



HEALTH SERVICES COMMISSIONER

2003 ANNUAL REPORT



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STAFF OF THE HEALTH SERVICES COMMISSIONER AT 30 JUNE 2003

Position	Staff Member(s)	Responsibilities
Manager, Executive Services	Michael McDonald	Manages the operation of the <i>Health Records Act 2001</i> (HRA) and corporate support services.
Manager, Assessment & Investigation	Lynn Griffin	Manages the assessment, acceptance, resolution and referral of all new complaints.
Chief Conciliator Senior Conciliators	Teresa Punshon Keith Jackson Kath Kelsey	Manages the conciliation unit. Supervises conciliators in their casework and conciliates the more difficult cases.
Conciliators	Orysia Ckuj, Christine Lalor, Koula Louras, Lynn Buchanan, Mark McPherson	Assist parties with a complaint to reach a resolution in a confidential and privileged setting.
Conciliation Administration Officer Registrar	Julie-Anne Balash Shiranee Sinnathamby	Provides administrative support to the Conciliators Liaises with the professional Registration Boards and assists the Manager, Assessment & Investigations.
Legal Policy & Project Officer	Fahna Ammett on secondment Angela Palombo acting	Assists in the implementation of the HRA including educating and training health service providers and holders of health information. 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.
Project Officer	Diane Spartels	Responsible for the HSRC 'Best Practice' guidelines for complaint handling.
Project Officer	Loretta Hoban	On line compliance and education project.
Inquiry Officers	Heather Andrew Jill Aitken Anna Boulton Piotr Nyczek	Receive inquiry calls, case manage complaints in the early stages and provide advice to health service users and providers.
Aboriginal Liaison Officer	Melanie Fraser	Supervises, monitors and conciliates complaints concerning indigenous Australians and conducts outreach work.
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	Susan Herbert	Provides executive, administrative and keyboard support to the Commissioner.
Receptionist	Kate Adamson	Sandra Popovski (Mental Health Review Board) provided support receptionist duties for the Office in the 2002/2003 financial year.

COMMISSIONER'S SUMMARY

The coming into force of the *Health Records Act 2001 (Vic)* (HRA) on 1 July 2002, led to an extremely busy and proactive year for the Office of the Health Services Commissioner (OHSC). In addition, the high media profile given to the publication of the Royal Melbourne Hospital Inquiry in August 2002, meant the Commission was brought to the attention of many more people than had previously been the case. I welcome this exposure, as it assists in making the Commission more accessible.

The co-operation of the Board of Directors, Chief Executive Officer and Staff of the Royal Melbourne Hospital made it possible to complete a complex Inquiry on schedule and many quality changes have been made as a result.

Effective complaints handling needs to be impartial, accessible, confidential and speedy. During the year under review, we have found many new ways of reducing waiting lists. This has been a major challenge for my staff and one which they have taken on with vigour. It is always annoying when inevitable delays occur, but we do our very best to minimise them.

Co-operation with the 12 health service registration boards continues to be cordial and successful. Exchanges of ideas between the Boards and the Commission are useful in developing policy, implementing legislation and dealing with the problem of the very unusual, but difficult "rogue" practitioners or firms who do not see complaints in a positive light. Co-operation has continued at the national level between all Commissioners and also with organisations such as the ACCC.

One thing that does not change from year to year is the aspirations of consumers. Once again, most people who come to the Health Service Commissioner (HSC) with a complaint are seeking quality changes. They want to know what went wrong and why, and they want to make sure that it doesn't happen to someone else. This may involve changes brought about in the resolution of an individual case or, it may be that action is required at a more systemic level. The OHSC has been involved in an extremely large number of important policy initiatives including Ministerial Advisory Committees, Working Groups and Policy Planning Sessions. We have worked closely with the Victorian Quality Council and with the Australian Safety and Quality Council, especially on its Open Disclosure Project. This Project, which has developed standards to allow hospitals and others to provide accurate, open information following an adverse event, is a most important initiative and has my full support.

In our health services, we have hard working Complaints Liaison Officers who deal with complaints at the quarry face. The work is often stressful and difficult, and the OHSC continues to provide support for them through contact with individual Officers, providing technical support and through the committee of the Health Services Liaison Association.

As in previous years, I thank the Members of the Health Services Review Council, whose expertise and support is invaluable. During the year under review, Julie Rolfe and Meredith Carter resigned from Council to take up work elsewhere. I thank them for their work with the OHSC.

