may infer the quality of clinical care is low.<sup>25</sup>

## What makes a good health care complaints system?

Complaints handling has been described as “an essential component of quality management”. (Preface to Standards Australia’s Complaints Handling (1995))

According to the Australian Standard, a “comprehensive complaints system should:

- (a) Increase the level of consumer satisfaction with the delivery of products and services and enhance the consumer/provider relationship.
- (b) Recognise, promote and protect consumers’ rights, including the right to comment and complain.

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<sup>22</sup> Hickson, Gerald B., Federspiel, Charles F., Pichert, James W., Miller, Cynthia S., Gauld-Jaeger, Jean., Bost, Preston, **Patient Complaints and Malpractice Risk** in *Journal of the American Medical Association*, June 12, 2002 – Vol 287, No. 22, pp 2951-2957

<sup>23</sup> *Ibid*, p 2951

<sup>24</sup> *Ibid*, pp 2954-2955

<sup>25</sup> O’Brien, Mark, **The Link Between Communication and Risk Mangement**, (ARCHI seminar, May 2002) Cognitive Institute of Australia (Queensland) 2001.

- (c) Provide an efficient, fair and accessible mechanism for resolving consumer complaints.
- (d) Provide information to consumers on the complaints handling process....
- (e) Monitor complaints in an endeavour to improve the quality of products and services.” (Standard, p 4)

The Standard also specifies as essential elements of effective complaints handling –

- *Fairness* to both parties;
- *Adequate Resources*;
- *Visibility* – So that both the service and the right to complain are well publicised;
- *Access* for all, including readily available and clearly expressed information;
- *Assistance* with the formulation and lodgement of complaints;
- *Responsiveness* – That is, courteous and quick handling of complaints;
- *Remedies* – The process should have the capacity to determine and implement remedies;
- Appropriate and systematic *Data Collection*, including the ability to identify recurring or systemic problems;
- *Accountability* and reporting on the complaints handling process, against documented performance standards;
- Regular *Reviews*.

### **The United Kingdom NHS**

The “new” NHS Complaints System, introduced in April 1996, came about as a response to the Wilson Report, published as “Being Heard” in 1994. That report recommended, amongst other things, that the Health Services Commissioner be given the power of clinical investigation, that there be training for complaints personnel and that there should be separation of disciplinary elements from complaints procedures.<sup>26</sup>

The new complaints procedure also responded to “what are regarded as key issues for service users” in the handling of complaints. Leading factors identified in more than one survey were:

- speed of response – 75%;
- keeping complainant informed about progress – 59%;
- knowing who is dealing with the complaint – 45%;
- how helpful and friendly staff are – 44%;
- knowing the complaint will be dealt with fairly – 44%;
- having clear complaints procedure – 43%;
- receiving a written explanation – 39%;
- receiving an apology if the organisation is wrong – 29%;
- having senior staff investigate – 24%;
- receiving compensation – 15%. (McCrimdle and Jones, *op.cit*, p 42)

The Wilson Report had also recommended seven guiding principles, which the Government adopted in March 1995. These are:

- responsiveness;
- cost-effectiveness;
- impartiality;
- speed of response;
- accountability;

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<sup>26</sup> McCrimdle, J and Jones, R.K, **Preliminary evaluation of the efficacy and implementation of the new NHS complaints procedure**, International Journal of Health Care Quality Assurance 11/2 (1998) p 42

- quality enhancement;
- accessibility;
- simplicity;
- confidentiality. (*ibid*, p 41)

The New South Wales Ombudsman says, in *Effective Complaints Handling* (June 2000) that good systems “provide at least three tiers of review. This should be clear to all users of the system,” including the complaint handlers.

The first tier is registration and attempted resolution by frontline staff. (In the case of health and disability complaints, this would involve personnel such as hospital complaints staff, patient liaison officers, local area coordinators.)

The second tier is reference to and investigation by an identified complaints mechanism, which may be a more senior office within the same body (such as a hospital’s chief executive) or an external office such as the OHR. If the consumer remains dissatisfied, conciliation, mediation, or further direct negotiations over remedying the grievance should be attempted.

