Submission to

Review of Health Services
Conciliation & Review Act

August 2012
This submission was prepared by Meredith Carter
Principal of Meredith Carter & Associates with assistance
from a reference group comprising:

Mary Draper CEO Health Issues Centre,
Liza Newby Board Director, Health Issues Centre,
Dr Leanna Darvall and
Maureen Willson Director of Quality Risk Consulting.

Health Issues Centre
Ph: 61 3 9479 5827
www.healthissuescentre.org.au

Meredith Carter & Associates
Mobile: 0400 511763
consultmeredith@gmail.com
About Health Issues Centre

Health Issues Centre works towards a health system with equitable health outcomes, organized around the interests of consumers, who as health service users, carers and citizens are actively involved in shaping the health care system and in decisions about their health.

We promote improvements to the health care system from the perspectives of consumers, with an emphasis on equity, and promote and provide expertise on consumer participation in health.
Table of Contents

About Health Issues Centre ................................................................. Error! Bookmark not defined.

Summary ........................................................................................................... 7
Recommendations ............................................................................................. 8
Section 1: Introduction ................................................................................... 13
  Complaints and health sector regulation......................................................... 13
  Recommendations .......................................................................................... 15
Section 2: What should be the key features of Victoria’s future health complaints system? ......................................................... 16
  Fair outcomes.................................................................................................. 16
  Fair communication processes ....................................................................... 17
  Fair procedures ................................................................................................ 18
  Principles to promote fairness.......................................................................... 20
  Recommendations .......................................................................................... 20
Section 3: What features of the current system should be kept or enhanced? ............................................................... 22
  Best practice complaints handling ................................................................. 22
  Public Interest and parallel processes ............................................................ 22
  Notice.................................................................................................................. 23
  Disclosure ......................................................................................................... 23
  Responses .......................................................................................................... 24
  Recommendations .......................................................................................... 24
Section 4: How can the Act better protect healthcare users? .......................................................... 26
  Powers to initiate investigations ................................................................... 26
  Consistency with other consumer protection laws ........................................... 26
  Open Disclosure ............................................................................................... 26
  Recommendations .......................................................................................... 29
Section 5: What controls should be placed on the powers of the Commissioner to protect healthcare users? .................................................................................... 31
  Unregistered providers ................................................................................... 31
  Enforceable Code of Conduct ...................................................................... 31
Recommendations .................................................................................................................. 32
Section 6: How can the Act provide a more accessible, efficient and effective complaints handling process? ................................................................. 34
  Local Level Complaints Resolution .............................................................................. 34
  Recommendations ........................................................................................................ 36
Section 7: How can the Act best support health care users and providers to understand and navigate the health complaints system? ................................................................. 37
  Ensuring access .............................................................................................................. 37
  Institutional and system wide strategies ...................................................................... 38
  Improving Awareness .................................................................................................. 39
  Focus on under-represented groups ........................................................................... 39
  Recommendations ........................................................................................................ 39
Section 8: How can the Act best support continuous quality improvement across the health care system? ........................................................................................................ 41
  Hospital complaints management .............................................................................. 41
  Prevention Unit ............................................................................................................. 41
  Recommendations ........................................................................................................ 42
Section 9: What are the most appropriate governance and accountability arrangements’ for the Commissioner? .................................................................................................. 43
  Promoting quality assurance and transparency ......................................................... 43
  Recommendations ........................................................................................................ 44
Section 10: Conclusion ...................................................................................................... 45
Summary

Health Issues Centre advocates that the Health Services (Conciliation and Review) Act should enshrine the centrality of consumer willingness to complain and the principles that would support this. Essentially, our submission starts from research indicating that consumers are less satisfied with the management of complaints than other parties and that this needs to be understood and addressed in this Review.

We argue that to be effective the health complaints system must respond to the expectations of health consumers. Our response to the Review focusses on what those expectations are, the extent to which they are met and what the principles underpinning a responsive complaints system might look like from a consumer perspective.

Key features of an effective health complaints handling system will aim to ensure consumer confidence in all three domains of fairness: procedures, communications and outcomes. Our submission builds on these fundamentals. It makes a range of recommendations for improvement in these and other areas.

Our submission also builds on the understanding that there are different narratives about how harm to consumers and consumer complaints about their health care are dealt with. One narrative is about regulation of providers and identification and regulation of problematic providers or practitioners. Another narrative is about fair forms of dispute resolution.

Another narrative is about how health care is made more safe and effective and patient centred and the best ways to do this, including a just culture and open disclosure. Each has their place, but also there needs to be some cross fertilisation and learning. At the centre, consideration needs to go to the best experience and outcome for the health consumer, both in their health care and in dealing with issues that arise for them when their health care is deficient in some respect.

All the evidence points to cultural as well as legislative or regulatory reform as important outcomes of the current review. Effective implementation of Open Disclosure right across the health sector will go a long way to achieving this.

Early local resolution, an apology and validation that some form of harm has occurred, support for the consumer, an explanation of why something happened and what changes will be implemented are all important to reducing complaints to the Office of the Health Services Commissioner (HSC). They are critical to an effective response to many consumer concerns and complaints.

This still leaves a range of other causes of complaints for the HSC and other health regulatory agencies to deal with. In addition to the new regulatory
structure we look forward to seeing the complaints handling system well resourced.

Health Issues Centre considers that the Discussion Paper for the Review has provided a good account of the range of issues that need to be addressed and has been helpful in framing our responses.

Recommendations

1. That reform of the Health Services (Conciliation and Review) Act (the Act) should enshrine the centrality of consumer willingness to complain and have regard to the Coroners Act 2008 reforms incorporating enhanced responsiveness in its objectives or principles.

2. That a fair health complaints system must incorporate:
   • Procedures that are fair from the perspective of complainants as well as providers,
   • Fair processes for communicating with complainants, and
   • Outcomes that respond to the expectations of complainants.

3. Principles that should be adopted to support a fair consumer focussed complaints handling system are that it must:
   • Be accountable to the public through regular reporting and evaluation of its impact and outcomes including follow up of implementation of recommendations for action by providers.
   • Aim to address the concerns of the particular complainant as well as the public interest.
   • Focus on outcomes that include attention to both validation of the complainant’s concerns, and what changes will be implemented to avoid a recurrence of the problem.
   • Ensure clear communication and provide personal support for the complainant.

4. Additional fundamental principles of complaints handling that should be legislatively acknowledged are that it should:
   • Be and be seen to be impartial - fair and unbiased.
   • Be and be seen to be independent.
   • Have timely and transparent processes.
   • Promote communication of an early apology for what has gone wrong.

5. That reform of the Act should aim to strengthen the HSC in terms of all aspects of best practice complaints handling including not only
conciliation but also investigative and prosecutorial powers and enhancing quality assurance across the health system.

6. That the focus of the Victorian complaints handling system should be enhanced in terms of its public interest role as well as its individual complaints handling role.

7. That where public interest investigations or hearings are warranted, the Act state that parallel processes may be utilised so far as feasible to ensure the expectations of the individual complainant are also addressed.

8. That the legislation also clarify that the referral of a matter to a registration board for investigation of standards issues should not of itself preclude ongoing attempts by the HSC to resolve other aspects of the complaint through conciliation or other processes.

9. That the legislation should provide the flexibility for the HSC by exception in appropriate circumstances to defer conciliations; investigate without notice to the practitioner concerned without requiring Ministerial approval; to refer matters for further investigation by another body at any stage of the complaints handling process; and to disclose matters arising in conciliation if necessary to protect the public interest.