Staff of the OHSC continue to benefit from in-house training seminars and in particular, I thank: Rosemary Barker from the Department of Human Services, David Brown and Amanda Robertson from the Public Records Office, David Lescun and David Howell from the Metropolitan Ambulance Service. As well, Charles Khoo presented an overview of cultural awareness training and Eva Wakim, Cuc

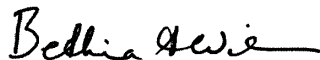
Lam and Ron Murray presented specific training in relation to the Arabic, Vietnamese and Aboriginal communities to staff.

Tribute to Dr Helen Rabbette

Dr Helen Rabbette was a Member of the Health Services Review Council. She died on 22 February 2003. Helen's achievements were many and varied, including her work in physical education, her teaching career, her interest and work in special education, her dedication to Rotary International, her role as a businesswoman and her passionate interest in family, education, health, reading, wine and travel. Helen was a lovely person to work with, and we were very sad to lose her.

Thanks to Anne Mullins

In the early implementation stages of the HRA, the OHSC was fortunate to have Anne Mullins working with us. The Health Records team and I thank Anne for her contribution, which has a continuing role in assisting us in our often complex work.



Beth Wilson

Health Services Commissioner

HEALTH SERVICES REVIEW COUNCIL **PRESIDENT'S REPORT 2002/2003**

The Report of the Council for this year builds substantially on the work undertaken during the previous year 2001/2002.

The Council has been involved in undertaking a major project, for which funding was foreshadowed in our last report, and which is detailed later in this report.

The Council and the Health Services Commissioner were also involved in consultations dealing with the medical indemnity insurance crisis in Victoria - and were consulted on many of the issues subsequently the subject of legislation by the Victorian Government, seeking to deal with this problem.

In addition, 2002/03 saw the first period of operation of the Health Records Act - providing significant privacy protection of and access to health and medical records for Victorians. The Health Services Commissioner has ensured a smooth introduction and implementation of the legislation and effective handling of the complaints that arose during the year.

THE COUNCIL

Under the Health Services (Conciliation and Review) Act 1987, the Council has the following functions: -

1. To advise the Minister on the health complaints system and the operation 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 in the Act;
4. To advise the Minister and 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.

MEMBERSHIP

During the relevant period the Council comprised: -

Michael Gorton

- Michael is a partner with Russell Kennedy, Solicitors, with experience in corporate and commercial law, and a special interest in Health Law. He has qualifications in law and commerce, and has an extensive background in the community sector. Michael was awarded Honorary Fellowships by the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists. He was, until 1999, Victoria's first permanent male Commissioner with the Victorian Equal Opportunity Commission, and is Deputy Chairperson of the Infertility Treatment Authority.

Michael is a former National President of Greening Australia; former Victorian President of the United Nations Association of Australia; and former Co-Chair of Reconciliation Victoria Inc.

Dr Paul Nisselle

- Paul has been a provider representative on the Health Services Review Council since 1994. He was in general practice in Elwood for 18 years before accepting appointment, in 1989, as Chief Executive of the Medical Indemnity Protection Society, a company through which doctors obtain professional liabilities insurance. He is a Past-President and Past Chairman of AMA Victoria and served on the Federal Council of the AMA for 10 years. Thinly disguised as "Dr Paul", he has, since 1982, discussed a wide range of medical topics, in a fortnightly segment on ABC Radio, principally through 774 ABC Melbourne.

Pamela Barrand

- Pamela is a lawyer with the Youth Legal Service of Victoria Legal Aid. She is a Board Member of the Eastern Health Network, a member of the Mental Health Review Board and participates in a number of community working groups including City of Whitehorse Youth Issues Working Group, Refugee Youth and Justice Working Group and the Court Network Consultative Group of the Children's Court.

Julie Rolfe

- Julie is Manager of the Premier's Drug Prevention Council. With a background as a lawyer and social worker, Julie has held a range of positions in the public and community sectors. Her employment history also includes working as an independent research and evaluation consultant on a local, regional, statewide and national basis. Julie is a Williamson Fellow, having participated in the Community Leadership Program in 2001.

Marcia Coleman

- Marcia Coleman has had extensive high level experience in the health sector spanning the last 27 years. Her experience has been heavily oriented to the identification and management of risk and key issues, change management, corporate governance, communication and consultation. She is presently Chairman of Australians Donate, the peak body for organ and tissue donation for transplantation in Australia.

