HEALTH SERVICES COMMISSIONER

Annual Report

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STAFF OF THE HEALTH SERVICES COMMISSIONER AT 30 JUNE 2002

Position	Staff
Manager Executive Services	Michael McDonald manages the implementation of the Health Records Act (HRA) and corporate support services.
Chief Conciliator	Teresa Punshon manages the conciliation unit.
Manager, Assessment & Investigation	Lynn Griffin manages the assessment, acceptance, resolution and referral of all new complaints.
Registrar	Shiranee Sinnathamby liaises with the professional Registration Boards, assists the Manager, Assessment & Investigations and manages FOI requests.
Senior Conciliators	Keith Jackson and Kath Kelsey supervise conciliators in their casework and conciliate the more difficult cases.
Conciliators	Orysia Ckuj, Christine Lalor, Alex Crozier, Koula Louras, Lynn Buchanan assist parties with a complaint to reach a resolution in a confidential and privileged setting.
Aboriginal Liaison Officer	Melanie Fraser supervises, monitors and conciliates complaints concerning indigenous Australians and conducts outreach work.
Inquiry Officers	Heather Andrew, Jill Aitken, Anna Boulton, and Piotr Nyczek receive inquiry calls, case manage complaints in the early stages and provide advice to health service users and providers.
Legal Policy & Project Officer	Fahna Ammett assists in the implementation of the HRA including educating and training health service providers and holders of health information. She also Provides legal advice to the Commissioner and oversees Freedom of Information requests.
Project Officer	Susan Joseph assists in the implementation of the HRA including educating and training health service providers and holders of health information.
Corporate Services Officer	Philip Punshon provides corporate support services and oversees the Information Technology (IT) function.
Information Services Officer	Colin McKnight provides IT support and assistance to staff and hospitals.
Executive Assistant	Suzie Aron provides executive, administrative and keyboard support to the Commissioner.
Receptionist	Kate Adamson , Kate Kennedy, and Sandra Popovski (Mental Health Review Board) provided receptionist duties for the office in the 2001/2002 financial year.

COMMISSIONER'S SUMMARY

This year the Office of the Health Services Commissioner (HSC) has been extremely busy. The office receives a very high number of requests for presentations and in the year under review these amounted to 151. This is pleasing because HSC is becoming better known which is consistent with our duty to be accessible. As well, the passing of the *Health Records Act* 2001, with implementation date of 1 July 2002, has meant the office deals with a broader group of stakeholders than was previously the case. In the past HSC dealt with health service providers and consumer groups. The Health Records Act covers any person or organisation who holds health information and HSC has been in regular contact with insurers, schools, employers and many others.

The restructuring of the office, which began last year, has begun to affect the workload of staff in a positive way. Many more cases are proceeding to conciliation at an early stage and the staff have been most inventive in finding ways of speeding up the complaints process. Delays do still occur and we are always looking for ways to try to minimise these as speedy complaints resolution is important for a successful outcome.

The HSC continues to have cordial and cooperative relationships with all twelve disciplinary boards including the Medical Practitioners Board, Dental Practitioners Board, Psychologists Registration Board and the Nurses Board. As well as being useful in complaints handling, these discussions assist in policy development and in nurturing quality improvements in our health services.

Most people who come to the HSC with a complaint are seeking quality changes. For this reason the Commissioner is involved in quality initiatives at the state and national levels. The establishment of the Victorian Quality Council within the Department of Human Services has been an important initiative and the Commissioner has been included on an advisory group to help set the Council's agenda. The Commissioner is also a member of the Working Committee of the Australian Safety and Quality Council's Open Disclosure Project. The Project will develop standards to allow hospitals and others to provide accurate open information to patients, their families or carers in the event of an adverse outcome.

The Commissioner continues to have a strong interest in the work of the complaints liaison officers and is a member of the Health Services Liaison Association Committee (HSLA). The HSC offers orientation and training programs for anyone who deals with complaints handling. HSC also provides the venue for HSLA Committee meetings.

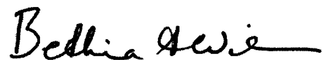
I take this opportunity to thank the members of the Health Services Review Council (HSRC) who have continued to provide expert advice and support. During the year under review Anthony Seyfort and Dimity Fifer left the Council and their work and advice is much appreciated.

Staff of the HSC continue to benefit from in-house training seminars. This year the presenters were:

Sandy Dean, Woundscope, Melanie Hendrata, Sentinel Events Project, Rural and Regional Health, Department of Human Services, Sonia Simpson, Manager Professional Conduct, NSW Medical Board, Professor Paul Mullen and Dr Grant Lester, Forensicare, and Professor Stephen Cordner, Victorian Institute of Forensic Medicine.

Tribute to Pamela Gilbert

During the year under review Pamela Gilbert, who worked with the HSC since 1990 until her resignation on 14 August 2001, accepted a position within the Department of Human Services. I take this opportunity to thank Pamela for the work that she did during those years and to wish her well in her future endeavours.



Beth Wilson
Health Services Commissioner

HEALTH SERVICES REVIEW COUNCIL PRESIDENT'S REPORT 2001/2002

Issues relating to complaints and litigation in the health system have featured in the media over the last 12 months.

The crisis in medical indemnity and insurance, the escalating costs of litigation and claims and the need to ensure greater focus on prevention and risk management have received much examination by Federal and State Governments and their agencies.

The Council has been gratified to note that throughout those substantial discussions, forums and meetings, there has been consistent and substantial support for the role and functions of the Health Services Commissioner, as that office operates in Victoria. This is in no small part due to the way in which the present Commissioner conducts her role.

We note the initiatives announced by the Victorian Government to address these concerns - notably the foreshadowed legislation on "Open Disclosure" which will assist in promoting more effective communication between doctor and patient after and adverse incident.

Whilst there is much to be done in restructuring the medical indemnity industry, our framework for dealing with complaints and claims and systems for redress for those who suffer injury, we should not lose sight of the need for quality and safety, appropriate risk management measures, and appropriate responses to complaints of adverse events or injuries when they arise.

THE COUNCIL

The Council has undergone some revision during the last twelve months, following amendments to the Health Services (Conciliation and Review) Act 1987.

The Act now requires the Council:-

1) To advise the Minister on the health complaints system and the operations of the Commissioner;

2) To provide expertise, guidance and advice to the Commissioner;

3) To promote the Commissioner, the operations of the Commissioner, and the guiding principles;

4) To advise the Minister and the Commissioner on issues referred to the Council by the Commissioner;

5) With the Minister's approval, to refer matters relating to health service complaints to the Commissioner for inquiry.

The Council is pleased to see this review of its functions, following extensive consideration and consultation.

MEMBERSHIP

As at 30 June 2001 the Council comprised:-

Mr Michael Gorton (President)
Dr Paul Nisselle
Ms Pamela Barrand
Ms Julie Rolfe
Dr Helen Rabbette
Ms Marcia Coleman
Mr David Brous
Ms Lou Tehan
Ms Kathy Wilson

The Council is comprised of representatives of providers, users and independent people in relation to the health system. Following enactment of the Health Records Act 2001, the Council was expanded to include a representative with experience of matters affecting the privacy of individuals in relation to health information, and a person with experience or an ability to represent the interests of organisations that handle health information.

During the year we were saddened by the death of Mr Neil Wighton Naismith, who had been a member of the Council for many years, and contributed greatly to the work of the Council, as well as many other community bodies. His contribution will be missed.

We also note the resignation of Ms Dimity Fifer and Mr Anthony Seyfort, two other long-standing members of the Council, who made a valuable contribution to the work of the Council over several years. We thank them for their great support of the Council and their efforts, and offer our best wishes to them for the future.

HEALTH SERVICES (CONCILIATION AND REVIEW) (AMENDMENT) ACT 2001

This amending legislation drew to a conclusion the work of the Council and the Government in relation to reform of our legislation.

Following release of a Discussion Paper by the Minister for Health, there was extensive consultation with community groups and the health sector generally.

As a consequence, draft legislation was developed taking up many of the issues raised by the Council and others.

The Council supported the new legislation and we were delighted that it received bipartisan support in the Victorian Parliament.

The Council participated in the Working Party, which developed the Discussion Paper, and assisted during the consultation and a drafting exercise in relation to the reform legislation.

The legislation amends the role and functions of the Council. It increases the functions and powers of the Commissioner and makes a number of administrative changes which will greatly enhance the effectiveness of the legislation.

HEALTH RECORDS ACT 2001

Following enactment of the Health Records Act 2001, the Council membership was increased to include representation of consumers and holders of health information. The Council has, with the Commissioner, participated in briefings and consultations promoting the legislation, which commenced on 1 July 2002. We note that the Commissioner conducted a number of consultations with major stakeholders, including consumers, doctors groups and health institutions, employers and others. Members of the Council were able to participate in those consultations.

We congratulate the Commissioner on a smooth introduction of the legislation, noting the substantial education and information campaign which preceded its enactment.

The Council has developed a number of initiatives which it will be implementing over the next 12 months to further monitor the progress of the legislation and any issues which it may raise.

"BEST PRACTICE" GUIDELINES FOR COMPLAINT HANDLING

In our last report the Council noted that it was developing proposals to support the training and education functions of the Commissioner. Council emphasised the need to ensure that health institutions were better guided and assisted to properly deal with health care complaints at source. By dealing with complaints early and on site, it was hoped that health institutions would reduce the cost, delay and effort required in dealing with formal complaints once they were elevated to complaints to the Commissioner or, indeed, litigation.

We are delighted to report that the Council has secured funding for a 12 month project to develop "Best Practice Guidelines" for complaint handling, which will involve the development of standards or guidelines for health institutions, and the Council will pilot implementation of the guidelines with appropriate monitoring and review.

It is hoped that the project will therefore develop materials which greatly aid hospitals and other health institutions in dealing with complaints at source.

The project will be managed jointly by the Council and the Commissioner's office, and the Council will consult regularly with a stakeholders group comprising representatives of consumers, health institutions, insurers and Government.

We thank the Minister and the Department for assisting the Council with funding for this project.

WORKING WITH THE COMMISSIONER

The Council continues to work to support the Commissioner and her office. It works closely with the Commissioner and her staff.

The Council again notes the extensive work carried out by the Commissioner, Beth Wilson, in relation to information and education, and in particular, making herself accessible to a wide range of community and health industry groups. Her level of activity has increased significantly, with the introduction of the Health Records Act. We note that the support and response she receives from these groups is substantial. As a result of her strenuous efforts, the office of the Commissioner remains valued by the community.

As noted, the Victorian model is held up as an example for complaint handling. We note the strong support advocated by medical groups and doctors groups in particular, who believe that the Victorian model represents a more cost effective way of dealing with health care complaints and in avoiding recourse to litigation. The conciliation success rates achieved in the Commissioner's office are a testament to the hard work of Beth Wilson and her staff.

During the year the Council worked with the Commissioner in relation to the information and education campaign leading up to the enactment of the Health Records Act.

The Council provided advice and assistance to the Commissioner in relation to a number of issues which arose during the course of the past 12 months including medical indemnity, consumer complaints, cosmetic surgery issues and complaint prevention.

The Council provided advice to the Commissioner in relation to the report recently released by her in respect of the Royal Melbourne Hospital. That report is now in the hands of the Minister, and we are pleased that the Government has now accepted and are implementing the Commissioner's recommendations.

SPECIFIC ISSUES

The Council had occasion to deal with a number of specific issues during the last 12 months, notably:-

1) Issues arising from the Health Records Act, and potential conflict with the Commonwealth Privacy Act;

2) Advice to Government and to the Opposition Spokesperson in relation to the Health Services (Conciliation and Review) (Amendment) Bill 2001;

3) Participation in the "Open Disclosure Project" of the Australian Safety and Quality Council - a project seeking to establish guidelines permitting doctors and health institutions to apologise and enter into frank discussions with patients after an adverse incident. We note that the Victorian government has foreshadowed the introduction of "Open Disclosure" legislation for this year;

4) Working with the Commissioner to analyse and review the various statistical information and data maintained by the Commissioners office, to identify trends in complaints.

The Council also assists on an ad hoc basis, by consulting with the Commissioner, in relation to various submissions and material which the Commissioner issues from time to time.

THANKS

At the time of consideration of the amending legislation before the Victorian Parliament, we were gratified by the support from parliamentary members for the work of the Commissioner and the Council.

> "The Health Services Review Council plays an integral and vital role in its relationship with the Commissioner and the Minister.... it is important that Victorians have a safe and secure health system and feel that they have some comeback and an opportunity for criticisms where it is due, to be able to air grievances and know that the grievances and problems can be dealt with security and confidentiality".
>
> Honourable Andrea Coote MLC (former Council President)

Council is grateful for the support shown for its work by the Victorian Government and by Parliament.