10. That the legislation should include requirements that:

   - The results of at least key investigations be published on the Internet along with recommendations made for change to health service providers;
   - That providers should be required to advise what changes as a result of HSC recommendations (however arising ie including conciliations and investigations) have been made within 3 months; and
   - That advice regarding the changes made should also be provided to the relevant complainant(s).

11. That the HSC should have the power to initiate inquiries or investigations on being alerted to an apparent breach of standards and any legislative requirement to first obtain Ministerial approval should be removed.

12. That the legislation should provide the HSC with powers consistent with broader national consumer protection now provided under the Australian Consumer Law.
13. That the legislation should include a formal power for the HSC to obtain as required information from parties in conciliation or under investigation consistent with its powers under the Health Records Act.

14. That consistent with the Health Practitioner National Regulation Law (Victoria) Act the jurisdiction of the HSC should be extended to students enrolled in approved programs of study.

15. That the Wrongs Act be amended to adopt a broad definition of apology making any admission of fault be it express or implied inadmissible in any civil action arising out of an adverse health event and that the Victorian government identifies and takes all other measures to ensure that there are no unnecessary legal or insurance-based barriers to Open Disclosure.

16. The amendments be matched by a corresponding legal obligation to give consumers an explanation of what went wrong following an adverse event in health care.

17. That the Department of Health and other appropriate bodies offer incentives for support, coaching and or training to be made available to assist practitioners and health services how to best offer a sincere and effective explanation of what went wrong and apology.

18. That legislative amendment to the Act include introduction of a negative licensing framework in Victoria for implementation as a matter of urgency with features including:
   - A Code of Conduct applicable to all unregistered/licensed persons holding themselves out as offering health care enforceable by the HSC
   - A public register of prohibition orders (accessible to consumers in a range of ways including through the HSC website)
   - Criminal offences with sanctions including imprisonment for breach of the Code
   - A power for the Health Services Commissioner to issue public warnings about practitioners or organisations that on investigation have breached the Statutory Code and or have been convicted of an offence and pose a risk to the health or safety of the public.
   - That the Directors of corporations also be subject to naming and or criminal offences for any breach of the Code by persons employed by or otherwise associated with their organisation.
19. That options to introduce a complaints advocacy service be explored, including a local level complaints advocacy model potentially based on the New Zealand Health and Disability Advocacy Service (NZHDAS).

20. That the Review adopts the proposals outlined in the Discussion Paper designed to promote simpler and more responsive complaints lodgement processes.

21. That the Act specify a requirement that the HSC provide support for vulnerable people to make complaints including refugees, people from culturally or linguistically diverse backgrounds, people with disabilities and prisoners.

22. That the HSC conduct ongoing monitoring of who does complain including groups that research identifies as less likely to do so and assess whether the support provided to vulnerable groups is effective in increasing the level of complaints made by them.

23. That the Act incorporate a legislative requirement requiring systemic links between the deliberations of Community Advisory Committees, Quality Committees and the HSC and that the Department of Health provide incentives to support such links.

24. That a new title such as Health Complaints Bureau or Health Complaints Office be considered.

25. That the new Health Services Commissioner undertakes a review of local complaints management in their first year with view to ensuring consistency and effectiveness of local complaint management.

26. The Health Services Commissioner’s responsibility to ensure that complaints are used for system improvement be strengthened in the legislation and include identifying areas of health service delivery where effective Open Disclosure processes are not in place.

27. That the Act reformulate the role of the Health Services Council to promote a proactive role including in terms of:
   - Promoting accountability and transparency of the work of the HSC;
   - Prevention and quality assurance across the health system; and
   - Review of the HSC office priority setting and strategic plans.

28. That the Act require establishment of a Consumer Advisory Group to assist the HSC and consideration be given to appropriate Terms of Reference for this group including a particular role in advising on how best to reach and support under-represented groups.
Section 1: Introduction

The Health Services (Conciliation & Review) Act 1987 has two equally important roles. The first is to provide a trusted mechanism to resolve the complaints of individual consumers when this has not occurred at the local level. The second is to pursue appropriate responses to any public interest issues arising from consumer complaints.

There are several implications of these twin roles. The health complaints system serves as a key strategy for ensuring the quality and safety of health care. Trends in health complaints are an important way to help identify when things are going wrong and what changes need to be made to improve the health system.

The health complaints system also helps ensure confidence in health care. It does this in several ways. It reassures the public that the system is alert to errors and is prepared to act with alacrity when things go wrong to rectify them. For example where a complaint indicates harmful or substandard practices associated with a specific institution the Office of the Health Services Commissioner (HSC) can recommend changes.

It also reassures the community that where the public interest requires regulatory action it will be taken. For instance if a complaint reveals concerns about the competence of a practitioner the HSC can recommend that regulatory action be initiated to ensure they either improve their practice or refrain from practising inappropriately or, where necessary, at all.

Complaints and health sector regulation

Without consumers as the key initiators and witnesses to complaints investigations and regulatory determinations, regulation of the health sector and maintenance of its quality would be significantly more difficult.¹

Making a complaint and following it through requires considerable commitment and emotional effort on the part of the complainant. When individual consumers experience good complaints handling it can help to restore their personal trust in the health system and their confidence in health services. There is also evidence that good complaints management can contribute to healing for the practitioner(s) involved as well.²

Best practice standards for complaints management in Australia are available. However when it comes to health care complaints, people who have a complaint about their experience of health care are a key source of

¹ Resolution Resource Network and Health Issues Centre, Bringing in the Consumer Perspective, October 2004, p.15.
information on which standards investigations are based. When they do complain they may find their complaint is ‘diverted’ into public interest processes managed by registration boards that rely on their involvement but do not necessarily provide them with support or address their concerns.3

The Discussion Paper cites recent research findings that even where consumers were seeking sanctions regulatory procedures were initiated in less than 10 per cent of these cases. The same research suggests that even when complaints remain with the HSC there is a low correlation between the results sought by consumers (other than apology or explanation) and the outcomes that eventuate.4

In other words much of the contribution health complaints make to quality improvement and maintenance of standards relies heavily on the willingness of aggrieved consumers to participate in processes that are not designed to resolve their concerns.

Importance of consumer confidence

The health complaints system also relies on the cooperation of providers. Ensuring the confidence of both consumers and providers that the complaint handling system is fair and will be responsive to their expectations is crucial.

However the Review Discussion Paper highlights that consumers are markedly less likely than providers to be satisfied with the HSC complaints handling processes. Health Issues Centre strongly agrees with the suggestion of the Discussion Paper that these higher levels of dissatisfaction indicate that reform is timely.

The Discussion Paper also notes that the Victorian Health Priorities Framework 2012-2022 identifies improving health experiences as a key priority along with improving their health status.5 Ongoing high levels of consumer dissatisfaction with the health complaints system will inevitably erode public confidence in it. Trust in the health sector more broadly will also suffer if the public lacks confidence that the right thing will be done when things go wrong.

Therapeutic and preventive role

Reforms to the Victorian Coroners Act were enacted in 2008 to enhance the potential for examination of what has gone wrong, to contribute in two valuable areas:

---

3Resolution Resource Network and Health Issues Centre, Bringing in the Consumer Perspective (Consumer Perspective), October 2004, p.12
Prevention; and
Therapeutic jurisprudence.\textsuperscript{6}

The Coroners Court now has a stronger emphasis on prevention and “therapeutic jurisprudence” principles. The motivation for these changes was recognition that information from the Coroner’s investigation process could be an important resource for assisting in preventing health-care related deaths and assist in the healing process for both affected families and health practitioners. The Chief Coroner has noted that the new Act is specifically intended to contribute to a better understanding of the nature of adverse events in health care including:

- Health policy reforms; and
- Changes to existing practice.