The third tier in the Ombudsman’s model system is the referral of the complaint to an outside agency – either the Ombudsman or the OHR in the case of health and disability – for further attempted alternative dispute resolution. The last resort is any legal remedy that may be obtained.

The NSW Ombudsman’s paper states that referral procedures should be known to all frontline staff; complaints must be dealt with quickly to ensure satisfaction; all complaints, including oral complaints, should be recorded by agencies as a management tool for service improvement, and that interviews are the “best cost-benefit handling method” for complaints before they are referred to a more senior or external mechanism.<sup>27</sup>

The New South Wales Health Care Complaints Commission sees it as essential for health and disability complaints commissions to:

- be independent of health (and disability) care providers and government, and to be adequately resourced so that they are publicly perceived as independent;
- have special expertise in health (and disability) sectors, clinical governance, relevant law and investigations;
- provide consumer advocacy and support in complaints handling at the frontline or local level;
- offer a broad range of complaint resolution processes;
- promote awareness of systemic issues arising from complaints.<sup>28</sup>

## **Training and education for complaints staff**

Quality training, in relevant and specialist areas, is also an essential aspect of good complaints handling systems. A useful set of recommendations from the *Final Report of the Review of the Financial Industry Complaints Service 2002* may be worthy of consideration for the purposes of this Review.

Recommendation R 7.4 states that ongoing training and education should address issues relating to:

<sup>27</sup> NSW Ombudsman, *Effective Complaint Handling* p 30

<sup>28</sup> Adrian, Amanda, Health Care Complaints Commissioner, personal communication 2003

- Knowledge requirements – knowledge about conflict, industry practice and cultures, aspects of negotiation, communication, procedural elements, self knowledge, decision making and ADR.
- Skills – assessing a dispute for ADR, gathering and using information, defining a dispute, communication, managing a process, managing interaction between parties, negotiation, being impartial, making a decision, concluding a process.
- Ethics – promoting the service and processes accurately, eliciting and exchanging information, managing termination of a process, exhibiting lack of bias, maintaining impartiality, ensuring appropriate outcomes.<sup>29</sup>

The FICS Report also recommends reference to NADRAC's *A Framework for ADR Standards* (Canberra, Attorney-General's Department, 2001)

In summary, most assessments of what constitutes a good complaints system include the elements discussed above.

## **What outcomes for health systems can result from health and disability complaints commissions?**

The Office of Health Review reported in its 2000-2001 Annual Report that 19% of complaints handled in that period resulted in changes to systems, practices or procedures. In 2001-2002, OHR reported that 29% of cases resolved mainly or partly in favour of the complainant "led to some systemic improvement such as a change in policy or procedure". (Annual Report, p 7)

It is not possible to assess how significant or real these "systemic improvements" are, because of lack of detail in the reporting. There is some (anecdotal) evidence that, rather than forcing a "change in policy or procedure", investigation of complaints by the OHR may highlight the extent to which existing policies and procedures – for instance, in public hospitals – are not complied with.

The Office of Safety and Quality's **Annual Complaints Report** for Metropolitan Hospitals and Health Services in 2001-2002 recommends (p 3):

- 1 Quarterly collation and analysis of complaints data from metropolitan hospitals and health services be continued and reported to the State Health Management Team.
- 2 A six monthly report of complaint analysis is tabled with the WA Council for Safety and Quality.
- 3 The de-identified Quarterly Complaints Report continues to be sent to hospitals and health services for comparison and benchmarking purposes.
- 4 That a methodology be developed through the Office of Safety and Quality to measure and report improvements as a result of complaints and consumer feedback.

The emphasis on measurement and regular analysis and reporting in these recommendations provides a useful pointer as to ways in which the Office of Health

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<sup>29</sup> *Review of FICS – Final Report*, p 73

Review and the Council for Safety and Quality in Health Care might combine their efforts and influence, to achieve real improvements in the health system.