We again recognise the boundless energy of Beth Wilson, as Health Services Commissioner and the great support she receives from her staff. They are to be congratulated for another successful year. Those staff also assist the Council in its work and deliberations, for which we are grateful.

We have had great support from the Minister and the Department, and particularly note the funding now available to the Council for its project, which we hope will have a significant impact on complaint handling in Victorian health institutions.

Finally, I congratulate and thank my fellow Council members, who have given much of their time and energy on the many tasks of the Council. Unfortunately for them, the level of activity of the Council continues to increase.

Michael Gorton
President
Health Services Review Council

STATUTORY FUNCTIONS

THE ROLE OF THE COMMISSIONER

The HSC was established in Victoria in 1988. The Commissioner's role is to receive, investigate and resolve complaints from users of health services, to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The *Health Services (Conciliation & Review) Act 1987* states that the Commissioner is to:

a) deal with users' complaints; and

b) suggest ways in which the guiding principles may be carried out and help service providers to improve the quality of health care.

The purposes of the Act include:

a) to provide an independent and accessible review mechanism for users of health services; and

b) to provide a means for reviewing and improving the quality of health service provision.

GUIDING PRINCIPLES

The guiding principles of the Health Services (Conciliation & Review) Act promote:

a) quality health care given as promptly as circumstances permit; and

b) considerate health care; and

c) respect for privacy and dignity of persons being given health care; and

d) the provision of adequate information on services provided or treatment available in terms which are understandable; and

e) participation in decision making affecting individual health care; and

f) an environment of informed choice in accepting or refusing treatment or participation in education or research programs; and

g) reasonable access to information in records relating to personal use of the health care system except information which is expressly prohibited by law from being disclosed or information contained in personal notes by a person giving health care; and

h) the confidentiality of personal health records.

EXPECTATIONS AND STANDARDS

The guiding principles establish the range of responsibilities for health services and the basis upon which a person might complain that a breach of these responsibilities has occurred. They establish a framework for the HSC to become involved in improving health services and reporting on the problems identified and the improvements made.

HEALTH RECORDS ACT 2001

The HSC is also responsible for the implementation and administration of new legislation dealing with privacy of an individual's health information. The *Health Records Act* 2001 commenced on 1 July 2002. The purpose of the Act is to promote fair and responsible handling of health information by:

(a) protecting the privacy of an individual's health information that is held in the public and private sectors; and
(b) providing individuals with a right of access to their health information; and
(c) providing an accessible framework for the resolution of complaints regarding the handling of health information.

From 1 July 2002 organisations holding health information must manage the health information they hold, which relates to individuals, in accordance with the Health Privacy Principles in the *Health Records Act* 2001, subject to any specific provisions about the management of health information in any other Act.

Individuals are now able to seek access to their health information held by any person or organisation that holds it in the private sector (The *Freedom of Information Act* 1982 continues to provide a mechanism for individuals to seek access to their health information held by public sector organisations).

Complaints by individuals about an interference with their privacy because their health information has not been managed in accordance with the Act or they have experienced difficulties with accessing their health information, can be made to the HSC. The HSC can assess complaints and if a complaint is accepted it may be conciliated or investigated.

OTHER STATUTORY ROLES

The HSC provides training to a wide range of health service users and providers. This is in accordance with our functions as outlined in section 9 of the Act. A supportive working relationship exists between the HSC and the complaints liaison officers at public hospitals and many other health services in Victoria. Dialogue continues between the HSC, consumer representatives including the Health Issues Centre and health service providers and their associations.

LIAISON, TRAINING & PROMOTION

The HSC consults regularly with the 12 professional Registration Boards about complaint handling in accordance with section 19(6) of the Act. Regular meetings between the HSC and the Boards are held to determine the most effective and

efficient ways of handling complaints about registered practitioners. This process avoids double handling and ensures the legislative requirements are met. The Commissioner also discusses relevant issues with the Ombudsman, the Mental Health Review Board, the Intellectual Disability Review Panel, the Office of the Public Advocate, the Coroner, the Commissioner for Equal Opportunity and other relevant authorities. These links assist our work, especially where the management of complaints involves more than one office.

The Commissioner places strong emphasis on promotion and training to improve accessibility of the HSC to the public and health service providers. During the year under review the HSC has been represented at many conferences and venues to promote the work of the Office. The Commissioner gave addresses, lectures and training at over 100 venues. Consumers of health services from the non metropolitan regions, children and adolescents, Koori and Aboriginal Australians and people from non English speaking backgrounds have been under represented as complainants and an outreach program has been introduced to make the service accessible to them. The HSC brochure has been produced in 15 languages. The employment of a full-time Aboriginal liaison officer has assisted with this. Summary of her work appears in this report.

OVERVIEW OF COMPLAINTS

Throughout this Annual Report anecdotal information has been used to illustrate the types of complaints received. **Details have been altered to protect confidentiality** and, wherever possible, actions taken or resolutions achieved have been indicated. Outcomes cannot be indicated where the matter is still in progress.

PUBLIC INTEREST ISSUES

Complaints can indicate trends within the health care system that have implications for the general public. Public interest is defined by the following criteria:

1. The circumstances outlined in the complaint are likely to affect a significant number of people.

2. These circumstances impact on certain population groups.

3. The complaint is indicative of a systematic flaw or the result of a deficiency in policy or procedures.

4. The complaint raises an issue that is individual in nature but that occurs unreasonably often, suggesting a systemic problem exists.

These criteria have been used to highlight complaints as they move through the system so the public interest issue may be given appropriate attention in conjunction with the individual's complaint. A review of complaints so labelled has highlighted a number of issues.

Misleading advertising

The HSC has received complaints from people who believe they have been misled by advertising and have paid high prices for medical procedures without the desired outcomes. Examples of such services include some impotency clinics and clinics providing cosmetic treatments such as Botox injections and liposuction.

On January 29, 2001 the HSC cooperated with the ACCC by participating in a Web Sweep looking for health services and products making unrealistic promises. The HSC has also cooperated with the ACCC using a shared Memorandum of Understanding by arranging for consumers with concerns about advertising to be referred to the ACCC.

Staff employed by clinics offering health services contacted HSC concerned about advertising practices they found unethical and possibly unlawful. HSC does not have jurisdiction to receive complaints from employees unless they have the consent of patients. The ACCC and the Medical Practitioners Board of Victoria can deal with such complaints and complainants were given guidance to assist them to make complaints to these organisations.

People continue to raise issues about the cost of health services. Those who are privately insured are concerned about the high costs they face after contributions from their funds. Those who rely on bulk billing are also commenting that clinics are no longer offering this service. This is even more of a problem for people in rural areas who have little or no alternatives in health services.

The HSC has limited powers to assist such people and is concerned that their health needs are not being met. Where appropriate they are referred to agencies such as the Health Insurance Ombudsman or the ACCC and the HSC to bring these concerns to the attention of appropriate policy makers, government and professional associations.

A woman complained that the Clinic in her town had changed hands and would now only offer bulk billing to aged pensioners. She said that she lived on a very limited income and often could not afford to pay at the time of consultation. With the encouragement of HSC she asked her doctor if allowances could be made for her to pay her account within two weeks of a consultation. The doctor agreed to this arrangement.

ANALYSIS OF COMPLAINT TRENDS

2001/2002 SUMMARY

In the past, potential complaints were counted once as telephone calls and again as complaints when they were entered onto the database. To achieve greater data reliability a new practice was adopted and appears in this report. Complaints are now counted either as telephone calls or as they were received in writing. This could make it look as if fewer complaints were received during the period under review than in the previous period. Such a comparison would be invalid, as the old system reported the amount of work done by the Office while the new system reports the number of complaints actually handled.

Complaints and enquiries are received on the telephone, by mail and in person. Some of these involve giving advice and information and are recorded as enquiries. People who make complaints about health services are sent a complaint form and the details are recorded as a case on the database. About one half of these initial contacts go on to become managed complaints (cases) when a complaint form is returned. The total number of enquiries and cases for 2001/2002 is 7891.

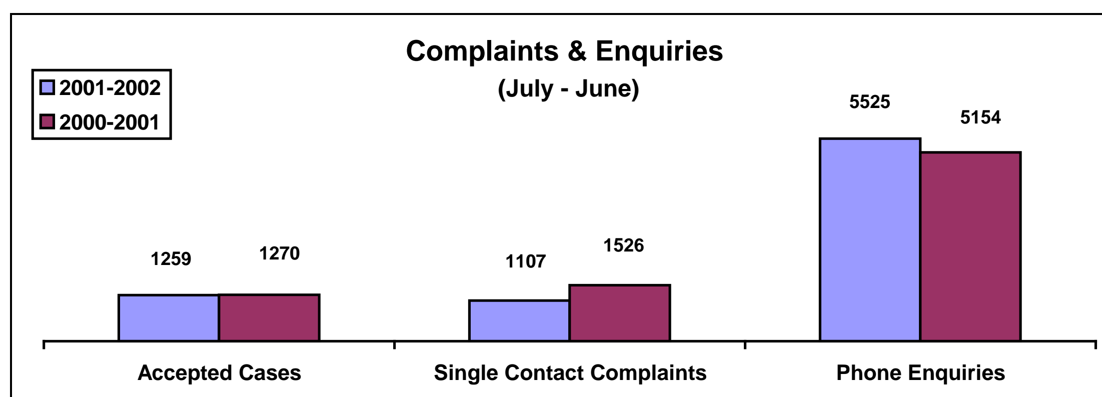
When a complaint is made, a prompt and courteous response and, where appropriate, an apology assists the matter to be resolved promptly. On the other hand delays, secretiveness, refusals to respond can escalate disputes. The Commissioner is grateful to all providers who responded to complaints and assisted in their resolution. Thanks are also due to those who take the time and effort to lodge a complaint. All parties are urged to view complaints in a positive way so they can raise important issues and lead to quality improvements. Most complainants are seeking improvements in services and they tell HSC they want to know what went wrong and why, and they seek reassurance that what happened to them will not happen to someone else.

Table 1 below shows the complaints and enquiries received by the Commissioner during 2001/2002 and Figure 1 gives the number of complaints and enquiries for the past two years.

Table 1. New Complaints and Enquiries

	Complaints		
Enquires by telephone	**Single contact**	**Accepted Cases**	**Total**
5525	1107	1259	7891

Figure 1. Complaints & Enquiries



In 2001/2002 the total number of enquiries was 5525 compared with 5154 in the previous year. This is an increase of 371 or 7% over the previous year. While the number of overall complaint calls and letters decreased from 2796 in 2000/2001 to 2366 in the year under review, the number of accepted cases (1259) was similar to that of the previous year (1270). As in previous years approximately half of the complaints received by HSC are closed following a single contact. The other half proceed to become accepted cases.

ENQUIRIES

An enquiry is defined as a contact with the Office that is usually outside of HSC jurisdiction and is not considered to be a complaint case. A telephone enquiry can often be answered immediately as the caller is given advice or referred appropriately.

In the period from July 2001 to June 2002 the Office received 5525 telephone enquiries. Thirty three percent of callers were referred to other agencies. The remaining 67% related to:

- 14% fees
- 10% to food and environmental health issues
- 11% concerning access to records
- 32% concerning health insurance issues and the remaining related to public hospital waiting lists and aboriginal enquiries.

SERIOUSNESS

Although all complaints are serious to the individuals concerned, and all are handled with diligence, for management purposes complaints are rated on a scale for seriousness when they are first accepted by the Commissioner and again when they are closed. It is often difficult to assess seriousness at the start of a complaint. This practice of revising the rating at the time of closure has led to fewer complaints being rated as highly serious and to more being rated lower on the scale. The seriousness of complaints is not necessarily correlated with the amount of time and resources required to resolve a matter. It is not uncommon for less serious complaints to consume large amounts of time and for serious complaints to be resolved comparatively easily.

Complaints often raise more than one issue and it is only the primary issue, which is reported here.

Seriousness Rating

During the year under review HSC changed the database used to manage complaints. The new system has a three-point rating: High, Medium and Low. This differs from the 5 point rating of previous years recorded as serious, substantial, routine, minor and trivial. The new ratings are:

1. **Low**: the problem should be easily resolved by a phone call or letter and an explanation. Included are complaints that are frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.

2. **Medium**: there has been a misunderstanding; issues frequently involve access to records, disputes about costs, discourtesy, diagnostic or treatment errors without serious sequelae.

3. **High**: there are significant quality assurance implications, changes in practice are needed to avoid a recurrence or there is a need for policy development. These also include complaints associated with personal injury, professional misconduct, unlawful or unethical acts, lack of informed consent with serious adverse outcomes.