There are clearly similarities between the need to be responsive to affected complainants in investigating health complaints to the need to be responsive to affected families in coronial investigations. We note that the new Coroners Act included objectives to encourage court practices that are responsive to the families and other people affected by coronial investigations, including the diverse cultural views and practices for dealing with death. These objectives include acknowledging:

- The need to avoid unnecessary duplication and to expedite investigations
- The distress of families and their need for support
- The need for families to be informed about the process and progress of an investigation and
- The effect of unnecessarily lengthy or protracted investigations.\textsuperscript{7}

Key features and principles that would enhance responsiveness to complainants and support their centrality to the effectiveness of the health complaints system are outlined in the next section.

**Recommendation**
1. That reform of the Health Services (Conciliation and Review) Act (the Act) should enshrine the centrality of consumer willingness to complain and have regard to the Coroners Act 2008 reforms incorporating enhanced responsiveness in its objectives or principles.


\textsuperscript{7} Coroners Act 2008 Sections 7 and 8.
Section 2: What should be the key features of Victoria’s future health complaints system?

This section of our submission responds to Review Question 1. It discusses the relationship between consumer perceptions of fairness in the complaints system and their acceptance of outcomes of complaints handling. It also proposes some principles to promote fairness from a consumer point of view.

Research into patient expectations suggests there are three core dimensions to fairness in health complaints handling from a consumer perspective:

- It must have fair procedures for handling complaints,
- It must be backed by fair communication processes, and
- It must have fair outcomes.\(^8\)

Reforms in all three dimensions must be key features of legislative and other changes ensuing from the current Review and some of the critical ones are discussed here. Further issues are discussed later in this submission.

Fair outcomes

Obviously if a consumer is going to make a complaint it is important that the potential outcomes respond to what they are aggrieved about. It is sometimes suggested that consumer complaints are simply an unfortunate expression of an increasingly litigious culture.

Research findings do not bear this out. Those who are more seriously injured are more likely to litigate. However the major themes emerging from the evidence of why patients litigate are as much about preventing similar incidents in the future and seeking an explanation as to what has happened as for financial recompense.\(^9\)

Consistent with this the Discussion Paper notes there are four key areas of remedy sought by complainants to the HSC:

- **Restoration** including reimbursement, waiver of fees, or financial compensation for lost wages, pain or suffering (87%);
- **Communication** including information about what happened, an expression of responsibility or an apology (57%);
- **Corrective action** to reduce the risk of harm to others (46%); and

---


Sanction such as disciplinary action (17%).

What is frequently critical to consumer satisfaction with complaints handling processes is whether there is an attempt made to right the wrong they consider has occurred. This is often cast in terms of ensuring that whatever has gone wrong doesn’t happen again to someone else. However more than altruism, it means helping to restore the complainant’s own sense of justice. Specifically in terms of the outcomes sought it means both:

- Validation of their concerns; as well as
- That their complaint results in changes to prevent the problem recurring.

These outcomes may be more important in many cases than compensation. Further as Bismark et al put it, where corrective measures could be taken this outcome “should not be denied simply because no one considered whether lessons could be learnt.”

**Fair communication processes**

This dual motivation may be seen to reinforce research findings across a range of jurisdictions internationally that fair outcomes alone do not determine consumer confidence in the fairness of complaints handling. Just as poor communication is often critical to whether a complaint is made in the first place, so it is often how the outcome of a complaint is conveyed as much as the results of an investigation that matters.

This might be obvious when it is considered that so often what a complainant seeks is an explanation of what went wrong and that similarly it is not always readily possible to attribute individual blame let alone to restore the consumer to their former position. In this light it is not surprising that interpersonal...
communication has been shown to play a major role in consumer views about whether the handling of their complaint was fair.

Consumers are more likely to feel justice has been done in the complaints handling process if they experience good communication. They expect clear information about the complaints handling procedures and a swift response. However these may be less important than the attitudes of the people involved.

For example impartiality and independence of the complaints handling personnel is considered vital. Respectful conduct is basic and face to face meeting is highly valued both with the complaints handling personnel and the practitioner(s) involved. Sympathetic explanation of what happened by the practitioners involved is also particularly useful, above all including acknowledgement of error where it has occurred. Complainants often consider explanation to be more important than an apology.\textsuperscript{15} This issue is discussed further in relation to the issue of Open Disclosure.

Research also demonstrates that consumer communication concerns extend to action on the outcomes. They not only want agreement that something needs to be done about the problem their complaint highlights. Studies of complaints involving hospitals find that for consumers to be satisfied with the complaints process they must receive both advice about what steps will be taken to address standards of care, and confirmation that these steps have been taken.\textsuperscript{16}

**Fair procedures**

Unfortunately as noted in the Introduction there is considerable consumer dissatisfaction with the current complaints system. One of the critical issues is the importance of procedures that promote resolution of the consumer’s express aims. A failure to address the complainant’s expectations may arise where the complaint concerns a practitioner not subject to licensing who may be less likely to comply with the complaints resolution process. Appropriate responses to the current limitations of the HSC in dealing with these practitioners are discussed further in Section 5.

Alternatively the focus on the specific outcomes sought by a complainant can be derailed where matters raise public interest concerns. This particularly applies once a decision has been made that a referral to a registration board for investigation of a practitioner is required. The current legislation requires that action by the HSC goes into abeyance. The matter may or more

\textsuperscript{15} Roland D Friele and Emmy M Sluijs, Patient Expectations of fair complaint handling in hospitals: empirical data. BMC Health Services Research 2006, 6:106

\textsuperscript{16} Ibid.
commonly may not be referred back to the HSC at the end of the registration board or tribunal processes which may be many months or even years later.\textsuperscript{17}

We recommend that there should be parallel processes to ensure that both the specific concerns of the complainant as well as any public interest issues arising are addressed.

The role of registration boards and tribunals is to protect patient and public safety in health care by assessing the level of compliance with practice standards by individual practitioners.\textsuperscript{18} This public interest role may or may not align with the concerns of the particular complainant. This is reinforced by the findings of a recent review of medical board/tribunal decisions in Australia and New Zealand that though:

“...the most prevalent outcome for affected patients was being upset at what had occurred ... in 78% of cases (380/485), there was no mention in the tribunal determination of physical or psychiatric harm to the patient as a result of the misconduct.”\textsuperscript{19}

Nor will it necessarily result in any system changes at the level of the institution at which the incident occurred. If it does, this is not necessarily conveyed to the consumer who made the complaint. Illustrative of this are study findings that complainants commonly find staff of registration Boards helpful and pleasant when they contact them but not proactive in initiating contact or keeping them updated.\textsuperscript{20}

While addressing the public interest in standards of health care and performance of providers is vital to the quality of the health care system, so too is consumer confidence that in making a complaint their individual

\textsuperscript{17} During 2010-11, 4,288 (52.7\%) of the 8,139 new notifications lodged under the National Law were closed. The remaining matters lodged during the year were still open on 30 June 2011, reflecting the complexity of some cases and the point in time at which others were lodged. The Australian Health Practitioner Regulation Agency and National Boards Annual Report 2010-11 p.62 http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx The HSC process can also be lengthy. The HSC generally accepts a complaint only after an attempt has been made to resolve it at the local level with the provider. Assessment of how the complaint should be managed must be undertaken by the HSC within 84 days but complainants may then wait at least four months for their complaint to be assigned to a conciliator. Most complaints closed during conciliation are settled within twelve months but over 40\% take longer with 8\% conciliated over more than two years. State of Victoria (2012) Review of the Health Services (Conciliation and Review) Act 1987, Department of Health Chapter 3.


concerns and expectations will be addressed. This confidence must clearly be improved.