The New South Wales office came into existence to prevent the re-occurrence of another Chelmsford. The Queensland office began, at least in part, as a response to the scandal of the “notorious Ward 10B of the Townsville Regional Hospital in the 1980s”.<sup>30</sup> It ought to be the case that tragedies such as these could not occur again, given the legislated powers of the ‘public watchdogs’ in all the Australian States and New Zealand.

In addition to its reports to Parliament and through the media on the cases it prosecutes, the New South Wales office has initiated and reported on its inquiries into public interest issues – such as its report on Cosmetic Surgery in Australia (HCCC, October 1999) and its joint publication (*Fair treatment?* July 2000), with the Australian Competition and Consumer Commission, on the advertising and promotion of medical and health services. This is a valuable function.

The experience of the New South Wales Health Care Complaints Commission (HCCC) is a useful indication of what a large and well resourced health and disability complaints body can achieve, and what contribution it can make to the quality of the overall health system. As part of its submission to the Review of the Office of Health Review, the HCCC provided a copy of its May 2002 *Values, Strategic Directions and Organisational Model*. This 34-page booklet documents the organisation’s strategic plan for achieving its goals of “comprehensive and responsive complaints resolution” and quality improvement in the health system. It lists the organisation’s main strategies in relation to these goals and the activities by which the strategies will be advanced. The booklet is the “digest” version of the HCCC’s 2002-2005 Strategic Plan. The Reference Group noted the dual focus of the Strategic Plan – “Looking Out” to complaint resolution and systemic improvement, and “Looking In” at organisational and individual competence and performance.

For example, under the heading “What we need to do”, strategies listed are “Conciliation, Consultative Resolution, Investigation by the HCCC, Prosecution by the HCCC, Other resolution strategies, e.g: mediation, facilitated resolution and mutual case evaluation.” Some of the activities include:

- Developing policy and guidelines to provide advice service for complaints resolution for individual health practitioners and health services – for both referred complaints and complaints they are dealing with at the frontline.
- Strengthening the complaint resolution and investigation advisory service for health services and health practitioners in private practice.
- Providing corporate, clerical and executive support systems to underpin complaint resolution.
- Providing training and support for staff to ensure best practice across resolution strategies.
- Working with the Health Conciliation Registry to ensure appropriate referrals to improve the satisfaction in the conciliation process.
- Assisting complainants referred for conciliation to identify issues for resolution.

Under “What we need to do – Working with our stakeholders” are listed the HCCC’s stakeholders –Consumers and the broader community, health service providers, the Parliamentary Committee on the HCCC, the Minister for Health, Health professional registration boards, health professional organisations, non-health Government and

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<sup>30</sup> Hovenga, Evelyn J.S., in Thomas, *op.cit.*, p 55

non-Government agencies and the media. Strategies listed under “How do we get there?” include:

- Developing projects to improve consumer input and feedback in HCCC functions.
- Developing projects to improve health service provider input and feedback in HCCC functions.
- Improving collaboration with Consumer Consultative Committee.
- Promoting HCCC representation on committees and working parties with consumer organisations, health and other external government and non-government agencies.
- Using the processes and outcomes of Parliamentary Committee on the Health Care Complaints Commission inquiries to improve HCCC services.
- Increasing Commissioner/senior officer involvement in CEO and other inter-agency initiatives, such as the NSW Quality Council.
- Improving the HCCC’s active and balanced engagement with the media.
- Contributing to health professional education programs.

It should be recognised that the HCCC is resourced to a degree not matched by any other State health and disability complaints commission. The full range of activities and strategies for improving the health system in New South Wales could not be replicated in Western Australia without a significant increase in resources. The New South Wales body, for instance, has its own legal and clinical advisers, as well as significant clerical support for every function of the office. However, it could be argued that the HCCC justifies - and repays the community for - its significant establishment, by fulfilling effectively the role of community watchdog, consumer advocate and, via the Conciliation Registry, alternative dispute resolution mechanism.

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## **APPENDIX 5**

# **INTERSTATE COMPARISON OF HEALTH COMPLAINT MECHANISMS: SCOPE AND LEGISLATION**

The following is a broad cross-jurisdictional analysis of legislation in Australia. Additionally the Private Health Insurance Ombudsman is a statutory body with powers and functions as set out in the *National Health Act 1953* (Commonwealth). The Ombudsman's main role is to provide private health insurance members with an independent service for health insurance problems and enquiries relating to hospitals, medical practitioners and some dentists.