Table 3. Seriousness by Issue at Closure

	Low	Medium	High	Total	
Access	112	126	55	**293**	12%
Administration	24	12	12	**48**	2%
Communication	128	111	60	**299**	13%
Cost	103	23	25	**151**	6%
None	66	62	35	**163**	7%
Rights	88	78	57	**223**	9%
Treatment	364	583	267	**1214**	51%
Total Closed	**885**	**995**	**511**	**2391**	100%
	37%	42%	21%	100%	

During the period under review 2391 complaints were closed of which 995 (42%) of complaints were regarded as medium, 885 (37%) low, and the remaining 511 (21%) high. Of the complaints regarded as highly serious 267 (52%) involved treatment issues, 57 (11%) rights issues, 55 (11%) access issues, 60 (12%) communication issues and 12 (2%) administration issues.

Treatment issues regarded as highly serious primarily consisted of inadequate treatment (34%), negligent treatment (15%), inadequate diagnosis (15%) and unskilful or incompetent treatment (14%).

COMPLAINTS

In the twelve months under review the Office received 2366 new complaints comprising 1107 single contact complaints, where the complainant is encouraged to approach the health service provider to seek a resolution, and 1259 complaints (accepted cases), which were confirmed in writing.

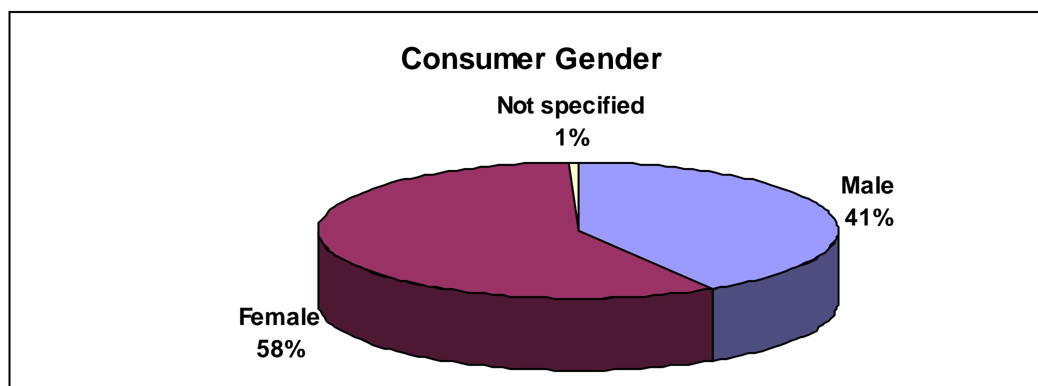
WHO COMPLAINED?

A complainant is defined as the person who makes the complaint. This is most often the patient or user of the health service. Women complained and were nominated as the consumer in complaints more often than men. While we do not know why this occurs it may be because women are more frequent users of health services and because they also tend to be the carers of people using health services.

Table 4. Consumer Profile

Age Range	Female	Male	Unknown	Total
01 to 04	17	17	0	**34**
05 to 14	10	14	0	**24**
15 to 24	48	31	0	**79**
25 to 34	107	25	0	**132**
35 to 44	100	49	0	**149**
45 to 54	134	53	0	**187**
55 to 64	69	36	0	**105**
65 to 74	39	33	0	**72**
75 +	53	39	0	**92**
Unknown	797	683	12	**1492**
	1374	**980**	**12**	**2366**

Figure 2. Consumer Gender



HOW COMPLAINTS ARE MANAGED

The Act requires that complaints made on the telephone or in person be confirmed in writing. Assistance is offered to people needing it, however many preliminary complaints are not confirmed in writing or the complaint form is not returned. The legislation anticipates that consumers will attempt to resolve issues themselves wherever possible and staff advise complainants, where appropriate, to make direct contact with the service provider. It is expected that many of the unconfirmed complaints are resolved in this way.

Table 5. Resolution Stages

Stage of Complaint Process		%
Closed in Enquiry (Single Contact Complaints)	1011	42%
Closed in Assessment	1148	48%
Closed in Conciliation	231	10%
Closed in Investigation	1	0%
Total Cases Closed	**2391**	**100%**

RESOLUTION AT ENQUIRY/ASSESSMENT STAGE

The enquiry telephone line operates from 9am to 5pm, five days a week. At other times messages may be left on the answering machine. Enquiry officers are usually the first point of contact for members of the public and have a broad knowledge of health issues and, where appropriate, provide referrals to other agencies if the enquiry does not come within the jurisdiction of the HSC.

When enquiries are received by telephone, an enquiry officer listens and assesses the issue/s the caller is presenting. If the complaint is about a health service provider, and the complainant is unable to resolve the matter directly, a complaint form is sent out. The caller is asked to complete the form, sign an authorisation and give details of the complaint.

Enquiry officers record all potential complaints on the database as cases. If a complaint is not confirmed in writing, the matter is closed although complaints identified as serious may be followed up.

If a complaint is from a person from a non-English speaking background the enquiry officer may access interpreter services and assist the complainant in lodging the complaint. Enquiry officers also interview prospective complainants when they present in person.

Confirmed complaints are entered on the database in detail, including a summary of the complaint. A hard copy file is made up and an acknowledgment letter sent to the complainant. The complaint is sent to the health service provider who is asked to respond within 28 days. A response may be in writing directly to the complainant or sent via the HSC depending upon the circumstances. The majority of complaints are resolved at this stage. A provider may prefer to arrange a meeting with the complainant in an endeavour to resolve the matter.

A man complained that a crown made by his dentist did not fit properly and caused discomfort when eating. The dentist responded by saying the crown was well made and that the man would get used to it. The man sought a second opinion that confirmed that the crown was of an acceptable standard, but suggested some modification to another tooth to assist the bite. The first dentist agreed to this suggestion and provided the treatment at a reduced cost to resolve the complaint.

Table 6 below shows the broad resolution categories for these complaints.

Table 6. Resolution in Assessment

Outcome	2000/01	2001/02
Declined	12%	20%
Referred elsewhere	2%	7%
Withdrawn by user	2%	0%
Investigation unwarranted	2%	0%
Unsubstantiated	7%	0%
Remedial action	4%	0%
Fee waived/reduced	4%	0%
Procedural change	3%	1%
Explanation offered	59%	47%
Apology	5%	2%
Concern registered	0%	6%
Costs refunded	0%	2%
Objective Not Obtained	0%	3%
Referred to Board	0%	7%
Service obtained	0%	2%

As in previous years, the most common means of resolving complaints, in the initial stages, is through the provision of an explanation.

From 1 July 2001 the work practices of the Office were re-structured. This has meant complaints that have not been resolved informally in the first phase may be assessed as appropriate for conciliation.

CONCILIATION REPORT

The year under review has been especially demanding because of internal restructuring and reworking of the complaint handling process. In addition, there have been legislative amendments which have enhanced the capacity of the Commissioner to deal more effectively with the conciliation of complaints.

As a result, many more complaints are referred into conciliation at a much earlier stage. This has been a positive initiative as, early intervention in often difficult and multifaceted circumstances, increases the opportunities for constructive outcomes. In addition, a large number of complaints, previously on waiting lists at different stages within the Office, were referred into conciliation at the commencement of this period. As a result, the conciliation team expanded from 3 to 6 conciliators with the addition of an administration officer to manage the increased workload.

Although the types of complaints referred to conciliation varies widely, a number of recurring issues emerge. The most significant of these continues to be failures of communication between some health service providers and their patients.

A woman complained she was unable to obtain consistent information from her son's treating doctors as to the circumstances surrounding his death. The providers gave conflicting information which led the family to form the opinion that the doctors were negligent in their care of the patient.

Issues about errors in diagnosis are also frequently raised.

A man, suffering from continuous chest pain complained about having to see a specialist for a number of years following an unsuccessful operation. The doctor told him he would have to live with his condition. The man sought a second opinion and was diagnosed with a large hernia within the chest region which was treated successfully.

Conciliation continues to be regarded by health service consumers and providers as a successful mechanism for the resolution of complaints, including matters that might otherwise be dealt with by litigation. The level of co-operation of parties with the conciliation process is high and there is considerable recognition that the processes are impartial and fair. Many health service consumers have expressed a preference for conciliation even though they have the option of formal litigation. They view conciliation as a "gentler" or more therapeutic form of jurisprudence than the more adversarial approach.

Two hundred and thirty one complaints were closed in conciliation in this period. Ninety two percent were resolved, one per cent was referred to registration boards from conciliation and the remaining seven per cent were non-conciliable.

Table 7. Resolution by Conciliators

Conciliation	2001/02	2000/01
Resolved	**92%**	**89%**
Apology given	6%	0%
Change in procedure/policy	1%	0%
Compensation	20%	0%
Explanation/Information provided	65%	0%
Referred to Board	**1%**	**0%**
Non-conciliable	**7%**	**11%**
	100%	**100%**

REGISTRAR'S REPORT

The structural changes within the office resulted in the Registrar being able to devote a larger proportion of time to engage in discussions with the 12 professional Registration Boards in relation to complaints handling.

The Boards now send complaints to the HSC on a daily basis. This allows discussion of those complaints within a week or less of a Board complaint being received. Similarly, HSC complaints are sent to the Boards regularly for early discussion.

Regular meetings with the Registrars of all Boards have been ongoing. This exchange of information has resulted in complaints received by Boards, which are suitable for conciliation by the HSC, being referred to the Commissioner without delay and complaints received by the Commissioner, which fall into the category of unprofessional conduct, being referred by the Commissioner to the relevant

Registration Board either at the very early stage of the complaint or following receipt of a response from the provider. Following the formal referral of a complaint to a Board the file is closed. However, complainants are aware that, following the Board's investigations, it is possible for the file to be re-opened to address the compensable issues. In the same way, the Boards refer to the Commissioner any complaints considered to be more suitable for the Commissioner to consider.

During the year under review 597 HSC complaints were discussed with the Registration Boards with 71 of these being referred formally to the Boards – almost as many referrals as in the previous year. Sixty-one of the referrals were to the Medical Practitioners Board of Victoria. Similarly, a large number of the Boards' complaints were sent to the Commissioner for comment. Two hundred and ninety seven came from the Medical Practitioners Board. Out of a total of 45 HSC complaints, which were discussed with the Dental Practice Board of Victoria, 6 were referred formally for consideration by the Dental Board. The remaining seven HSC referrals were shared by the Pharmacy, Chiropractors, Physiotherapists and Nurses Boards.

The Registrar's functions include the approval and assessment of new complaints received in the office and providing advice and support as a member of the Assessment Team as well as managing the FOI function. There was a marked increase in the number of FOI requests processed in the last financial year. In comparison with the previous year's three FOI requests, during the past year, fifteen FOI requests were processed involving twenty-eight files. This increase coincided with the publicity given to the Health Records Act 2001.

Waiting list practitioners

There has been some concern about the practice adopted by some chiropractors of signing up patients on long-term treatment plans and committing patients or their relatives to payment plans commencing with down payments. The concern is because some of the patients are infants or very young children who may eventually be damaged by long-term treatment, which in some cases, are found to be unnecessary.

Complaints of this nature are more suitable for the Board to consider and are therefore, referred. In the event that the treatment was found to be unnecessary those complaints may be referred back to the Commissioner for issues about refunds or compensation to be addressed.

ABORIGINAL LIAISON OFFICER'S REPORT

The year under review has seen a number of changes to the Aboriginal Liaison Officer's (ALO) role and function. This has improved significantly the services provided to Aboriginal and Torres Strait Islander consumers and providers of health services.

In July 2001, the ALO was relocated from the enquiries area to the Conciliation Unit. This has enabled her to deal with a complaint from beginning to end; meaning that consumers and providers have dealt with one person from the moment a telephone enquiry is made through to the complaint being conciliated.

There were 62 formally lodged complaints and the most common issues complained of included:

- Inadequate/wrong treatment
- Communication
- Accessing services
- Breaches of confidentiality
- Discrimination

A major achievement was the design and production of a brochure for Aboriginal and Torres Strait Islanders entitled "Problem with a health service or the privacy of your health information?" A refrigerator magnet was also produced and both have been widely distributed. The plain language brochure received favourable feedback and was later used as a basis for designing the HSC's general brochure.

Leading up to the introduction of the Health Records Act, the ALO presented a number of information sessions to Aboriginal consumers and health providers on privacy issues and more generally about the services of the Office. It is anticipated that more outreach services will be performed in the coming year.

An Aboriginal woman complained that despite several examinations and tests being conducted, gynaecological staff at a rural public hospital failed to detect a benign tumour. She says the tumour was so large it was pressing against her spine and affecting her ability to walk.