One way to ensure that both sets of issues are addressed is to make the HSC a one stop shop to receive health complaints. Whether received by a Board or the HSC in the first instance the HSC should coordinate an initial independent investigation of the issues. This would ensure the consumer concerns were well understood in addition to passing on standards issues to the relevant board for investigation of any performance assessment and disciplinary action required.

Principles to promote fairness
Key features of an effective health complaints handling system will aim to ensure confidence in all three types of fairness: procedures, communications and outcomes. It also means the complaints handling system should be underpinned by principles explicitly designed to respond to the reasonable expectations of consumers when they make a complaint, to act reasonably in its demands on complainants, and to minimise any harmful impact of its processes on complainants and practitioners where possible.

These principles are recommended below.

Recommendations
2. That a fair health complaints system must incorporate:
   - Procedures that are fair from the perspective of complainants as well as providers,
   - Fair processes for communicating with complainants, and
   - Outcomes that respond to the expectations of complainants.

3. Principles that should be adopted to support a fair consumer focussed complaints handling system are that it must:
   - Be accountable to the public through regular reporting and evaluation of its impact and outcomes including follow up of implementation of recommendations for action by providers.
   - Aim to address the concerns of the particular complainant as well as the public interest.
   - Focus on outcomes that include attention to both validation of the complainant’s concerns, and what changes will be implemented to avoid a recurrence of the problem.

21 See also Resolution Resource Network and Health Issues Centre, Bringing in the Consumer Perspective, October 2004. p.15.
22 Roland D Friele and Emmy M Sluijs, Patient expectations of fair complaint handling in hospitals: empirical data. BMC Health Services Research 2006, 6:106
• Ensure clear communication and provide personal support for the complainant.

4. Additional fundamental principles of complaints handling that should be legislatively acknowledged are that it should:
   • Be and be seen to be impartial - fair and unbiased.
   • Be and be seen to be independent.
   • Have timely and transparent processes.
   • Promote communication of an early apology for what has gone wrong.
Section 3: What features of the current system should be kept or enhanced?

This section of our submission responds to Review Question 2 and considers the need for the HSC to address all aspects of best practice in complaints handling.

Best practice complaints handling
The Discussion Paper indicates that the strength of the Victorian health complaints system lies in its conciliation focus whereas best practice might lie in combining the strengths evident in other health complaints handling systems. These include providing the Commissioner with prosecutorial powers as in New South Wales and New Zealand and enhancing the quality improvement focus as in Queensland.

Health Issues Centre agrees that the Review should recommend legislative and other reforms supporting best practice. This should draw on the experience of each of the jurisdictions above and others, and on systems that deal with non-health related complaints. Questions that might be explored in relation to other jurisdictions include whether these other models have been more effective in achieving:

- Prevention,
- Consumer satisfaction,
- Levels of compensation.

It is noted that the outcomes of the recent review of the NSW Health Complaints Commission may be particularly useful along with submissions made by key stakeholders such as the Public Interest Advocacy Centre.\(^23\)

Public Interest and parallel processes
In particular, as in other jurisdictions, the focus and capacity of the HSC to deal with public interest issues should be enhanced. This includes matters that arise outside a specific complaint. For example they may be matters exposed by the media. Alternatively they may be brought to the attention of the HSC by members of the public who do not fit the current narrow definition of complainant in the Act.

Where public interest issues arise out of a complaint capable of conciliation, Health Issues Centre believes the HSC needs to have the flexibility to also address the public interest issues. We note that in our view this latter option will not in many cases prevent a parallel process such as conciliation continuing should the complainant seek broader outcomes than sanctions against the provider.

\(^23\) Public Interest Advocacy Centre (PIAC), Improving healthcare rights through better complaints systems and advocacy (Better Complaints Systems and Advocacy), Submission to the Joint Parliamentary Committee on the Health Care Complaints Commission, February 2012
As discussed in the previous section and above, Health Issues Centre supports the view that in general a referral to a registration board for consideration of standards issues should not result in a failure to address other reasons that motivated the consumer to make the complaint. Attempts to resolve those other aspects of the complaint by the HSC should generally be continued.

However in some instances the public interest may mean conciliation should be deferred in order to conduct necessary investigations of the matter. Affected complainants should be consulted before any conciliation is deferred for such reasons which we consider should be the exception rather than the rule.

**Notice**

If it is considered that giving notice to a practitioner or organisation may seriously prejudice an investigation, or may place someone’s health or safety at risk or may place someone at risk of harassment or intimidation, then conciliation will obviously need to be deferred.

We also support the HSC having the same power as the registration boards to investigate matters without giving the practitioner (or organisation) notice. In line with the principles we have outlined and the practice of the registration boards we support an exception basis for this power.\(^{24}\) However the current constraint requiring Ministerial approval before the use of this power by the HSC should be removed.

**Disclosure**

Confidentiality is a basic aspect of the conciliation process. However, should standards issues arise during the course of conciliation, the HSC should also be able to refer the matter to the relevant registration board again having consulted with at least the complainant(s) affected.

Again on an exception basis and in consultation with at least the relevant complainant(s), Health Issues Centre supports the broader proposal that information arising from a conciliation process may be disclosed to other appropriate agencies. The test should be that the public interest in disclosure outweighs the public interest in protecting the confidentiality of that information.\(^{25}\)

This is particularly important where a practitioner may simply move interstate and set up shop again. It is noted that all the Acts with such provisions have corresponding offences to address improper disclosure of information. Again these provisions highlight that clear and empathetic communication with the complainant will generally be required before such steps are taken.

\(^{24}\) The Australian Health Practitioner Regulation Agency and National Boards Annual Report 2010-11, p.55

Responses
There is strong evidence that a key aspect of consumer expectations is that there will be change as a result of health complaints. There is disappointing lack of evidence that this commonly occurs.

It is noted that public statutory authorities and entities must provide a written response to Coronial recommendations within 3 months. The Coroner must publish these responses on the internet along with findings, comments and recommendations made following an inquest, unless otherwise ordered by a Coroner. In addition the Coroner must provide this information to affected parties. Commentators have noted that:

“While this does not constitute any form of enforcement role for the coroner, it goes a significant way to leveraging responses to (if not compliance with) coroners’ recommendations. In so doing, it entrenches the public health function of coroners and significantly escalates the importance of their recommendations.”

Health Issues Centre supports introduction of similar provisions in the Health Services (Conciliation and Review) Act.

Recommendations
5. That the Review should aim to strengthen the HSC in terms of all aspects of best practice complaints handling including not only conciliation but also investigative and prosecutorial powers and enhancing quality assurance across the health system.

6. That the focus of the Victorian complaints handling system should be enhanced in terms of its public interest role as well as its individual complaints handling role.

7. That where public interest investigations or hearings are warranted, the Act state that parallel processes may be utilised so far as feasible to ensure the expectations of the individual complainant are also addressed.

8. That the legislation also clarify that the referral of a matter to a registration board for investigation of standards issues should not of itself preclude ongoing attempts by the HSC to resolve other aspects of the complaint through conciliation or other processes.