### **AUSTRALIAN CAPITAL TERRITORY**

*The Community and Health Services Complaints Act 1993* (ACT) ("The Complaints Act") provides the mechanism for the resolution of complaints between users and providers of health services. Section 6 of the Complaints Act establishes an office called the Health Complaints Unit and the appointment of the Commissioner for Health Complaints ("the Commissioner") pursuant to section 8.

Section 53 of the Complaints Act provides for a Code of Health Rights and Responsibilities ("the Code") that the Minister may approve by instrument.

Grounds for a complaint include:

- a provider acted unreasonably by not providing a community service or a health service or in the manner of providing a health service or a community service;
- the provision of a community service or a health service or part of it was not necessary;
- the provider acted unreasonably in denying or restricting access to information or in disclosing information;
- where a provider has unreasonably disclosed information about a user;
- when a provider has not acted fairly or taken action in relation to a complaint that could have been made to the Commissioner;
- failing to have regard to the relevant standards, this includes service delivery standards;
- failing to take note of the requirements under the *Disability Services Act 1991* (ACT);
- when a provider has disregarded the Code;
- when a provider has failed to exercise due care and skill; and
- failing to provide information on the prognosis, treatment, services, and to treat the person with dignity and respect.<sup>1</sup>

After assessment of a written, signed and identifiable complaint the Commissioner may refer the complaint to another body, refer for conciliation, investigate or take no further action.<sup>2</sup> The Commissioner shall not refer a complaint to a conciliator if it appears that the complaint indicates the existence of a significant issue of public safety or public interest.

A complaint may be dealt with by way of conciliation (section 32); investigation (section 40) referred to the relevant registration board (section 23) or by splitting the complaint if applicable (section 25). When dealing with a complaint the Rules of Natural Justice are applicable, however the Commissioner is not bound by the rules of evidence.<sup>3</sup>

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<sup>1</sup> Section 22 of the *Health Complaints Act 1993* (ACT)

<sup>2</sup> Section 23 & 26 of the *Health Complaints Act 1993* (ACT)

<sup>3</sup> Section 15 of the *Health Complaints Act 1993* (ACT)

Certain matters relating to the *Health Records (Privacy and Access) Act 1997 (ACT)*, may be reviewed by the Commissioner. In this regard, a decision made by the Commissioner may be reviewed on application to the Magistrates Court and an appeal mechanism is available to the ACT Supreme Court on an order from the Magistrates Court.<sup>4</sup>

The Complaints Act provides for interaction between the Commissioner and the relevant professional board regarding complaints.<sup>5</sup>

If a complaint is investigated, the Commissioner has the power to:

- require that the person provide information or documents,
- request the person to attend before him and be examined; and
- request a magistrate to issue a warrant.<sup>6</sup>

A Health Rights Advisory Council is established to advise the Minister and the Commissioner in relation to the redress of grievances relating to health services or their provision. The Council also advises the Minister on educating and informing users of their rights and referring matters to the Commissioner.<sup>7</sup>

## **NEW SOUTH WALES**

The *Health Care Complaints Act 1993 (NSW)*, (“the HCC Act”) established the Health Care Complaints Commission (“the Commission”) on 1 July 1994 as an independent statutory body. The HCC Act also establishes the Parliamentary Committee on the Health Care Complaints Commission, which monitors and reviews the exercise by the Commission of its functions. This Committee is empowered to veto the Minister’s proposal to appoint a person as Commissioner.<sup>8</sup>

Broadly, the Commission:

- deals with complaints relating to health practitioners and health services;
- takes prosecution action in tribunals and professional standards committees;
- publishes and distributes information on the complaints process and outcomes;
- monitors, identifies and advises on trends in complaints and recommends policy changes;
- provides for the development of a Code of Practice, to have effect this must be incorporated or adopted by, the regulations; and
- consults with groups.<sup>9</sup>

Pursuant to section 7 of the HCC Act a complaint may be made concerning:

- the professional conduct of a health practitioner,
- a health service which affects the clinical management or care of an individual client,
- a health service provider, or

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<sup>4</sup> Sections 39A, 39E, 39F & 39G of the *Health Complaints Act 1993 (ACT)*

<sup>5</sup> Sections 56, 57 & 58 of the *Health Complaints Act 1993 (ACT)*

<sup>6</sup> Sections 45, 46 & 49 of the *Health Complaints Act 1993 (ACT)*

<sup>7</sup> Sections 61 & 62 of the *Health Complaints Act 1993 (ACT)*

<sup>8</sup> Section 66 of the *Health Care Complaints Act 1993 (NSW)*

<sup>9</sup> Section 80 of the *Health Care Complaints Act 1993 (NSW)*

- a health service provider even if, at the time of the complaint the provider is not qualified or entitled to provide the health service concerned.

Section 8 of the HCC Act prescribes who may make a complaint. On receipt of a written complaint an assessment is made within 60 days as to whether the complaint is investigated, conciliated, referred to the Director General, referred to another person or body, or declined<sup>10</sup>.

If a complaint is under investigation, powers exist under the HCC Act to enter, search and seize items<sup>11</sup>. There is a provision for an authorised person to obtain a search warrant under certain circumstances, as well as offence provisions for non compliance<sup>12</sup>.

When a complaint has been investigated and after consultation with a registration authority, the Commission must take action as prescribed in section 39 of the HCC Act.

Complaints dealt with by conciliation are referred by the Commission to the Health Conciliation Registry. The Health Conciliation Registry does not have the power to deal with complaints referred by any other means.<sup>13</sup>

### **NORTHERN TERRITORY**

In the Northern Territory the *Health and Community Services Complaints Act 1988* (NT), ("the HCSC Act") establishes the Health and Community Services Complaints Commission and the Administrator may appoint a Commissioner on receipt of a recommendation from the Legislative Assembly.<sup>14</sup>

Matters relating to a health service may be referred to the Commissioner by the Legislative Assembly.<sup>15</sup>

Section 23 of the HCSC Act provides that a complaint may be made if:

- a provider acted unreasonably by not providing a health or community service;
- the provision of health or community service or a part was not necessary;
- the provider acted unreasonably in providing a health or community service or in the manner of providing that service;
- the provider acted unreasonably by denying or restricting a user access to records or information, or in disclosing information about the user;
- failure to investigate a complaint properly or take the proper action;
- when a provider does not exercise due care and skill, fails to treat a person in an appropriate professional manner or respect a user's privacy and dignity;
- failing to provide information on the user's condition, treatment options, prognosis and not given adequate opportunity to make an informed choice of treatment services.<sup>16</sup>

<sup>10</sup> Sections 9, 20 & 22 of the *Health Care Complaints Act 1993* (NSW)

<sup>11</sup> Section 33 of the *Health Care Complaints Act 1993* (NSW)

<sup>12</sup> Sections 34, 35, 36, & 37 of the *Health Care Complaints Act 1993* (NSW)

<sup>13</sup> Sections 47 & 57 of the *Health Care Complaints Act 1993* (NSW)

<sup>14</sup> Sections 7 & 9 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>15</sup> Section 21 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>16</sup> Section 23 of the *Health and Community Services Complaints Act 1988* (NT)

Complaints may be made orally, however the complaint must be confirmed in writing, or made in writing in the first instance, signed and identifiable.<sup>17</sup>

The Commissioner must assess the complaint within 60 days and does one or more of the following:

- refers the complaint for conciliation, dealt with under Part 6 of the HCSC Act;
- investigation, dealt with under Part 7 of the HCSC Act;
- if the complaint concerns a registered provider notifies the relevant professional board,
- refers the matter to the appropriate body under other legislation if applicable, or
- takes no further action, and  
where a complaint deals with more than one subject matter the complaint may be split.<sup>18</sup>

Public interest complaints are drawn to the attention of the conciliator by the Commissioner.<sup>19</sup>