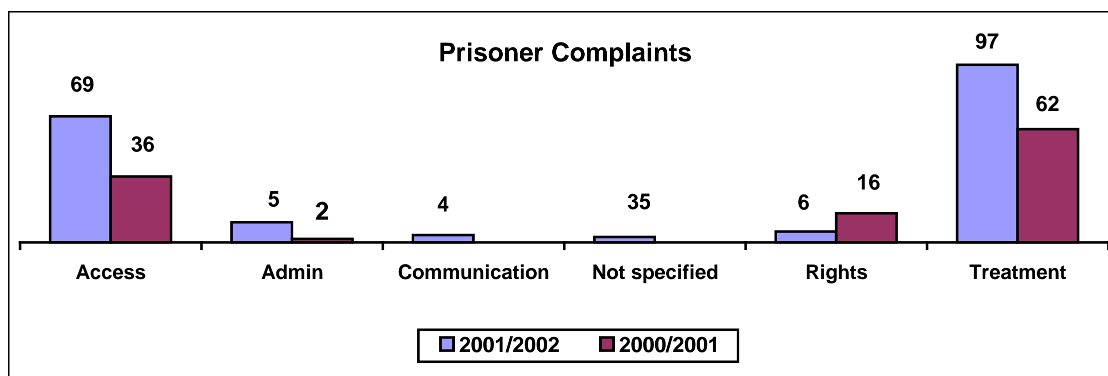
An Aboriginal man complained that an Aboriginal health service breached his confidentiality by speaking to family members about his condition without his consent. He was also unhappy that he had been banned from using the service.

PRISONER COMPLAINTS

Prisoner Complaints have risen by 64% from 116 in 200/2001 to 190 in 2001/02. Visits to metropolitan and regional prisons have continued to make HSC, accessible to prisoners.

Five metropolitan, assessment and country prisons were visited during the year. Wherever possible, attempts are made to resolve prisoner's verbal complaints on the day of the visit. About 100 complaints have been accepted and resolved during these visits. Complaints were also received in writing throughout the year.

Figure 3. Prisoner Complaints



Generally, issues of complaint remain the same as in previous years and focus on access to services including delays in treatment and on inadequate treatment. Within treatment issues, medication regimes are a dominant cause of complaint, with many prisoners wanting access to antipsychotics, benzodiazepam, and pain killing medication. Some prisoners want to change treating doctors because of medication issues, however, in these instances, prisoners are advised that medication regimes are based on the clinical judgement of the treating doctor, and HSC does not become involved.

There are also frequent complaints about accessing dental services and the waiting times to see dentists. Most prisons have only sessional dentists and prisoners are triaged according to urgency. As prisoners may have high dental needs, there is a strong demand for the services. Patients are categorised according to treatment needs and eligibility or treatment based on the length of the sentence. These criteria are clearly defined in the Department of Human Services, *Minimum Prisoner Health Care Standards.*

A prisoner complains he is unable to get dental treatment despite requesting this at least three times. He has been in significant discomfort for the last four months. His face is swollen and he is quite distressed. Contact from HSC results in an undertaking to reassess the prisoner and he receives treatment soon after.

The protocols set up between HSC, the State Ombudsman and the Prisoner Healthcare Unit at the Department of Human Services remain effective, with liaison regarding complaint management occurring routinely. The Prisoner Health Care Unit at the Department of Human Services, which monitors the standards of the provision of services to prisoners, receives copies of complaints where the prisoner agrees to this. The State Ombudsman forwards complaints to this Office where the issue concerns medical care, and complaints received by the HSC regarding correctional issues are routinely forwarded to the Ombudsman. Joint visits to prisons from the Ombudsman and the HSC can also take place. The cooperation between the two offices is a valuable means of ensuring prisoners' rights are addressed.

OUTCOMES

HOW WERE THE COMPLAINTS RESOLVED?

During the period under review 2391 complaints were closed. Forty two percent (1011) were closed at the enquiry stage, that is, a contact with the Office that did not develop into a complaint case because it was not confirmed in writing. A further forty eight percent (1148) were closed at the assessment stage and ten percent (231) closed in conciliation. One complaint was closed following a formal investigation.

Table 8. Complaint Resolution by Stage

Stage of Complaint Process	Number of Complaints	%
Enquiry Stage	1011	42%
Assessment	1148	48%
Conciliation	231	10%
Investigation	1	0%
	2391	100%

REASONS FOR COMPLAINTS

Complaints received by the Commissioner are classified according to their underlying issues. The broad categories are as follows:

Access refers to availability of services in terms of location, waiting times and other constraints that limit use of the service;

Treatment refers to diagnosis, testing, medication and other therapies provided;

Communication refers to manner of communication such as rudeness, disinterest, quality and quantity of information provided about treatment, risks and outcomes and prognosis;

Cost refers to information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;

Rights refers to rights to privacy and dignity, consent to treatment, reasonable access to records; and

Administration refers to support services for providers such as reception, waiting lists, cleaning services, etc.

Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue. In 178 complaints an issue was not specified and it is likely that these complaints were not confirmed in writing.

Primary issues in complaints 2001/2002

While the most frequently nominated issue was treatment nearly all complaints also include failures of communication**.** This year complaints about treatment accounted for 51% of all complaints, a total of 1205 compared with 1583 complaints in 2000/2001. Inadequate treatment complaints featured most prominently.

Table 9. Treatment

Treatment	**51%**
Inadequate diagnosis	168
Inadequate treatment	382
Medication	119
Negligent treatment	165
Other	30
Rough treatment	57
Unskilful/incompetent treatment	195
Wrong diagnosis	57
Wrong treatment	32
Total Treatment	**1205**

A woman complained that although she had been repeatedly reassured her breast lump was a cyst; she was eventually diagnosed as having cancer. It was shown during the course of the complaint that the woman had been referred for appropriate tests but these were all normal. The doctors explained that sometimes the outcomes of tests are not conclusive and new tests were conducted each time the cyst recurred. The delay of three months before diagnosis and treatment was not considered to have changed her treatment and prognosis.

A woman went to a public hospital for a hysterectomy. She had been expecting her ovaries would be removed and was distressed to learn, on recovery, this had not occurred. The Hospital responded by apologising for the failure in communication and reassuring her that her ovaries were healthy and it had not been necessary to remove them. She was happy with the explanation and the file was closed.

Table 10 below sets out the communication issues

Table 10. Communication

Communication	**12%**
Absence of caring	59
Failure to consult	29
Inconsiderate/undignified service	59
Other	9
Poor attitude/discourtesy	69
Wrong/misleading information	58
Total Communication	**283**

The number of complaints identified as being primarily about communication issues decreased from 350 in 2000/2001, to 283 in 2001/2002. Once again the most frequently mentioned communication issue is poor attitude and discourtesy.

A woman was taken to a public hospital by her carer. When the carer called the patient the next day she was put on hold and eventually the line was cut off. She planned to visit the next day but was called in the morning and told by a doctor that the patient had died. The Hospital explained in response to her complaint that they did not have her contact details and yet they had called her during the admission about minor matters. The Hospital apologised sincerely to the woman and explained how procedures and records had been changed to avoid a recurrence.

Table 11 below shows the types of complaints made in relation to rights.

Table 11. Rights issues

Rights	8%
Access to records	11
Accuracy of records	22
Assault	15
Discrimination	15
No/insufficient consent	24
Other	10
Privacy/confidentiality	53
Refusal to treat	18
Unprofessional conduct	31
Total Rights	**199**

Rights issues accounted for 199 or 8% of all complaints compared with 273 for 2000/2001. Rights issues included breaches of confidentiality and privacy, unprofessional conduct and failure to provide reasonable access to records.

A man complained his privacy had been breached by a receptionist at a medical centre who discussed his illness with a mutual acquaintance. He believed this had happened because the acquaintance had asked him how he was getting on since his recent illness. The practice manager responded to the HSC saying the receptionist denied telling anyone of the illness. Although it was not possible to resolve the complaint by establishing what had happened, the man was satisfied that the possible breach had been brought to the attention of the Clinic's managers.

Table 12 below sets out access issues raised in complaints

Table 12. Access issues

Access	13%
Communication breakdown	10
Delay in admission	14
Delay in treatment	88
Discharge arrangements	14
No/Inadequate service	113
Non attendance	18
Other	8
Refused admission	13
Refused to refer	3
Transfer	10
Transport	3
Waiting list	5
Total Access	**299**

Complaints about access to services increased in the year under review to 299 or 13% compared with 270 in 2000/2001. Issues raised included unavailability of services or treatment/admission delays.

A woman lives in a new housing estate with only one medical practice. When she needed to see a doctor to get a medical certificate she was unable to obtain an appointment and the receptionist suggested she simply come to the Clinic and wait. The woman says this is always at least an hour's wait and there are no alternatives for her.

A man complained that when he was injured in a traffic accident in a rural area, the regional hospital was unable to arrange to transfer him to any of the major city hospitals because no beds were available. The hospitals explained that the delay in access had occurred but had been unavoidable. The man had been admitted and treated at a large metropolitan hospital within a few days and had no ill effects from the delay.

Table 13 below sets out the cost issues raised in complaints.

Table 13. Cost issues

Cost	7%
Amount charged	54
Billing practices	51
Fraud	1
Health insurance	4
Information on costs	29
Other	3
Over-servicing	10
Public/private election	3
Total Cost	**155**

There were 138 complaints about costs in 2000/2001, compared with 155 or 7% this year. Complaints about costs are not accepted unless the complaint raises issues, such as communication, in addition to costs.

An elderly man who had been a member of a private health scheme for several years complained he was unable to pay the additional costs involved in hospitalisation. His doctor had charged him $80 for daily visits during his last admission and would not reply to his letters asking why the visits had been necessary. When the doctor learned of the man's circumstances she agreed to accept a reduced fee paid in instalments.

Table 14 shows the administration issues in complaints.

Table 14. Administration issues

Administration	2%
Advertising	5
Failure to provide certificate	6
Hygiene	7
Management Practices	13
No/inadequate response	4
Other	8
Policy	2
Quackery/legality	2
Total Administration	**47**

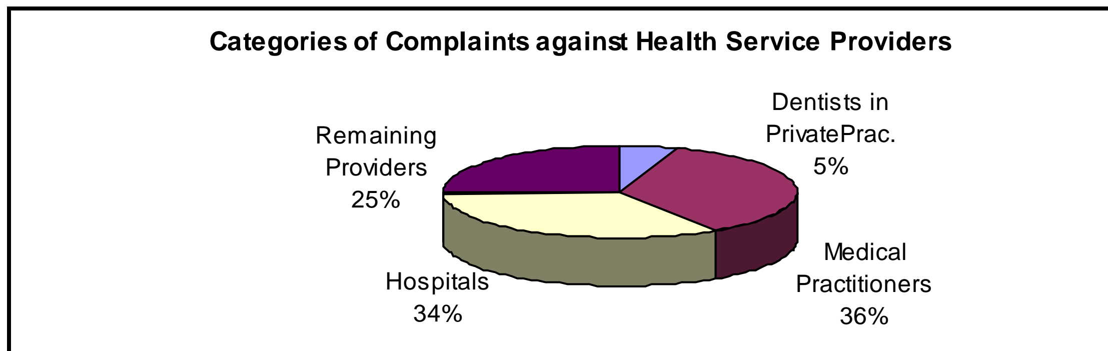
There were 47 complaints in 2001/02 about administration issues in health services compared with 58 in 2000/2001. These complaints are about the ways in which services are run rather than the medical or health components of services. Complaints include public health standards.

A woman telephoned the HSC because although she had paid for a consultation at the time of the visit, she was not given a receipt and therefore could not claim her rebate. She had made many phone calls to the Clinic but still the receipt was not sent as promised. After receiving the complaint through HSC, the Clinic sent the woman the receipt and the matter was closed.

CATEGORIES OF COMPLAINTS AGAINST HEALTH SERVICE PROVIDERS

Complaints about medical practitioners accounted for 36% of all cases. They were followed by hospitals at 34%, dentists in private practice at 5% and others 25%.

Figure 4. Categories of complaints against health service providers.