9. That the legislation should provide the flexibility for the HSC by exception in appropriate circumstances to defer conciliations;

26 Section 72 (3)-(5) Coroners Act 2008
27 Ian Freckleton, Opening a new page UMonashLRS 2009;4
investigate without notice to the practitioner concerned without requiring Ministerial approval; to refer matters for further investigation by another body at any stage of the complaints handling process; and to disclose matters arising in conciliation if necessary to protect the public interest.

10. That the legislation should include requirements that:

- The results of at least key investigations be published on the Internet along with recommendations made for change to health service providers;
- That providers should be required to advise what changes as a result of HSC recommendations (however arising ie including conciliations and investigations) have been made within 3 months; and
- That advice regarding the changes made should also be provided to the relevant complainant(s).
Section 4: How can the Act better protect healthcare users?

This section of our submission looks at Review Question 3 particularly in relation to specific powers available to the HSC. It particularly outlines Health Issues Centre’s support for several of the specific proposals made in Chapters 3 and 4 of the Discussion Paper. These are consistent with the principles of fairness outlined earlier. It particularly highlights the need for further legislative action to support the Open Disclosure Standard.

Powers to initiate investigations
Consistent with the powers in many other jurisdictions and the discussion above Health Issues Centre believes the HSC should have the power to initiate inquiries or investigations on being alerted to an apparent breach of standards. This should not be dependent on how the matter came to the attention of the HSC, for example whether through a complaint or not, or if it was via a complaint at what stage of the process the public interest concern arose. In addition the current requirement of Ministerial approval simply delays action and does not serve public safety. It should be removed.

Consistency with other consumer protection laws
Consideration should also be given to providing the HSC with powers consistent with broader national consumer protection now provided under the Australian Consumer Law. A “no wrong door” approach should apply so that the public is protected and consumers do not have to choose their jurisdiction to access the most appropriate remedy.

The HSC therefore should have powers to grant an injunction to prevent contravention of the law, issue a public warning notice and require a person to provide information to substantiate or support health or medical claims or representations they have made. The HSC should also have the power to disqualify a person associated with egregious conduct relating to health care from managing a health related corporation.

Consistent with the Health Records Act the HSC power to request information and documents during conciliation the Health Services (Conciliation and Review) Act should also include a formal power to obtain information from parties as required.

Further Health Issues Centre agrees that the jurisdiction of the HSC should be extended to students enrolled in approved programs of study consistent with the Health Practitioner Regulation National Law and AHPRA framework.

Open Disclosure
The Discussion Paper notes amendments to the Victorian Wrongs Act that were enacted following the insurance crisis in the early years of the current century. These included protection for health service providers (and their
insurers) from the use of an apology as an admission of fault or guilt that could be used in court cases brought in the wake of an adverse event in health care.

Much of the literature and research dealing with consumer expectations of complaints handling in health care emphasises the importance of apologies. Sincere expressions of regret when things have gone wrong along with explanations of what actually happened are considered to assist in at least three ways, including by promoting:

- Early resolution of the complaint,
- Healing for consumers, and
- Healing for practitioners.

The Discussion paper notes that the national Open Disclosure Standard developed in 2003 (following the Wrongs Act changes) has assisted in complaints resolution by the HSC. However it has not been enough to shift the focus of some insurers at least beyond mere avoidance of litigation towards support for conversations directed at solutions for the future.

Commentators have noted that the clear ethical obligation to be open and honest about what went wrong following an adverse event in health care is still honoured all too often in the breach. Madden and Cockburn note the 2,500 or so notifications to public and private medical indemnity insurers each year. They suggest research might usefully be undertaken to see if matters worth a precautionary notification of a potential claim to an insurer are matched by the provision of similar information or explanation to the patient concerned.

A range of barriers remain to open disclosure. The literature notes that frequently however practitioners need support and coaching as to the most

---

28 See the list of citations given in this regard in David McD Taylor, Rory S Wolfe and Peter A Cameron, Analysis of Complaints lodged by patients attending Victorian hospitals, 1997-2001, MJA 2004;181:31 at 34
effective way of making such apologies and disclosures.\textsuperscript{32} As Vincent and others put it:

"Communication assumes a special importance when things have gone wrong."\textsuperscript{33}

This means it is important it is done as well as possible.

Health Issues Centre considers the extent to which health services and practitioners use an Open Disclosure approach to respond to consumer perceptions of harm is crucial to early local management of complaints and how services and practitioners interact with the HSC in responding to formal complaints.

The Australian Commission for Safety and Quality in Health Care (ACSQHC) is currently reviewing the Australian Open Disclosure standard and its implementation. This has included a review of all recent related literature. Several of the conclusions they reached are very relevant to this Review.\textsuperscript{34}

The ACSQHC recommends that the revised Open Disclosure Standard should emphasise the importance of the process is a two-way exchange of valuable information. It needs to be seen as an ongoing dialogue that can redress harm and repair damaged relationships and contribute towards health system improvement.

It also recommends that the revised standard should emphasise that early management of an incident, especially the way communication is undertaken with patients, has been found to have a powerful effect on the patient perceptions of the incident itself, the levels of patient trust, medico-legal implications and results and eventual outcomes and residual harm.

A further barrier is the limitations of the protection provided by Victorian legislation. It does not protect providers where an apology is not crafted carefully enough to avoid any possible implication of fault or negligence. As others have noted this is clearly unsatisfactory.\textsuperscript{35}

It is not in the interests of either providers or consumers and needs to be rectified. We support both legislative change and an emphasis on support for a cultural shift consistent with the approach of what may be described as the Open Disclosure movement.

\textsuperscript{32} Melinda Shirley & Tina L Cockburn, 2007, Implementing the open disclosure of adverse events in Australia through a mediation skills models, Presentation to 11th Greek Australian Legal and Medical Conference Crete, Greece \url{http://www.lmconference.com.au/papers/2007/shirley_cockburn.html}

\textsuperscript{33} Charles Vincent, Magi Young and Angela Phillips Why do people sue doctors? A study of patients and relatives taking legal action, Lancet 1994;343:1609.at p.1613


\textsuperscript{35} See footnote 31 for selection of commentators.
We support adoption of a broad definition of apology as in the ACT and NSW. This prevents any admission of fault be it express or implied being admitted in any civil action arising out of an adverse health event. We also support the protection provided to practitioners being matched by a legal obligation to disclose along with incentives provided by the Department of Health and other appropriate bodies to support practitioners to make apologies and deliver effective explanations.

Support for cultural change as well as legislative action is particularly important given the ACSQHC conclusions from the research. That is, consumers often have different perceptions of harm to health practitioners. Practitioners may see harm in bio-medical terms (physical harm). Consumers value a range of factors in their experience of care (communication, information, being treated with dignity and respect as a person, empathy). This broad experience of harm may not always be well understood by clinicians coming from a different perspective. In many respects, complaints can be seen as consumers saying that they have experienced some form of harm, which may range from treatment issues to being treated without dignity and respect. Complaints also sometimes identify physical harm (an adverse event) that has not been otherwise identified.

This emphasis on what consumers think of as harm is consistent with the experience that when complaints are made it is often the non-clinical aspects (such as poor communication or loss of dignity) that propel a person into the formal complaints process. The ACSQHC notes that harm is experienced as psychological can be harder to address over the longer term than physical harm.

A second emphasis of the Review of Open Disclosure is the importance for consumers of the sense of breach of trust and the value of restoring trust. Consideration of complaint resolution at HSC level is framed by legally-based concepts of justice and fairness in process and outcome. However these other aspects of the experience of people making complaints are also important; including restoring trust and dealing with residual harm.

Recommendations

11. That the HSC should have the power to initiate inquiries or investigations on being alerted to an apparent breach of standards and any legislative requirement to first obtain Ministerial approval should be removed.