As part of the investigation process the Commissioner may require a person to attend before him and may examine that person on oath or affirmation. Additionally, the Commissioner may apply for a search warrant if applicable.<sup>20</sup>

When the Commissioner receives a complaint, which relates to a registration board, the Commissioner must notify and consult with the registration board regarding the registered provider. If both parties agree, the complaint may be referred to the relevant board. All boards must notify the Commissioner when they receive a complaint that falls within the ambit of the HCSC Act. The Commissioner may appear as a party to the proceedings in matters dealt with by the relevant board.<sup>21</sup>

Section 70 of the HCSC Act provides that the Commissioner and each relevant board must agree on appropriate written protocols taking into account the operation of the board and its disciplinary functions.

The Health and Community Services Complaints Review Committee is established pursuant to section 78 of the HCSC Act. The Committee's functions include:

- to review the conduct of a complaint and to make recommendations concerning the conduct of the complaint (an application to review a complaint is made by the complainant, the provider or as a referral from the Commissioner);
- to monitor the operations of this Act; and
- make recommendations on the procedures or processes for responding to complaints.<sup>22</sup>

Section 85 of the HCSC Act provides that persons exercising a power or performing a function under this Act are to have regard to the principles of procedural fairness.

Section 104 of the HCSC Act provides that the Minister may approve in writing the Code of Health and Community Rights and Responsibilities, which deals with

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<sup>17</sup> Section 24 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>18</sup> Section 27 & 32 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>19</sup> Section 39 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>20</sup> Sections 56 & 58 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>21</sup> Sections 68, 69 & 75 of the *Health and Community Services Complaints Act 1988* (NT)

<sup>22</sup> Sections 79 & 80 of the *Health and Community Services Complaints Act 1988* (NT)

principles specified in Regulations and may deal with other matters that are relevant to providing or using health or community services.

## **QUEENSLAND**

The Health Rights Commission was established in 1992 as an independent statutory office in accordance with the *Health Rights Commission Act 1991* (Qld), (“the HRC Act”).<sup>23</sup>

Queensland’s Governor appoints the Health Rights Commissioner. Rules or the practices of any court or tribunal as to evidence or procedure do not bind the Commissioner. However, the Commissioner is to proceed as informally with as much expedition, as practicable.<sup>24</sup>

The Commissioner is authorised to develop a Code of Health Rights and Responsibilities in consultation with interested parties, and the Health Rights Advisory Council for consideration of the Minister under Part 3 of the HRC Act. The Code may have regard to all matters that are relevant to the provision and use of health services and principles as prescribed.

The Health Rights Advisory Council is established to advise the Minister in the redress of grievances relating to health services; advising, educating and informing providers and users of health services; as well as the general operation of the Commission and any other relevant matters.<sup>25</sup>

Grounds for complaint of a health service include:

- a provider acted unreasonably by not providing a health service or in the way of providing a health service;
- the provider acted unreasonably in providing a health service;
- the provider acted unreasonably by denying or restricting a user access to records or information, or in disclosing information about the user;
- failure to investigate a complaint properly or take the proper action;
- when a registered provider acted in a way that would provide grounds for disciplinary action against the provider under the *Health Practitioners (Professional Standards) Act 1991* (Qld);
- when a provider acted in a way that provides grounds for a complaint against the provider under the *Nursing Act 1992* (Qld).<sup>26</sup>

The Commissioner may split a complaint, take action even if a provider is no longer registered and the complaint relates to the conduct or practice of the person as a registered provider, or refer a complaint to the relevant registration board if applicable.<sup>27</sup>

The Commissioner must consult with a provider’s registration board. This may be in the form of a standing arrangement or more specific consultation.

Under section 71 of the HRC Act, the Commissioner must assess the complaint within 60 days, however this may be extended in certain circumstances. The

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<sup>23</sup> Section 7 of the *Health Rights Commission Act 1991* (Qld)

<sup>24</sup> Sections 9 & 30 of the *Health Rights Commission Act 1991* (Qld)

<sup>25</sup> Section 41 *Health Rights Commission Act 1991* (Qld)

<sup>26</sup> Section 57 of the *Health Rights Commission Act 1991* (Qld)

<sup>27</sup> Sections 58, 60, 67 & 68 of the *Health Rights Commission Act 1991* (Qld)

Commissioner may decide to accept the complaint if all reasonable steps have been taken to resolve the complaint and reasonable opportunity to resolve the complaint, or to not accept the complaint if certain conditions apply under section 79 of the HRC Act.