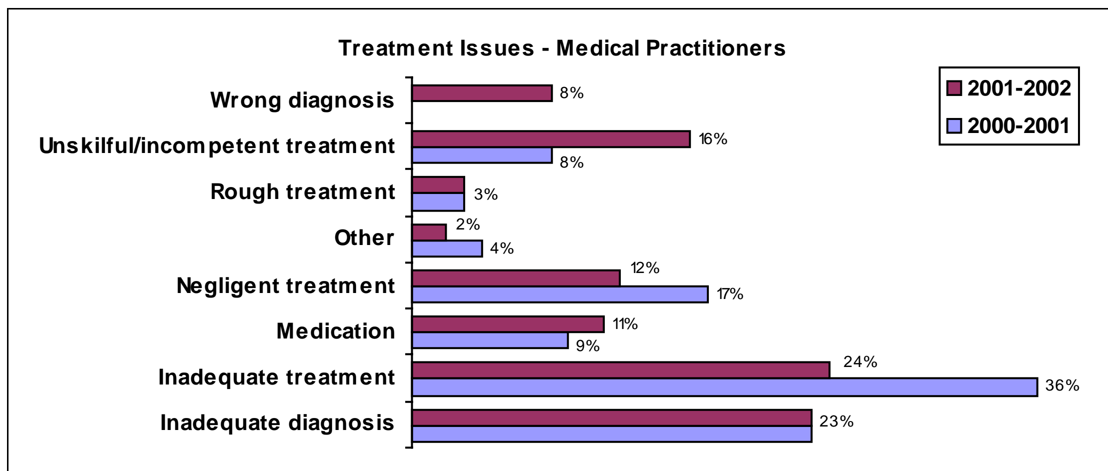
Private medical practitioners continue to be the subject of most complaints however they are, by far, the largest provider group. There was a decrease in the number of complaints this year (839) in comparison with last year, 1107. The percentage of complaints about doctors remained at 36%. Public hospitals are the next largest category. Complaints about employees of public hospitals are always recorded as a complaint against the institution rather than the individual. Doctors working from private hospitals, however, are considered to be private practitioners.

MEDICAL PRACTITIONERS

The category Medical Practitioners includes all doctors whether in specialist service provision or general practice. The most common issues in these complaints related to treatment.

Figure 5 below sets out the types of complaints about treatment made against medical practitioners over the past two years.

Figure 5. Treatment Issues – Medical Practitioners



The largest group of doctors is the General Practitioners (GPs). In 2000/2001 23% (197) of all complaints against doctors were made about GPs. Figure 6 below shows the categories of complaints made against GPs for the past two years.

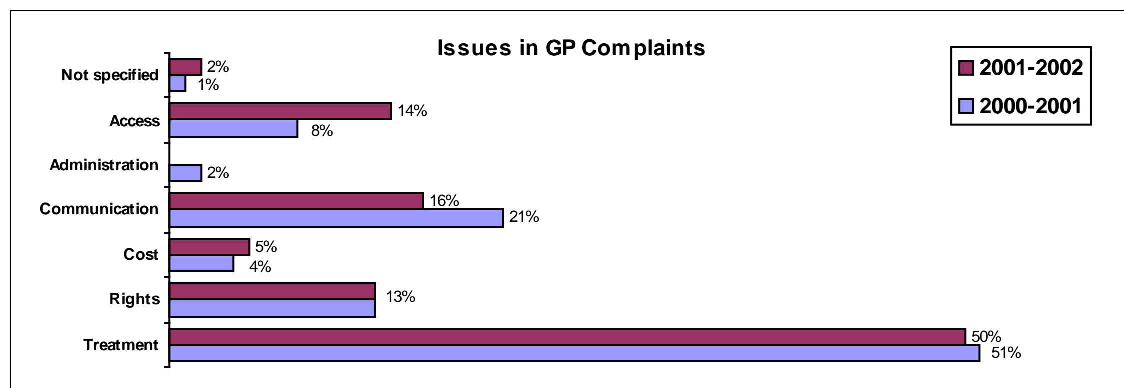
Appendix 2 lists the number of complaints about individual medical specialities

GENERAL PRACTITIONERS

The most common issues in complaints about GPs relate to treatment, recorded as inadequate treatment and diagnosis. Attitudinal problems and poor communication are also cited as cause for complaints.

A man took his infant daughter to a GP because he was worried about her persistent respiratory infection. He was upset that the doctor dismissed his concerns in a curt manner and did not examine the child. The complainant said he was aware that antibiotics were not always appropriate but he would have liked to see the doctor take some interest in the child and reassure him she was not at risk.

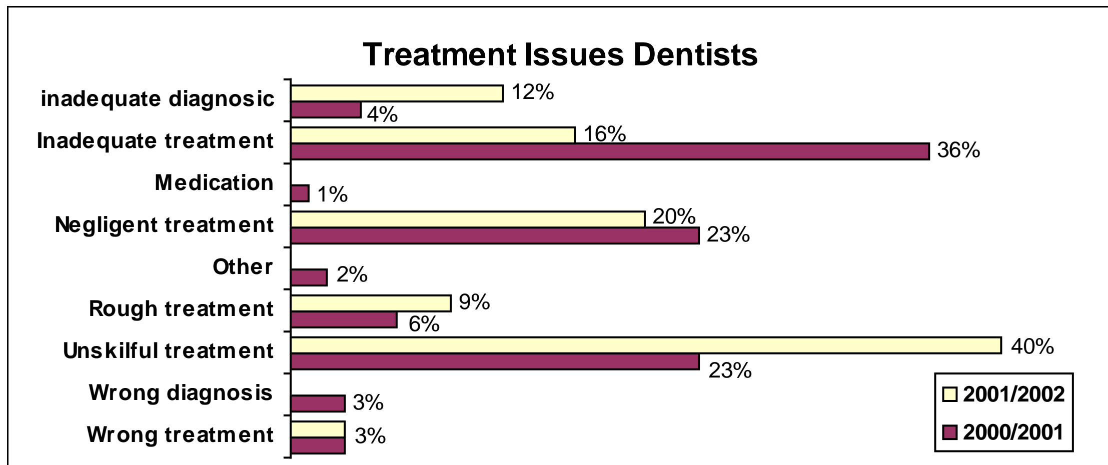
Figure 6. Issues in GP Complaints



DENTISTS

There were 126 complaints against dentists this year, 69 less than for the previous year. As in previous years, most complaints were resolved at the enquiry stage. . Treatment issues accounted for approximately 69% of the complaints with cost (12%), communication (7%), rights (5%), administration (1%) and 5% unspecified issues.

Figure 7. Treatment Issues Dentists



The treatment issues raised in complaints were mostly due to unanticipated outcomes such as infections, broken crowns and so forth. There were a small number of complaints about the outcome of cosmetic procedures and even fewer complaints about unsatisfactory dentures. There were several complaints about billing practices and it seems a few dentists are still not advising their patients adequately of the potential costs of treatment

A young woman had orthodontic treatment over a period of years. She believed the appearance of her teeth had not improved and her gums had been damaged by the treatment. The dentist offered a refund but the woman believed she might need more treatment to repair the problems. The complaint was eventually resolved in conciliation.

The HSC acknowledges the continued assistance provided by the Dental Practice Board of Victoria and the Australian Dental Association Victorian Branch in the resolution of complaints.

A woman called the HSC distressed that her husband who was working in a rural area was unable to see a dentist to treat his pain because he could not pay for the treatment in advance. She said he was being told they would only treat their existing patients or that new patients could not get credit for their first treatment. The HSC called the ADA to see if they could assist. The ADA called back with a name of a dentist willing to see the patient and the man was treated later that day.

DENTAL PROSTHETIST

There were 7 complaints against dental prosthetists, 15 less than for the last year. Issues about ill-fitting or uncomfortable dentures continue to appear as in previous years.

An elderly woman had been wearing the same dentures for many years and obtained approval to have new dentures made in a scheme subsidised by the Government. Despite many visits, she was unhappy with the new dentures and complained to the HSC seeking a refund of her costs. The prosthetist arranged for the woman to consult a dentist who said the denture was well made. She was encouraged to persist with the denture.

HOSPITALS

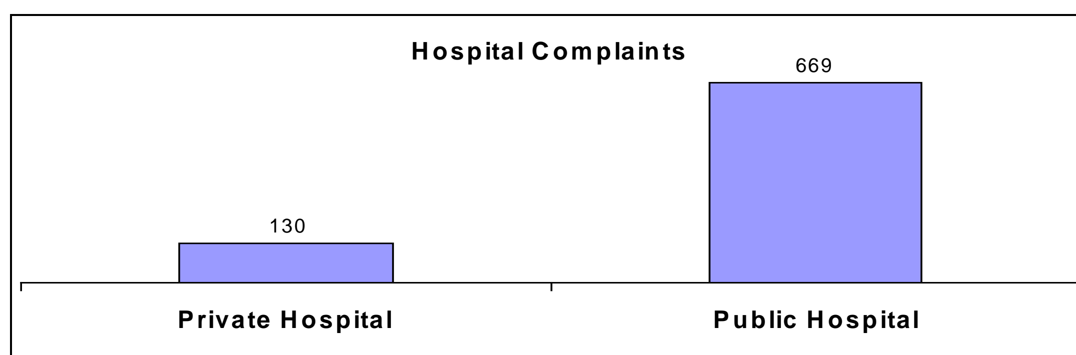
Complaints made to the HSC about hospitals

Public hospitals were the subject of 84% (669) of total hospital complaints made to the HSC and private hospitals accounted for 16% (130). This is consistent with past years. Hospitals, both public and private, were the subject of 34% of the total complaints received by the HSC in the 2001/2002 period.

All public hospitals have internal complaint handling systems. For this reason a large number of complaints are handled in-house and do not need to be referred to the Commissioner. Public hospitals are required to provide details of complaints to the Commissioner on a regular basis and these figures are reported in the section on the Health Complaints Information Program on page 31 of this report. The work of complaints liaison officers or patient representatives at the hospital level in complaints resolution is most important. There are approximately 150 of these people working in Victoria in the public and private sectors.

Figure 8 shows the number of complaints made by inpatients and outpatients of public hospitals directly to the HSC.

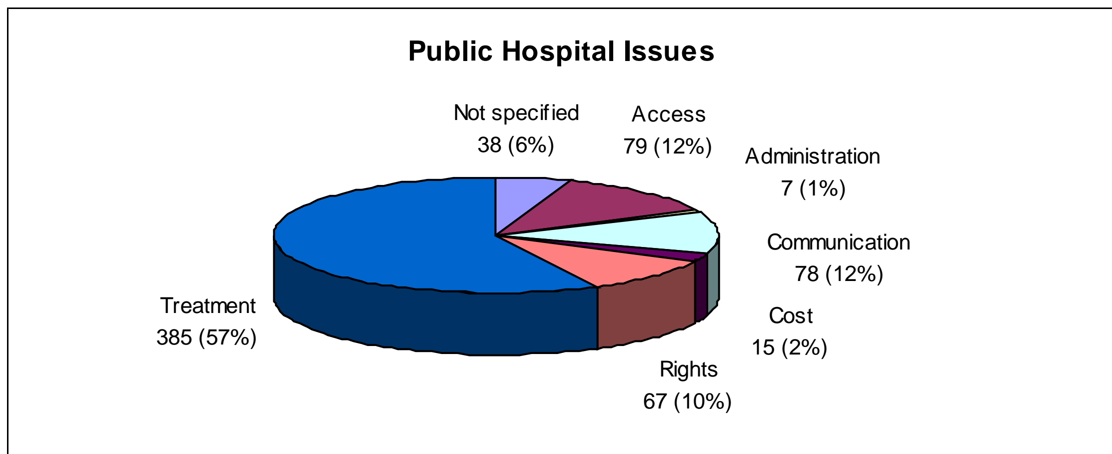
Figure 8. Public/Private Hospital Comparisons



PUBLIC HOSPITAL ISSUES

Figure 10 indicates the issues that made up complaints to the HSC about public hospitals. The most frequent issue is treatment (57%). Other issues are access (12%), communication (12%), rights (10%), cost (2%) and administration (1%).

Figure 10. Public Hospital Complaints



A woman attended a country hospital for the delivery of her baby. Her labour was long and difficult but she was reassured that all was well. Eventually it was clear she needed a caesarean section but as there were no facilities she had to be transferred to a metropolitan hospital. Sadly her baby died during the transfer. The matter was resolved in conciliation.