12. That the legislation should provide the HSC with powers consistent with broader national consumer protection now provided under the Australian Consumer Law.
13. That the legislation should include a formal power for the HSC to obtain as required information from parties in conciliation or under investigation consistent with its powers under the Health Records Act.

14. That consistent with the Health Practitioner National Regulation Law (Victoria) Act the jurisdiction of the HSC should be extended to students enrolled in approved programs of study.

15. That the Wrongs Act be amended to adopt a broad definition of apology making any admission of fault be it express or implied inadmissible in any civil action arising out of an adverse health event and that the Victorian government identifies and takes all other measures to ensure that there are no unnecessary legal or insurance-based barriers to Open Disclosure.

16. The amendments be matched by a corresponding legal obligation to give consumers an explanation of what went wrong following an adverse event in health care.

17. That the Department of Health and other appropriate bodies offer incentives for support, coaching and or training to be made available to assist practitioners and health services how to best offer a sincere and effective explanation of what went wrong and apology.
Section 5: What controls should be placed on the powers of the Commissioner to protect healthcare users?

In this section our submission responds to Review Question 4 especially in relation to unregistered providers.

Unregistered providers
The HSC has a particularly important public safety role in relation to unregistered providers and practitioners. These are the very many organisations and individuals who are not licensed or registered by another regulatory body. As the Review notes:

"The vast majority of unregistered health practitioners practise in a safe, competent and unethical manner."36

There are some fundamental reasons not all the practitioners and organisations offering health care are subject to registration boards. Most commonly it is because their area of practice is not considered appropriate to subject to registration or licensing.

Registration and licensing is a regulatory approach that is generally only imposed when the risks of unregulated practice are higher than the costs to the public interest that would ensue from regulation.

Sometimes the risks of unregulated practice are high but the area of practice or practitioner group is too ill-defined for registration as such to be effective. In other cases people and organisations that hold themselves out as offering health care are not subject to registration or licensing because there is no agreement that they are competent or offering health care at all. This may be because they are considered charlatans.

The types of unregistered practitioners or organisations the HSC most commonly receives complaints about are:

- Alternative therapists (not defined)
- Beauticians and beauty clinics,
- Laser therapists.37

Enforceable Code of Conduct
As described in Chapter 4.1.2 of the Discussion Paper, the Australian Health Ministers Advisory Council recently considered what to do about the behaviour of the small number of unregistered people offering exploitative, predatory and or illegal services to health consumers. It is consulting nationally about

---

37 Ibid.
options including a form of ‘negative licensing’ to be managed at the state level by the HSC (or its equivalent in other states).

Legislative reforms in this direction have already been passed in both New South Wales and South Australia (although not yet fully implemented in the latter). In effect they require unregistered health care practitioners to adhere to a code setting out expected standards of behaviour. If they are found after investigation to have breached those standards the relevant state health complaints Commissioner can order them to cease whatever behaviour is the problem or to cease practising at all. They are named on a public register consumers can access and breach of these orders constitutes a criminal offence for which they can be gaol.

Health Issues Centre considers these ‘negative licensing’ powers are likely to be far more effective than the limited naming powers that the Victorian HSC has and has rarely used. We support urgent implementation of a similar scheme in Victoria. This can be amended as appropriate when and if the Australian Health Ministers agree to a nation-wide scheme. We note also that it is important the provisions also apply to corporations to ensure that individuals cannot hide behind their corporate status to continue incompetent, manipulative or otherwise unethical practice.

Naming errant providers
The Victorian Health Services Commissioner can name providers in formal reports to Parliament. This is useful to generate public awareness of a problem but is a slow and cumbersome way of addressing public safety. The NSW Health Complaints Commissioner can also issue public warnings subject to certain safeguards which do not require the protection of a report to Parliament. The Victorian Act should include similar powers but in our view this should be an adjunct to the proposed Code and criminal sanctions not an alternative.

Recommendation
18. That legislative amendment to the Act include introduction of a negative licensing framework in Victoria for implementation as a matter of urgency with features including:
   • A Code of Conduct applicable to all unregistered/licensed persons holding themselves out as offering health care enforceable by the HSC
   • A public register of prohibition orders (accessible to consumers in a range of ways including through the HSC website)
   • Criminal offences with sanctions including imprisonment for breach of the Code
   • A power for the Health Services Commissioner to issue public warnings about practitioners or organisations that on investigation

38 Ibid p.30-31
have breached the Statutory Code and or have been convicted of an
offence and pose a risk to the health or safety of the public.
• That the Directors of corporations also be subject to naming and or
criminal offences for any breach of the Code by persons employed by
or otherwise associated with their organisation.
Section 6: How can the Act provide a more accessible, efficient and effective complaints handling process?

This section deals with Review Question 5. It looks at how the complaints system can be made more responsive to people’s needs. As noted above it is not easy to complain and it requires a level of commitment to the process which of itself may generate little personal gain. These issues are compounded if there long term relationships are involved as is frequently the case in health care.

Local Level Complaints Resolution
Research shows that consumers who have been through a formal complaints handling process may be unlikely to want to return to that provider.39 For many people changing provider will be seriously disruptive of their health care. For example, the complaint may concern the General Practitioner or Dentist who knows your long term medical or dental history and has the records of it. The process of changing providers is compounded for people with complex or chronic conditions, or limited alternative providers.

There is evidence that many consumer complaints in health care can be resolved in a relatively straightforward way at the local level, for example through hospital complaints units or liaison officers. However these local level complaints resolution mechanisms exist primarily in metropolitan public hospitals only. They are less likely to exist outside the metropolitan area, in private hospitals or in non-hospital settings.

Many studies have observed that an early and sincere apology goes a long way to defusing the heat in a complaint. While it should not be assumed that it is necessarily sufficient to resolving the complaint it can certainly help reduce the time and resources required to resolve it.40

As discussed above, many consumers also want to hear the relevant practitioner admit an error if it has been made.41 As noted previously the Open Disclosure Standard has been helpful in achieving such admissions and explanations. However it seems logical that it would occur more often, earlier and with less expense, emotional or financial, in a trusted complaints handling environment at the local level before it has been escalated to the level of the HSC.

40 See for example the list of references in this regard cited by David McD Taylor, Rory S Wolfe and Peter A Cameron, Analysis of Complaints lodged by patients attending Victorian hospitals, MJA 2004;181:31 at p.34
41 Roland D Friele, Emmy M Sluijs and Johan Legemaate, Complaints handling in hospitals: an empirical study of discrepancies between patients expectations and their experiences, BMC Health Services Research 2008, 8:199
While only a small proportion of complaints may result in changes at the service level, this is what many consumers want. Again this seems more likely to be achieved by early intervention at the local level. Unfortunately a study of complaints handling in Victorian hospitals between 1997 and 2001 found that very few complaints resulted in specific changes to hospital policy or procedure.\(^{42}\)

There is also evidence that in person interaction with the complaints handling body is important to consumer confidence. They want support and clear information about the processes and possible outcomes and they also want the complaints handling process to listen to their story, establish their particular needs and to be respectful of their experience.\(^{43}\) If this occurred right at the start of the process much frustration might be prevented.

In addition consumers and/or their family and friends are unlikely to have the skills or experience to match those of complaints managers, general managers and health professionals when trying to resolve a complaint. They are often angry and frustrated with a provider before they make a complaint.

While the best of hospital based patient advocacy services can provide support for complainants through their complaint and also assist early resolution, consumers with complaints about private providers do not have access to a similar service.