If a complaint is accepted about a provider for action that is not a registered provider the Commissioner may conciliate (under Part 6 of the HRC Act), investigate (under Part 7 of the HRC Act) or refer the health service complaint to another body.<sup>28</sup>

The Commissioner must allow for the public interest if a complaint is to be conciliated.

Other provisions in the HRC Act include:

- powers for entering and searching premises;
- an authorised person may apply to a magistrate for a warrant;
- the Commissioner or other person may apply to a Supreme Court of Queensland judge for a determination of the validity of a claim of privilege;
- registration boards may provide the Commissioner with information, comment and recommendations concerning health service complaints and the relevant registered provider; and
- the Commissioner may intervene in a disciplinary proceeding heard by a registration board.<sup>29</sup>

## **SOUTH AUSTRALIA**

Legislation regarding a mechanism to resolve health complaints is currently before the Parliament.

Presently the South Australian State Ombudsman's Office ("the Office") has a Consumer Health Complaints Unit, which can only accept public sector complaints. The Office has produced a checklist for public hospitals and health services when handling complaints from consumers and community members.<sup>30</sup>

The Office is established in accordance with the *Ombudsman Act 1972* (SA), ("the Act") and the Governor may appoint an Ombudsman pursuant to section 6 of the Act.

If a person does not wish to contact the public hospital or health service, the person may lodge a written or verbal complaint with the Office. After a complaint is received an assessment officer will respond by:

- asking the provider of the health service to contact the person direct,
- assess the complaint,
- offer confidential conciliation,
- conduct a preliminary or full investigation and recommend changes to health practices and policies.<sup>31</sup>

Parliament may refer a matter for investigation to the Ombudsman if it falls within his jurisdiction. The Ombudsman also has the power to investigate a complaint on his own initiative.<sup>32</sup>

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<sup>28</sup> Section 73 of the *Health Rights Commission Act 1991* (Qld)

<sup>29</sup> Sections 114, 116, 121, 128 & 130 of the *Health Rights Commission Act 1991* (Qld)

<sup>30</sup> SA State Ombudsman Annual Report 2000 - 2001

<sup>31</sup> *ibid*

<sup>32</sup> Sections 13 & 14 of the *Ombudsman Act 1972* (SA)

The Ombudsman may use formal investigative powers for complex or serious cases, involving public health service providers, health care centres and public hospitals.

The Ombudsman has the powers of a Royal Commission in conducting investigations and may enter and inspect any premises or place occupied by an agency to which the Act applies and anything in that premises or place.<sup>33</sup>

## **TASMANIA**

Tasmania operates under the *Health Complaints Act 1995* (Tas), (“the HC Act”) which commenced operation on 1 May 1997.

The Health Complaints Commission examines complaints against providers of health services across all aspects of health in the public and private sector.

Pursuant to section 5 of the HC Act a Health Complaints Commissioner (“the Commissioner”) is appointed by the Governor. The Commissioner is an independent statutory Commissioner who provides a service to consumers and health service providers and develops and reviews a Charter of Health Rights in consultation with interested persons and the Health Minister<sup>34</sup>. After approval from the Health Minister, the Charter of Health Rights is laid on the table of each House of Parliament.

The HC Act states who can make a complaint and under which circumstances, a public interest test may be applied by the Commissioner<sup>35</sup>. After a person qualifies, a complaint can be made to the Commissioner, the grounds include:

- where a health service provider has acted unreasonably in providing or not providing a service,
- where a provider has not exercised due skill,
- where matters of dignity, privacy and the right to give informed consent have not been addressed;
- failure to provide access to information concerning a person’s condition, prognosis or records;
- failure to provide information in plain English, as well as sufficient information on the treatment or health services available with sufficient time for the person to evaluate the options and make an informed decision;
- failure to correctly address a person’s complaint or failure to act in a manner consistent with the Charter of Health Rights.<sup>36</sup>

All complaints must be in writing, signed and identifiable, the Commissioner may make an exception in certain circumstances. The Commissioner must assess complaints within 45 days and decide whether to conciliate, investigate or dismiss the complaint<sup>37</sup>.