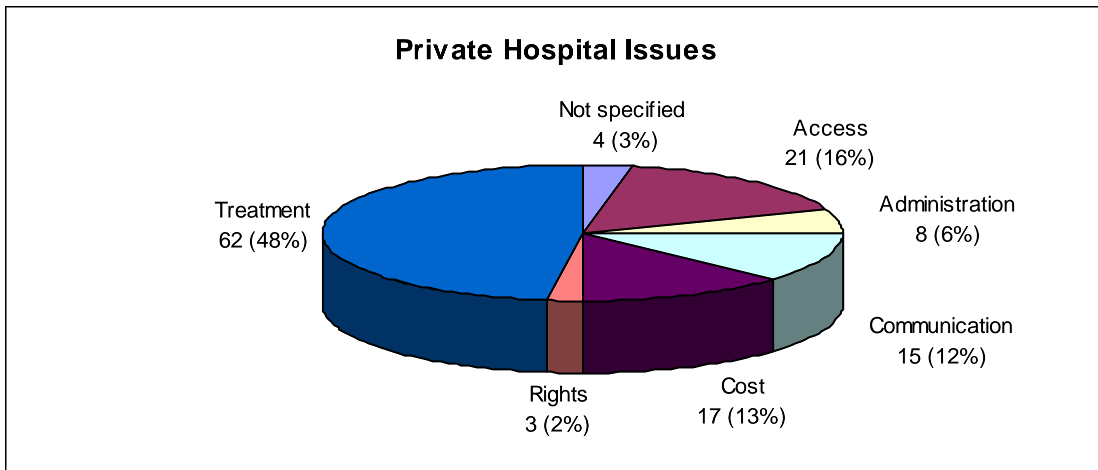
PRIVATE HOSPITALS

In 2001/02 there were 130 or 16% of all hospital complaints made about private hospitals compared with 121 in 2000/2001. As with previous years treatment issues remain the most common. In the case of private hospitals the treatment issues relate to staff other than doctors, as these hospitals usually do not employ their own doctors.

Figure 11 below shows the main issues in complaints against private hospitals. The most frequent issue complained about is treatment with 62 complaints. Other issues are access 21, cost 17, communication 15, administration 8 and rights 3.

A man was admitted to a small private hospital for a one day procedure. He suffered complications and needed to be transferred to a larger hospital. His family were upset that the nurse did not seem to be familiar with the equipment or systems at the hospital and no one was available to speak to the family and tell them what had occurred. The Hospital agreed that communication had been inadequate and that it would have been better to assign a more senior nurse to the patient.

Figure 11 Private Hospital Issues



PSYCHIATRIC SERVICES

In the past year, there were 147 complaints lodged against a number of psychiatric services and against psychologists. This is a slight decrease compared with complaints from previous years.

Figure 12. Psychiatric Services Complaints

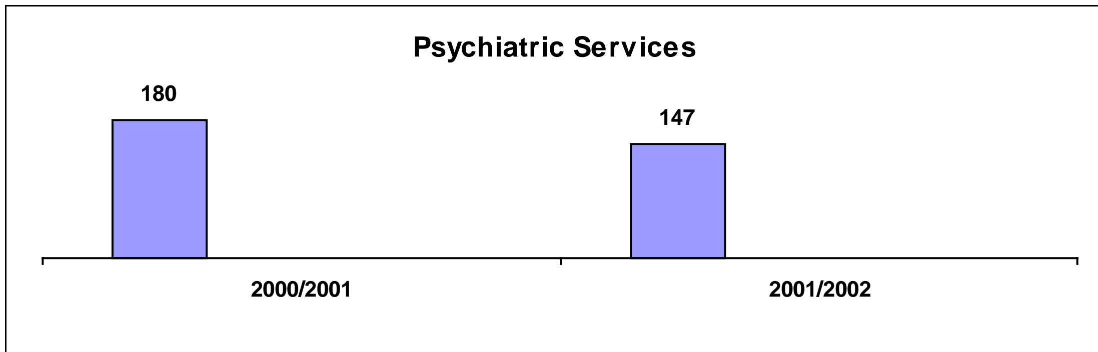
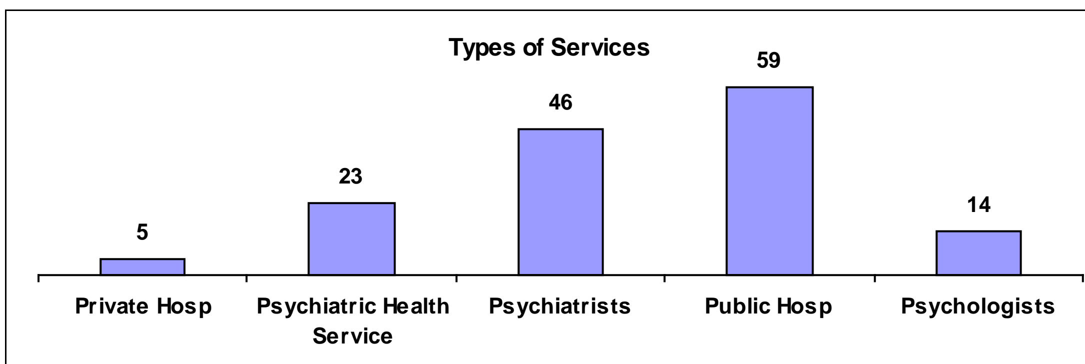


Figure 13 below shows the numbers of complaints made against each type of service.

Figure 13. Types of Service

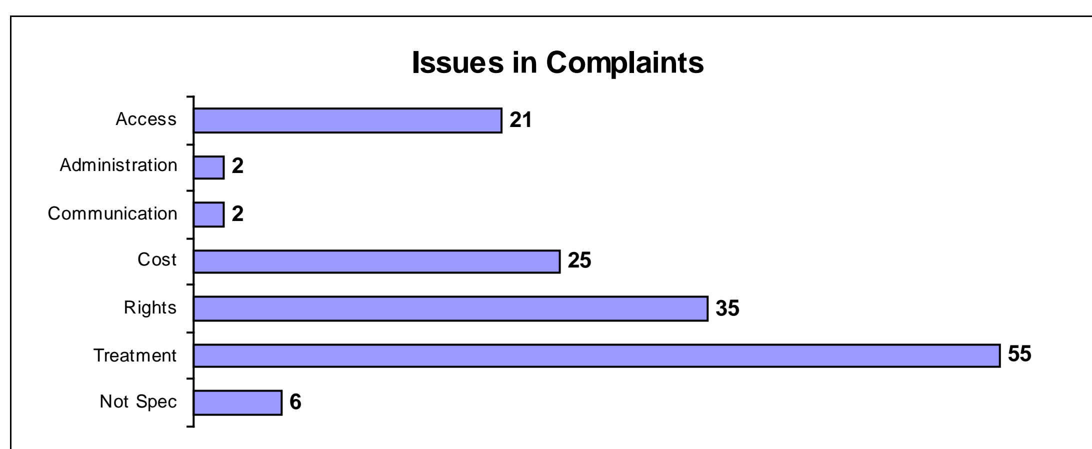


Complaints about psychiatric care in public hospitals decreased from 85 in 2000/2001 to 59 for 2001/2002. Five complaints were made against private psychiatric hospitals, although it should be noted that such complaints would normally be made against the admitting doctor. There were 46 complaints lodged against psychiatrists, 3 less than were recorded in the previous year. Complaints against psychologists increased from 8 in 2000/2001 to 14 in the period in review.

ISSUES IN PSYCHIATRIC SERVICE COMPLAINTS

Figure 14 below shows the primary issues identified in the 147 complaints received in the last year.

Figure 14. Issues in Psychiatric Complaints



The majority of complaints about psychiatric services centre on issues of treatment and patient rights. Some complainants who have been admitted for psychiatric care in hospitals feel aggrieved that they are required to take medication they consider causes upsetting side effects. Others do not believe they require medical treatment. Where complaints involve involuntary status, the complainants are advised of their right to appeal to the Mental Health Review Board.

A small number of people complain to the Commissioner about breaches of their human rights, including complaints about breaches of confidentiality, assault and unprofessional conduct by staff. These issues can be very difficult to resolve, as there is often a difference in perception between the service and the complainant about what might constitute reasonable care and treatment. The HSC endeavours to facilitate better communication between patients and services in these cases.

The Commissioner continues to receive calls from people who are concerned about the discharge of a family member from a psychiatric service. The family often feel unable to support the patient in the home and yet there may be nowhere else for them to go. The services explain they cannot keep a patient longer than treatment requires but discharge can raise issues of what support services are available within the community for a person who may not have a home or carers to assist them. This is a complex issue that needs to be addressed by all policy makers and services involved.

People with mental illness have the same rights to quality health care as all other patients and this should never be diminished by the fact that they are sometimes unable to consent to their treatment and care.

A man contacted HSC and complained he had been able to escape from a psychiatric facility and had been hit by a car. He felt he should not have been able to get out especially after being given medication. The service responded to the man saying he had not been an involuntary patient and had been free to discharge himself but they were very sorry he had been injured. Procedures had been introduced to provide additional checks to ensure patient safety.

HOSPITALS' COMPLAINTS DATA

COMPLAINTS MADE AT PUBLIC HOSPITALS

Information contained in this section has been compiled from complaints lodged directly with the CLOs of public hospitals. They utilise the Health Complaints Information Program (HCIP) to record and monitor complaints handled locally within the hospital. These complaints are separate to those lodged with the HSC.

The following trends comprise data provided by 43 public hospitals

WHO COMPLAINED AND HOW?

Fifty-two percent of complainants were female and 42% male. As expected, public patients comprised of the largest group (89%) and private patients (7%).

The majority of complaints were made via telephone call (41%) or letter (31%), 24% by personal visit and 4% by other means.

The age and gender profile of complainants is shown in Table 15 below

CONSUMER PROFILE

Table 15. HCIP - Age analysis

Age	Total
Under 1	4
1 – 4	51
5 – 14	64
15 – 24	81
25 – 34	102
35 – 44	115
45 – 54	142
55 – 64	136
65 – 74	105
75+	154
Not Specified	1376
Total	**2330**

Figure 15. HCIP - Gender

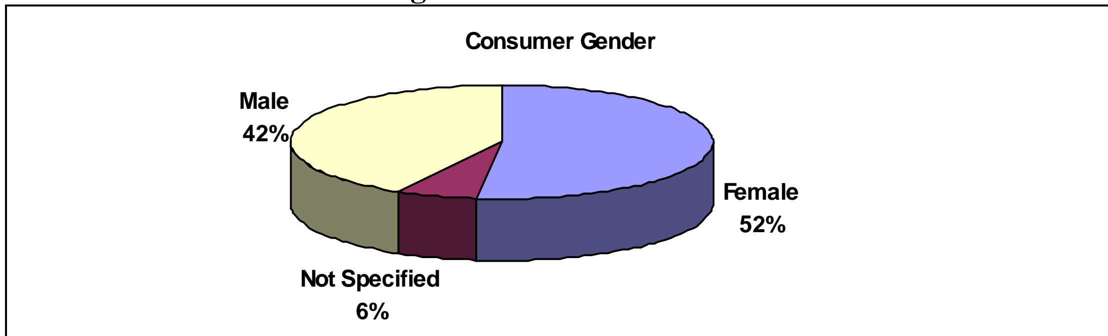
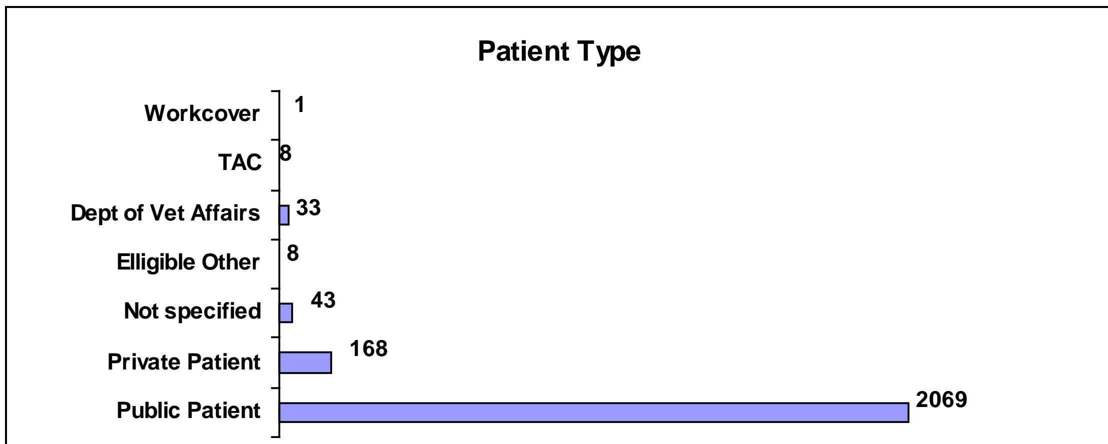


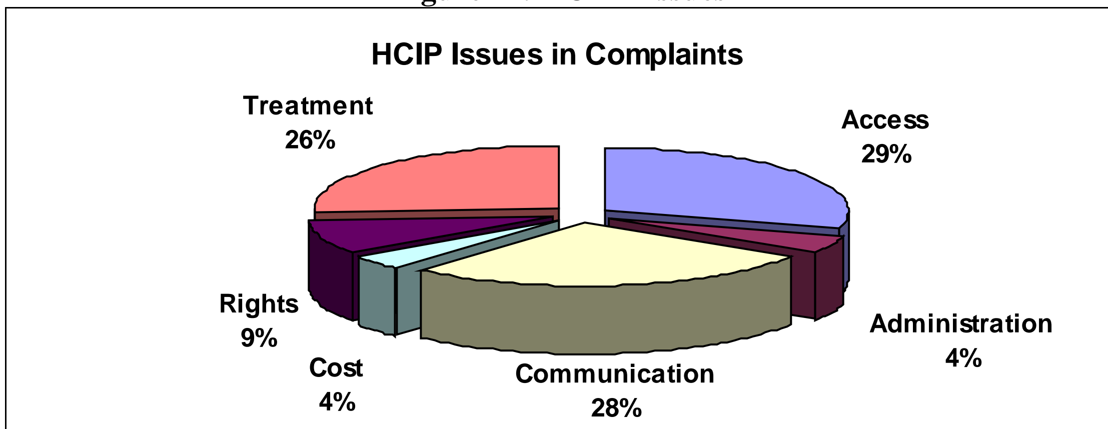
Figure 16. HCIP - Patient type



WHAT WAS THE COMPLAINT ABOUT?