For all these reasons we recommend the establishment of a complainant advocacy service.\(^{44}\) This could be an outreach arm of the HSC and complement the role of the existing hospital complaints officers. Alternatively an independent devolved model would allow the HSC to concentrate on investigation of more complex or intransigent complaints. An independent model could complement or offer an alternative to hospital based approaches, as well offering support for complainants with concerns about community based and private practitioners. Further discussion of the hospital based model is made in Section 8.

A model that has existed for many years in New Zealand is the New Zealand Health and Disability Advocacy Service (NZHDAS). Health Issues Centre agrees with the Discussion Paper that this model is worth exploring.


\(^{44}\) As proposed also by Resolution Resource Network & Health Issues Centre Bringing in the Consumer Perspective, October 2004, p.10 and recommended by the NSW Public Interest Advocacy Centre (PIAC), Improving healthcare rights through better complaints systems and advocacy (Better Complaints Systems and Advocacy), Submission to the Joint Parliamentary Committee on the Health Care Complaints Commission, February 2012.
The model offers independent localised early resolution and support for complainants, including support for self-advocacy. It also provides specialist advocacy for deaf people, refugee and migrants. The New Zealand experience demonstrates that having local advocacy services, readily accessible to consumers delivers substantial benefit to both consumers and the health care providers. In particular it helps prevent consumer concerns escalating into formal complaints, and reduces the related time and costs for all parties.45

Recommendations
19. That options to introduce a complaints advocacy service be explored, including a local level complaints advocacy model potentially based on the New Zealand Health and Disability Advocacy Service (NZHDAS).

---

45 See further discussion by Public Interest Advocacy Centre (PIAC) in Better Complaints Systems and Advocacy, Submission to the Joint Parliamentary Committee on the Health Care Complaints Commission, February 2012
Section 7: How can the Act best support health care users and providers to understand and navigate the health complaints system?

This section deals with Review Question 6 and considers how to ensure everyone who has a complaint can readily understand and pursue appropriate options for resolving their concerns.

Ensuring access
Data concerning who complains to the HSC is consistent with data from other jurisdictions in Australia and internationally. That is, complainants tend to be female, well educated, Australian born people who live in the metropolitan area. That complainants tend to be female may reflect that women are higher users of health services.

However the demographic profile of complainants does not otherwise reflect the major users of health services. The HSC does assist vulnerable groups to make complaints as reflected in the perhaps surprising number of complaints received from prisoners. However some groups such as refugees and others from culturally or linguistically diverse backgrounds remain dramatically under represented. For example the Discussion Paper notes only 2% of complainants in 2010/11 requested an interpreter with Greek the most common language other than English.

It is not known to what extent other major health user groups make use of the OSHC. These include for example older people, people with disabilities, people from culturally and linguistically diverse communities, and mental health consumers. However, under representation of some groups in the community is considered likely to reflect the difficulties of making a complaint, the emotional and intellectual resources required of patients to escalate a complaint to the level of the HSC and the lack of support provided to complainants particularly outside the metropolitan area and if their first language is not English. There is little detailed research into the reasons for this.

Preliminary studies suggest it is not necessarily related to lack of knowledge about the availability of the right to make a complaint. For example rural residents are under-represented overall. However at the same time there appears to be over-representation of complaints from residents of small, widely scattered rural communities as compared to those living in larger towns. Researchers have speculated that where there are limited alternative

---

46 State of Victoria, Review of the Health Services (Conciliation and Review) Act 1987, Department of Health 2012 p.15, and p.32 Note the Discussion Paper observes that prisoners are still more likely to make health related complaints to the Ombudsman’s office.
47 Ibid p.15
health care options available people may be less likely to complain about the provider that is available.48

In other words people may fear the loss of access to health services if they complain about them. In rural hospitals complaints liaison officers may be less likely to exist and/or may be less likely to have the autonomy and independence that would ensure they are not perceived as a ‘mouthpiece’ for the service.

The Discussion Paper makes a number of proposals designed to promote simpler and more responsive complaints lodgement processes that Health Issues Centre supports. They include amending the Act to make explicit a requirement to provide support for vulnerable people including refugees, people from culturally or linguistically diverse backgrounds, people with disabilities including intellectual disabilities, and prisoners.

Specific supports may be needed to assist complainants to formulate their complaint, such as people with disabilities whose disability may make this difficult, and support them through the process. The Discussion Paper also refers to research identifying particular subpopulations in New Zealand as less likely to complain including the elderly. Health Issues Centre recommends ongoing monitoring of who does complain including groups identified as less likely to do so and to assess whether the support provided to vulnerable groups is effective in increasing the level of complaints made by them.

Institutional and system wide strategies
Strategies at the institutional level to promote earlier resolution of complaints and more effective use of complaints systems include ensuring transparency of and promoting the profile of local level complaints processes.

Greater emphasis on consumer engagement more generally may also assist in rural areas. For example, the introduction of consumer or Community Advisory Committees has been useful in urban areas to raise the issues that are at the crux of many complaints in a depersonalised way. The data does not suggest that the rank order of issues about which rural consumers complain is different to those generating complaints by their urban neighbours.49

The effectiveness of this approach would be enhanced if the Act incorporated a legislative requirement backed by Department of Health incentives to support systemic links between the deliberations of Community Advisory Committees, Quality Committees and the HSC. For example the Community Advisory Committees could regularly review the results of patient complaints and patient satisfaction surveys, and add a consumer perspective to how rural hospitals or groups of providers such as GP Networks might respond.

48 Judith A Jones, Beth Wilson, John S Humphreys and others 2003, Rural consumers’ complaints about health services (Rural Consumers), Presentation to 7th National Rural Health Conference, Hobart
49 Ibid
Similarly benchmarking could be encouraged by supporting rural participation in a state wide network of Community Advisory Committees meeting regularly with the Health Services Commissioner and review of its data.

**Improving Awareness**

It is our view that in addition to the systemic issues proposed in other sections of this submission there are a number of relatively small changes that might also assist consumers and providers to understand and navigate the health complaints system.

The title obfuscates the role of HSC. The term Commissioner is of itself both formidable and non-informative. It does not evoke an image of a relatively informal and user friendly complaints resolution agency. Consideration of a title such as Health Complaints Bureau or Health Complaints Office would be improvements.

Awareness of the Office could also be improved by improving the accessibility of information about how to contact the office. For example the contact details for the Office are not on the home page of its website. The accessibility of this site to people whose language is not English also seems limited. PDF information in other languages about how to make a complaint can be found on the site but is not immediately obvious and not necessarily accessible.

**Focus on under-represented groups**

Again a strategic focus in terms of on under-represented groups might promote greater prioritisation to increasing awareness of the Office and its processes amongst these groups. This might build on existing strategies that may have been adopted. Examples might include seeking regular spots on major ethnic radio stations or newspapers, targeting public speaking engagements to rural areas, working with groups representing older people, people from culturally and linguistically diverse backgrounds, people with disabilities and mental health consumers.50

Publicising specific training of HSC staff might also be required in terms of highlighting its sensitivity to the needs of particularly vulnerable groups. This would help to reinforce for those groups the commitment of the Office to meeting their needs.

**Recommendations**

20. That the Review adopts the proposals outlined in the Discussion Paper designed to promote simpler and more responsive complaints lodgement processes.

---

50 While establishment of a mental health ombudsman has been proposed State of Victoria Review Discussion Paper Op Cit. p. 25 but it remains the case that complaints will be made by people with mental health problems about their general health issues.
21. That the Act specifies a requirement that the HSC provide support for vulnerable people to make complaints including refugees, people from culturally or linguistically diverse backgrounds, people with disabilities and prisoners.