The HC Act provides for matters to be dealt with by way of:

- Splitting the complaint (section 29);

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<sup>33</sup> Section 19 & 23 of the *Ombudsman Act 1972* (SA)

<sup>34</sup> Sections 6, 19 & 20 of the *Health Complaints Act 1995* (Tas)

<sup>35</sup> Sections 22 and 23 of the *Health Complaints Act 1995* (Tas)

<sup>36</sup> Jan O’Grady, Review of the Tasmanian *Health Complaints Act 1995*, as presented to 3<sup>rd</sup> National Health Care Complaints Conference, Melbourne, 2001.

<sup>37</sup> Section 25 of the *Health Complaints Act 1995* (Tas)

- Conciliation (section 31) privilege and confidentiality applies to information provided as part of this process;
- Investigation (section 40) includes the power to examine witnesses. A magistrate or justice may issue a warrant for entry and inspection of premises, items may be removed, examined or seized<sup>38</sup>;
- Referral of complaint to another authority for investigation (section 49).

Schedule 1 of the HC Act prescribes the services that are health services and services that are not health services.

## **VICTORIA**

The Office of the Health Services Commissioner was established in Victoria in 1988 under the *Health Services (Conciliation and Review) Act 1987 (Vic)*, (“the HSCR Act”).

The HSCR Act also establishes the Health Services Review Council (“the Council”). The Council’s functions include:

- advising the Minister on the health complaints system and the operations of the Commissioner;
- advising the Minister and the Commissioner on issues referred by the Commissioner, and
- with the Minister’s approval refer relevant matters to the Commissioner.<sup>39</sup>

Complaints may be made orally or in writing and the grounds for complaint include:

- a provider acted unreasonably by not providing a health service or in the way of providing a health service;
- the provider acted unreasonably in providing a health service;
- the provider acted unreasonably by denying or restricting a user access to records or information, or in disclosing information about the user; and
- failure to investigate a complaint properly or take the proper action.<sup>40</sup>

The Commissioner makes a preliminary assessment of complaints and must reject complaints that have already been determined by a court, registration board or tribunal. A complaint can be dealt with by way of conciliation or investigation if all reasonable steps have been taken to resolve the complaint with the provider. If the matter relates to a registration board, the complaint must be referred to the relevant board.<sup>41</sup>

Section 26 of the HSCR Act provides that that a person may refuse to produce documents on the grounds of legal professional privilege or where answering questions or producing a document may lead to incrimination. Additionally a warrant may be issued by a magistrate on certain grounds.

<sup>38</sup> Section 47 of the *Health Complaints Act 1995 (Tas)*

<sup>39</sup> Section 14 of the *Health Services (Conciliation and Review) Act 1987*

<sup>40</sup> Sections 16 & 17 of the *Health Services (Conciliation and Review) Act 1987*

<sup>41</sup> Sections 19, 20 & 21 of the *Health Services (Conciliation and Review) Act 1987*



## **APPENDIX 6**

# **WESTERN AUSTRALIAN PUBLIC PATIENTS' HOSPITAL CHARTER**

# **The Western Australian Public Patients' Hospital Charter\***

## **As a public patient you have the right to**

- Free public hospital services
- Treatment in order of need
- To be treated with respect and dignity
- Access to services throughout the state
- Explanation of treatment and consent before being treated
- A second medical opinion
- Advice on care when you leave hospital
- Confidentiality and access to your medical records
- Consent before being involved in training or research
- A simple procedure for making complaints

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\* Adapted from the poster version of the Western Australian Medicare Public Patients' Hospital Charter, published in 1995. The Charter was produced in booklet, poster and pamphlet form, (the pamphlet in 14 community languages), and distributed to every public hospital and health service in the state.