During the period under review hospitals received, and dealt with, 2330 complaints concerning 2998 issues. That is, there were 1.3 issues per complaint received and addressed by the hospital complaints liaison officer (or patient representative). A complaint may be multi-faceted and concerned with not only poor communication but also inadequate treatment. The diagram below shows the issues in complaints. A more specific analysis of issues forms appendix 3.

Figure 17. HCIP - Issues

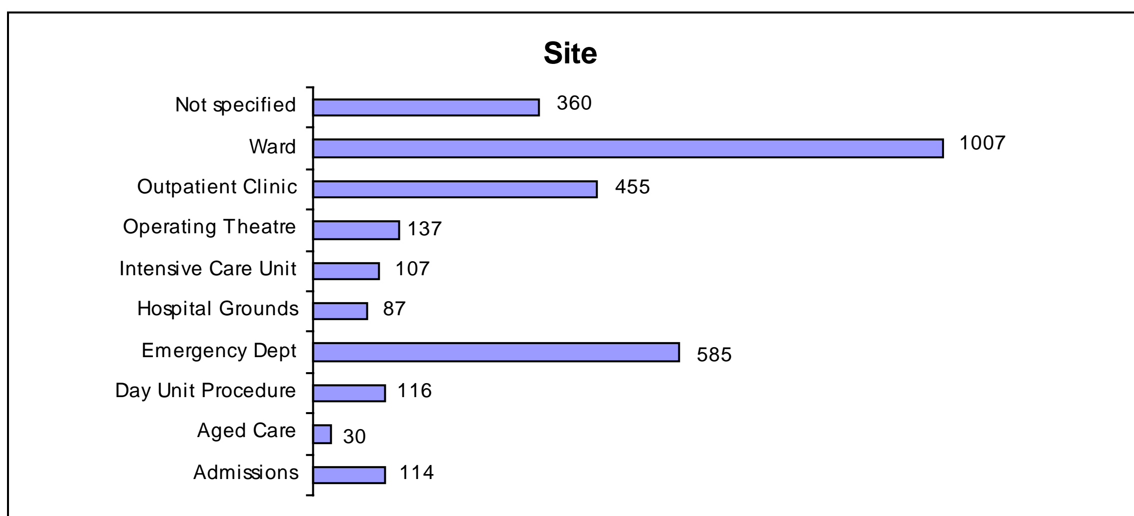


Access and communication were the two commonest issues in complaints, being 29% and 28% respectively, followed by treatment (26%).

SITE AND SERVICE AT TIME OF COMPLAINT

Thirty five percent of complaints occurred in the wards, 20% in the emergency department (of those hospitals which have an ED) and 15% in outpatient clinics.

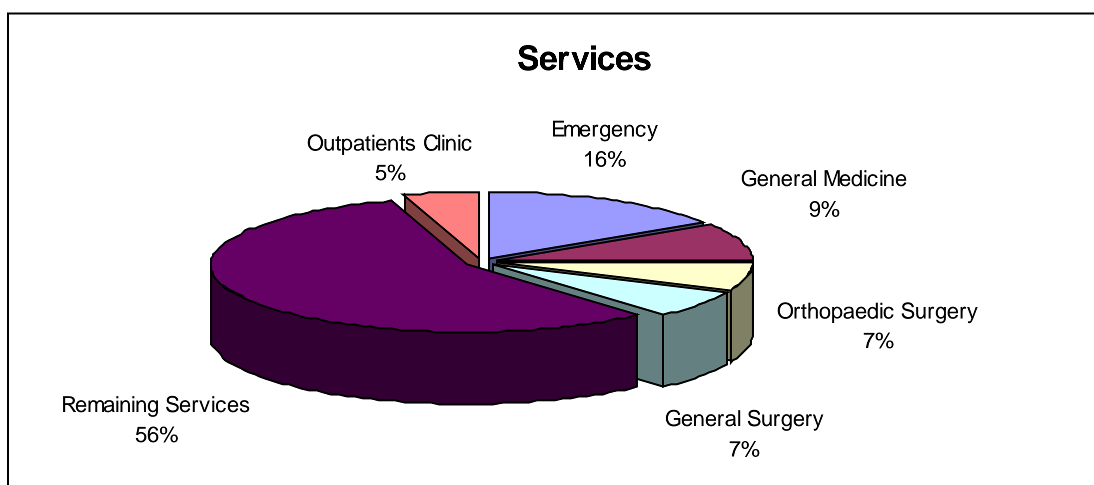
Figure 18. HCIP - Site



SERVICES

Five services made up 44 % of complaint issues received. Four hundred and seventy six (16%) concerned emergency services, 264 (9%) general medicine, 195 (7%) were regarding general surgery, 213 (7%) concerned orthopaedic surgery and a further 138 (5%) outpatients clinic. Appendix 4 gives a complete service analysis.

Figure 19. HCIP - Services



HOW SERIOUS WERE THE COMPLAINTS?

Eleven percent of complaints were categorised as serious or substantial and 68% as routine. The remainder were listed as either minor or trivial.

WHAT WERE THE OUTCOMES OF THE COMPLAINTS?

Seventy nine percent (2370) of closed complaints were resolved by either offering an apology (961), giving an explanation (662), acknowledging users' views (199), providing information (163) or providing a service or facility (162).

Two hundred and seventy five complaints (9%) lapsed as they were either unsubstantiated, had insufficient detail, were allowed to lapse by the user or were withdrawn by the user or not confirmed. One hundred and seventy five (6%) of the complaints lodged were referred elsewhere, 4% were not upheld and 2% resulted in having remedial action. For a full analysis refer to Appendix 5.

Table 16. HCIP - Outcomes of complaints

Stage of Complaint Process	Number of Complaints
Resolved	2370
Lapsed	275
Remedial	61
Referred	175
Not Upheld	117
Total Number of Complaints	**2998**

EXECUTIVE SERVICES

The Executive Services Unit provides corporate support services for the office including Finance, Human Resources, Information Technology, Purchasing, Vehicle Management, Building Services and Reception Services. It is also responsible for the implementation and operation of the *Health Records Act* 2001(Vic) and the provision of legal advice to the Commissioner and staff.

Health Records Act 2001 (Vic)

The *Health Records Act* 2001 (Vic) (HRA) was passed in April 2001 and became operational on 1 July 2002. The project plan developed for the implementation of the HRA listed a number of key outcomes including:

- consulting with key stakeholders;
- developing statutory guidelines;
- producing educational material;
- providing training; and
- offering advice.

Consultation occurred with a wide variety of stakeholders and a key feature of this consultation process was the establishment of provider and consumer reference groups. The initial focus of the HSC was on informing and educating providers of health services and holders of health information on how to comply with the legislation. The assumption was that if providers were aware of and complied with the legislation then the rights of consumers would be observed.

In consultation with the stakeholders and following the distribution of an Issues Paper and receipt of submissions, the Commissioner developed two sets of statutory Guidelines on Research and Transfer or Closure of the Practice or Business of a Health Service Provider. These became law when they appeared in the Government Gazette on 22 February 2002.

The need to provide education and training for holders of health information and consumers is resource intensive and ongoing. HSC's team has produced and distributed over 100,000 brochures on the HRA, written information sheets for targeted groups, written more than 50 articles for various publications and delivered presentations to over 170 groups.

Information about the HRA is also available on the HSC website at www.health.vic.gov.au/hsc.

The Commissioner and staff of the Executive Services Unit have provided advice on implementing the HRA to a vast array of stakeholders including: health service providers, government departments and agencies, local government, schools, holders of health information ranging from employers to kindergartens.

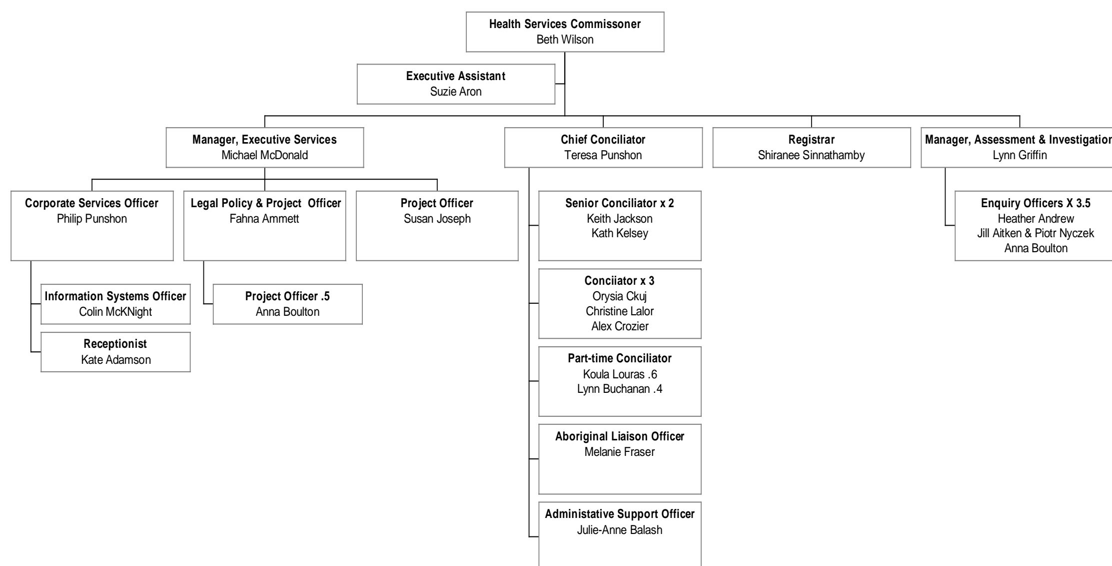
This Office has worked closely with Victoria's Privacy Commissioner, Paul Chadwick, and his staff at Privacy Victoria. The Privacy Commissioner is responsible for implementing the *Information Privacy Act* 2000. HSC and Privacy Victoria have presented jointly to a number of organisations and co-operated on other projects. This close cooperation assists both offices in ensuring our communication with stakeholders is consistent.

Human Resources

On 1 July 2001 the OHSC began operating under a new organisational structure to ensure the requirements of our legislation were met as effectively as possible. It established four main areas of operation being Executive Services, Conciliation, Registrar and Assessment and Investigation. The managers of each of these areas and the Commissioner form the HSC's Executive. This structure introduced streamlined reporting reducing the number of staff reporting directly to the Commissioner from nine to four and provided staff with more direct access and supervision by management.

Staff of the Commission

Organisational Structure



Merit and Equity Employment

The HSC supports specific initiatives of the Office of Public Employment Managing Diversity and Employment Equity goals. The office follows equal employment opportunity policies when recruiting.

The breakdown of staff by gender at 30 June 2002 was 18 women and 6 men.