22. That the HSC conduct ongoing monitoring of who does complain including groups that research identifies as less likely to do so and assess whether the support provided to vulnerable groups is effective in increasing the level of complaints made by them.

23. That the Act incorporate a legislative requirement requiring systemic links between the deliberations of Community Advisory Committees, Quality Committees and the HSC and that the Department of Health provide incentives to support such links.

24. That a new title such as Health Complaints Bureau or Health Complaints Office be considered.
Section 8: How can the Act best support continuous quality improvement across the health care system?

The focus of this section is on Review Question 7. It looks at ways in which complaints can promote better health care and systematic quality improvement.

Hospital complaints management
We have argued the local complaint resolution is a critical component of getting good complaints resolution for consumers and provide a direct opportunity for complaints to feed directly into quality improvement.

Health Issues Centre suggests there may also need to be a review of the current system of what are variously called patient advisors, patient representatives and complaints or complaints liaison officers who are employed in many hospitals. The system is ad hoc. It may not exist in smaller, private and rural hospitals or other health services. The hospital based complaints units also have varied autonomy and independence.

When the legislation was first enacted, these roles did not exist. They arose as a result of the role of the HSC and work done by early Health Services Commissioners. They now play a very important role. With the advent of Clinical Government Units, this role is now frequently incorporated in Clinical Governance or Quality and Safety units.

Anecdotally, health services staff have subsequently seen the role as less adversarial and contributing to quality improvement and resolution of issues. Open Disclosure has strengthened this relationship and patient advocates may support consumers in Open Disclosure processes. There is a network of patient advocates/complaint officers.

However, we know very little about how well they are working, where they exist, what types of skills these people have and need, the levels of remuneration and authority, how the role is conceived in different health services, their capacity to have influence and what the outcomes are. There is some state-wide data collected about types of complaints from health services, but the databases used to collect these have not been satisfactory and very limited use is made of the data to identify system wide areas for improvement.

Health Issues Centre recommends that the new Health Services Commissioner works with the Department of Health to undertake a review of local complaints management in their first year with a view to ensuring consistency and effectiveness of local complaint management.

Prevention Unit
In Section 1 of our submission we noted the modernisation of the Coroner’s Act has included explicit emphasis on prevention. This is reinforced by the
creation and resourcing of a special unit within the Office of the Coroner incorporating a Clinical Liaison Unit.

The expertise and research capacity provided by the Coroner's Prevention Unit (CPU) helps ensure the formulation of well-founded prevention recommendations as well as help monitor and evaluate the effectiveness of Coronial recommendations. In addition, the requirement to post Coronial findings, comments and recommendations on the web, as discussed previously in our submission also opens up public access in a way that not only promotes transparency and accountability.

It makes this information much more amenable to evaluation and research. This the potential to make a broader contribution to system wide quality improvement. It facilitates evaluation of findings and recommendations from legal, medical and public health and safety perspectives. In addition it assists assessment of the extent to which recommendations are capable of being implemented and, in fact, are being implemented.\textsuperscript{51}

**Recommendations**

25. That the new Health Services Commissioner undertakes a review of local complaints management in their first year with view to ensuring consistency and effectiveness of local complaint management.

26. The Health Services Commissioner’s responsibility to ensure that complaints are used for system improvement be strengthened in the legislation and include identifying areas of health service delivery where effective Open Disclosure processes are not in place.

\textsuperscript{51} Ian Freckleton, Opening a new page UMonashLRS 2009;4
Section 9: What are the most appropriate governance and accountability arrangements’ for the Commissioner?

This section of our submission considers Review Question 8. It suggests the governance of HSC also needs more transparency and possibly also focus.

Promoting quality assurance and transparency
It is noted that the current legislation defines the functions of the HSC Council. Health Issues Centre believes these functions should be recast to promote a more proactive role. The Council could play a strong and explicit role in promoting the system wide quality assurance, monitoring and evaluation role for the HSC we have supported in the previous sections.

There are parallels for the role envisaged for the Governance of the HSC in the Coronial Council. In addition to the role of the Coroner in providing advice to the relevant Minister (in its case the Attorney General), the Coronial Council itself has a legislative obligation to provide advice and make recommendations on matters of importance to the Coronial system.52

An important role of the HSC Council is an accountability role, ensuring that the HSC itself performs its full range of functions. The HSC Council would be better placed to play this role if the HSC itself has a stronger focus supported by a stronger data analysis capacity as discussed previously.

This capacity would support regular monitoring and reporting to health services and the public the trends revealed by the data collected. It is envisaged the data would not only be reported annually in Annual Reports but on the web and elsewhere and would range from the demographics of complainants, levels of satisfaction with complaints handling processes, key sources of complaint and remedies. It might also include for example, levels of compensation obtained for different types of complaint, etc.

In addition, Health Issues Centre also supports a clear role for the HSC Council in terms of review of the HSC office priority setting and strategic plans. A modern statutory body should continue to function independently in terms of complaints management but also have robust advice and support as to the best ways to achieve its functions and manage the resources available to it.

A broader role for the Council would help ensure that the Office maintains its own commitment to ongoing quality improvement and support its identification of priorities for the allocation and targeting of resources to for

52 Section 109 Coroners Act 2008
example, encouraging complaints from under-represented groups. In this regard it seems likely that it would be helpful for the HSC to establish a specific Consumer Advisory Council with representatives from under-represented groups to assist it in developing appropriate strategies targeting these groups.

The Queensland Health Commissioner must establish a Consumer Advisory Committee. The New Zealand Health and Disability Commission also has a Consumer Advisory Group whose task is to provide timely advice and feedback to the Commissioner on strategic issues:

- Handling of consumer complaints about health and disability services
- How to improve the quality of health and disability services
- Public interest issues where the Health and Disability Commissioner can take a lead
- Policy issues raised by the Commissioner
- Promotion and education.

Recommendations

27. That the Act reformulate the role of the Health Services Council to promote a proactive role including in terms of:
   - Promoting accountability and transparency of the work of the HSC;
   - Prevention and quality assurance across the health system; and
   - Review of the HSC office priority setting and strategic plans.

28. That the Act require establishment of a Consumer Advisory Group to assist the HSC and consideration be given to appropriate Terms of Reference for this group including a particular role in advising on how best to reach and support under-represented groups.

53 State of Victoria, Review of the Health Services (Conciliation and Review) Act 1987, Department of Health 2012 p. 80
54 See the NZ Health & Disability Commission website http://www.hdc.org.nz/about-us/hdc-consumer-advisory-group
Section 10: Conclusion

There are many other issues raised by the Discussion Paper and by consumers in relation to effective and fair management of health complaints. This submission addresses only some of them. However we have tried to ensure we have addressed some of the issues that are most important from a consumer perspective.

It will be clear from our responses and recommendations that we consider much of the reform required is in the realm of policy and practice as well as in the Health Services (Conciliation and Review) Act. This is consistent with our view that legislation alone is not sufficient to support the cultural shifts required. Further some of the reforms will be required to other legislation as well, such as the Wrongs Act.

It goes without saying that it is very difficult for legislative and policy reform to achieve reform in practice without the resources to implement them. We look forward to seeing a strong commitment from the Victorian Government. That commitment must be to not only reform the health complaints handling framework so that Victoria is the template for best practice, it must also be to ensure the resources are made available to put the template into practice.

Finally we hope that the reforms following the current Review will lead to the next review finding that both complainant and provider satisfaction with the Victorian complaints handling system is very high.