Customer Feedback

Evaluation Survey

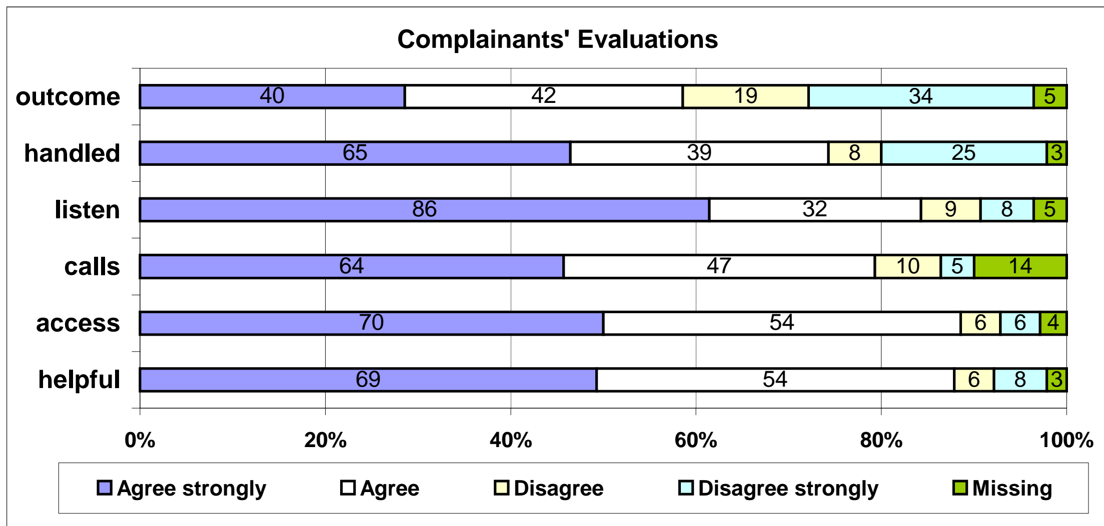
In February 2001 the OHSC commenced sending evaluation survey forms to all complainants and providers at the conclusion of a complaint. These surveys provide us with valuable feedback about our services, manner and efficiency. The form lists six items:

1. HSC staff were helpful in explaining the complaints process
2. I was able to speak to HSC staff when I needed to
3. HSC Staff returned my calls within 24 hours
4. I felt HSC staff listened to what I had to say
5. I was satisfied with the way the complaint was handled
6. I was satisfied with the outcome of the complaint

Respondents were asked whether they Strongly Agreed, Agreed, Disagreed or Strongly Disagreed with the question. The aggregated responses received are shown below.

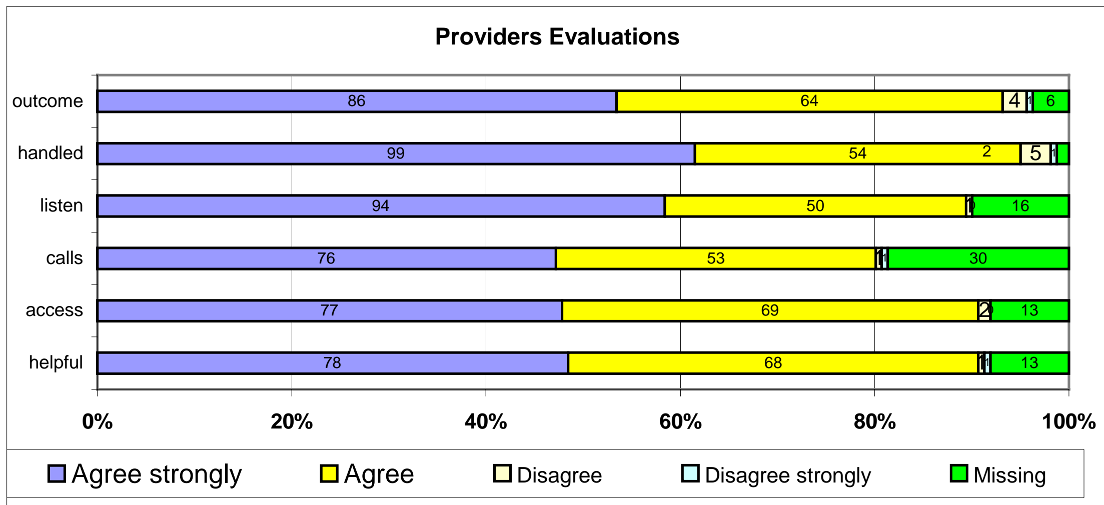
Complainants

The majority of complainants who responded were satisfied with the service provided by the OHSC. Over 87% said staff were helpful, they were able to access staff who listened to them and returned calls promptly. Seventy four per cent were satisfied with the way the complaint was handled and 58% were satisfied with the outcome of the complaint. Obviously not all complainants receive the outcome they were hoping for with 37% not satisfied. It is clear, however, the majority believe their complaint was handled appropriately.



Response Total = 140 from 720 sent (19% return)

Providers



Response Total = 161 from 720 sent (22% return)

Provider responses were also very positive. Ninety three per cent of providers who responded indicated they were satisfied with the outcome and with how the complaint was handled. Ninety per cent of providers agreed that the staff were helpful, they were able to access staff who listened to them and 80% agreed their calls were returned within 24 hours.

Finance

Budget

The Budget for the 2001/2002 financial year increased appropriately to resource the successful implementation of the HRA. The OHSC was allocated $1,744,009 (excluding indirect expenses) and expended $1,504,094 being 86% of its total allocation resulting in a surplus of $239,915. Over $220,000 of the allocated dollars were credited to our cost centre in June. A large proportion of this is for projects in 2002/2003 and will be carried over into the new financial year.

Financial Statements

	Allocated	**Actual**
Operating Expenses	$318,112	$260,486
Salaries	$1,400,397	$1,222,913
Sub Total	$1,718,509	$1,483,399
Capital Expenditure	$25,500	$20,695
Total	$1,744,009	$1,504,094

Expenditure

Direct Expenses

Salaries		$1,222,913
Administrative stationery & operating supplies	$14,463	
Advertising	9,194	
Books/publications/subscriptions/memberships	$7,341	
Computer systems - maintenance	$803	
Contractors	$24,397	
Furniture, fittings & equipment	$4,665	
Information technology costs	$10,732	
Interpreter Services	$5,887	
Maintenance	$917	
Medical reports	$26,521	
Meeting expenses	$3,796	
Miscellaneous	$21,455	
Postal /courier	$2,586	
Printing	$65,260	
Publicity & information	$2,691	
Staff development & seminars	$16,605	
Telephones	$23,833	
Travel-Airfares, Taxis, Personal Expenses	$17,063	
Vehicle	$109	
Workcover	$2,168	
Sub Total		$260,486
Capital Expenditure		$20,695

Total		$1,504,094
Salaries		$1,222,913
Administrative stationery & operating supplies	$11,973	
Books/publications/subscriptions/memberships	$4,427	
Computer systems - maintenance	$625	
Furniture, fittings & equipment	$1,327	
Income	($17,053)	
Information technology costs	$7,909	
Interpreter Services	$890	
Legal Services	$2,416	
Medical reports	$15,353	
Meeting expenses	$1,436	
Miscellaneous	$6,135	
Postal /courier	$1,554	
Printing	$5,365	
Publicity & information	$917	
Staff development & seminars	$12,531	
Telephones	$24,727	
Travel-Airfares, Taxis, Personal Expenses	$13,752	
Vehicle	$226	
WorkCover	$10,293	
Sub Total		$104,803
Capital Expenditure		$26,999
Total		$1,042,244

APPENDICES

APPENDIX 1 - Providers by Type

Dentists in Private Practice	**126**
Hospitals	**799**
Medical Practitioners	**839**

Remaining Providers

Alcohol & Drug Service	1	Not a health service provider (organisation)	18
Alternative therapist	9	Nurse	5
Ambulance Service	16	Nursing Home	4
Appliances and Equipment	1	Nursing service	6
Audiologist	1	Occupational therapist	1
Chiropodist	1	Optical dispenser	13
Chiropractor	13	Optometrist	5
Community Health Centre	46	Osteopath	1
Corrections Health	190	Pharmaceutical supplier	11
Counsellor	6	Pharmacist	11
Dental Prosthetist	7	Physiotherapist	6
Dental Surgery	7	Physiotherapy Service	1
Diagnostic Service	58	Podiatrist	6
Dietician	1	Podiatry Service	1
Dep't of Human Services	3	Psychiatric Health Service	23
Health Insurance	3	Psychological Service	2
Health Retreat	1	Psychologist	14
Hostel	9	Social Worker	1
Locum Service	2		**591**
Medical Clinic	73	**Not specified**	**11**
Medical Technician	8		
Not a health service provider (individual)	6	**Total**	**2366**

APPENDIX 2 - Medical Practitioner Specialities

Specialty	Total
Allergy	0
Anaesthetist	12
Cardiology	6
Dermatology	15
Ear, Nose and Throat	15
Emergency Medicine	1
General Surgery	128
General practice	197
Gastroenterology	4
Infectious diseases	1
Locum	5
Neurosurgery	0
Neurology	3
Obstetrics/Gynaecology	37
Oncology	8
Ophthalmology	14
Orthopedic surgery	7
Pediatrics	4
Pathology	2
Physical medicine	7
Plastic surgery	22
Psychiatry	46
Radiology	3
Rehabilitation medicine	2
Respiratory medicine	1
Rheumatology	1
Urology	7
Vascular surgery	1
Not specified	290
	839

APPENDIX 3 - HCIP Issues

Access	29%	Treatment	26%
Absence of caring	119	Absence of caring	29
Delay in admission	54	Inadequate diagnosis	68
Delay in treatment	179	Inadequate treatment	156
Discharge arrangements	69	Inadequate nursing care	126
Discharge/transfer	31	Medication omission/error	56
No/inadequate service	123	Negligent treatment	31
Non attendance	5	Other	136
Other	160	Rough treatment	30
Refused admission	5	Unskilful/incompetent treatment	27
Refused to refer	2	Unexpected outcome	79
Service busy	28	Wrong diagnosis	23
Transport	12	Wrong treatment	17
Transfer unsuitable	7		
Waiting list	81		
	885		**778**
Communication	**28%**	**Rights**	**9%**
Absence of caring	48	Accuracy of records	16
Conflicting information	43	Access to records	15
Communication breakdown	217	Assault	6
Failure to consult	38	Discrimination	28
Inadequate information	132	Failure to provide an interpreter	1
Other	100	No/insufficient consent	19
Poor attitude/discourtesy	227	Other	53
Undignified service	13	Property	47
Wrong/misleading Information	19	Privacy/confidentiality	50
		Refusal to treat	4
		Unprofessional conduct	30
	837		**269**
Cost	**4%**	**Administration**	**4%**
Amount charged	20	Failure to provide a certificate	1
Billing practice	18	Incorrect. Documentation	24
Information on cost	5	No/Inadequate response	23
Other	42	Other	19
Private health insurance	4	Policy	22
Public/private election	16	Public health standards	18
Unnecessary treatment	2	Treatment Cancelled	25
	107		**132**
		Total	2998

APPENDIX 4 - HCIP Service Provided at time of Complaint

Services		Services	
Accommodation Services	37	Neurology	65
Administrative Services	39	Neurosurgery	68
Admissions	43	Nursing Home	3
Aged Care	15	Nutrition	3
Alcohol & drug Services	3	Obstetrics	46
Anaesthetics	15	Obstetrics/Gynaecology	46
Audiology	9	Occupational Therapy	3
Awaiting admission	12	Oncology	39
Car Parking	59	Operating Theatre	31
Cardiac Surgery	21	Ophthalmology	83
Cardiology	66	Orthopaedic surgery	213
Chaplaincy	1	Outpatients clinic	138
Colorectal	11	Paediatrics	47
Day procedure	45	Pain services	1
Dentistry	11	Palliative care	2
Dermatology	6	Pathology	13
Ear, Nose & Throat	64	Patient Services	27
Emergency	476	Pharmacy	10
Emergency Triage	29	Physiotherapy	12
Endocrinology	18	Plastic surgery	46
Environmental services	13	Podiatry	2
Finance & Administration	14	Prosthetics/Orthotics	3
Food Services	11	Psychiatry	31
Gastroenterology	52	Radiology	59
General medicine	264	Reception/Administration	23
General practice	29	Rehabilitation medicine	27
General surgery	195	Renal/Nephrology	34
Gerontology	6	Respiratory Medicine	39
GP support Res. Services	1	Rheumatology	4
Gynaecology	14	Social work	10
Haematology	16	Speech therapy	4
Home Care	15	Specialist Medical	15
Hostel	3	Specialist Surgical	21
Infectious diseases	3	Spinal Injuries Unit	13
Intensive Care Unit	66	Telecommunications	3
Interpreter Services	2	Unknown	74
Medical administration	8	Urology	25
Medical technician	1	Vascular surgery	22
		Total	**2998**

APPENDIX 5 - HCIP Outcomes

Resolved	78%	Remedial	2%
Agreement reached	74	Censure or Reprimand	2
Apology	992	Remedial action	55
Compensation Paid	9	Caution or warning	4
Explanation offered	694		**61**
Fee waived or reduced	13	**Referred**	**6%**
Fee refunded	5	Outcome in Referral	175
Frivolous/vexatious	0		**175**
Information Provided	163	**Not Upheld**	4%
Misunderstanding resolved	53	Complaint not upheld	51
No further action required	0	No action possible	66
Service/facility provided	162		**117**
Users view acknowledged	199	**Lapsed**	**10%**
Waiting Time Reduced	6	Insufficient detail	79
	2370	Allowed to lapse by user	64
		Not confirmed	53
		Unsubstantiated	79
		Withdrawn by user	17
			275
		Total	**2998**