David Brous

- David is the Principal of the Impact Consulting Group, a Melbourne based public body and program evaluation practice. He is a former member of the Victorian Public Records Advisory Council and a former Senior Vice-President of the Victorian Branch of the Institute of Public Administration Australia. He has a strong interest in the provision of culturally appropriate health care services.

Lou Tehan

- Lou Tehan has a professional background in health and welfare (Division 1 Registered Nurse) in the primary and acute care sector in both management and direct service provision. She is rurally based and currently employed by Grampians Community Health Centre. Her working philosophy is grounded in the social model of health. Lou also has a masters degree in Creative Arts Therapy (RMIT) and as such works primarily with people who have Acquired Brain Injury and children with problems. Her private practice encompasses professional development and an educative aspect. Her work is underpinned by the belief that

given appropriate guidance people are able to find their own solutions through realising their own potential. Lou is a member of the Australian Creative Arts Therapy Association and Australian Health Professionals Association

Kathy Wilson

- Kathy has Postgraduate qualifications in health services administration and completed Undergraduate studies in community development. She was CEO of Inner South Community Health Service for 10 years and has been involved in the development of a broad range of public sector initiatives including refuge programs for women, public sector cooperative housing and the Victorian Women's Health Program. In 2001 she was awarded the Victorian Health Care Associations True Professionals Award for leadership excellence and contribution to the health sector. Kathy currently provides consultancy services to the public health and community sectors

Catherine Dean

- Catherine is a social worker who has worked in women's health for over 20 years. She has undertaken a range of roles, which have included direct services to women, policy development and program management in both acute and primary health settings. Through her extensive experience in the sexual assault field, Catherine has a particular commitment to working towards the elimination of violence against women and children. She coordinated the development and publication of national standards of practice for sexual assault services throughout Australia. Catherine currently works as part of the Quality and Safety team at the Royal Women's Hospital and has a Post Graduate Diploma in Dispute Resolution.

Meredith Carter

- Meredith was until recently, Executive Director of Health Issues Centre, a research and policy analysis group at the forefront of moves to promote responsiveness to consumer perspectives in the Australian health sector. Meredith is a lawyer with a long background in public policy and community affairs, currently including membership of the Board of Southern Health, the largest public hospital and health services group in Victoria, and the Consumer Law Centre Victoria.

The Council members are representatives of providers, users and independent people in relation to the health system. The Council includes a representative with experience in matters affecting the privacy of individuals in relation to health information, representing both interests of organisations that handle information as well as consumers.

At the end of the year we farewelled Julie Rolfe and Meredith Carter, both of whom have made great contributions to the work of the Council.

We were also saddened by the sudden death of Dr Helen Rabbette in February 2003. Helen had been a member of the Council for several years. She worked in physical education, was a teacher, contributed to special education and was a dedicated member of Rotary International. She had a strong role as a businesswoman and a passionate interest in family, education, health, reading, wine and travel. Helen was always a cheerful contributor and a wonderful colleague and I join with the Commissioner in acknowledging Helen's contributions and reaffirming how much she is missed.

HEALTH RECORDS ACT

The Council has monitored the introduction and operation of the Health Records Act, noting the great work of the Health Services Commissioner and her staff in ensuring adequate information and consultation with the Victorian community. Members of the Council have been involved in consultations with major stakeholders, including consumers, doctors' groups, health institutions and employers.

The Council assisted the Commissioner's Office in developing various submissions, including submissions in respect of the proposed National Privacy Code.

HEALTH RECORDS SEMINAR

As part of its commitment to monitoring the implementation of the Health Records Act, the Council conducted a major seminar in April 2003 – 'Health Records Act - A Year On'. The seminar canvassed the operation of the Act during its first year and sought community and industry feedback. The keynote speakers included the Health Services Commissioner, Beth Wilson, and the Law Reform Commissioner, Marcia Neave.

A panel of speakers also provided reflections on the operation of the Act, including:

- Jan Donovan - National Prescribing Service;
- Dr John North - Royal Australasian College of General Practitioners;
- Peter Devine - Independent Schools Association;

A strong attendance represented stakeholders from across Victoria, covering metropolitan and rural regions.

I am pleased to report there was a general consensus that the introduction of the Act had been relatively smooth and the Office of the Health Services Commissioner had been very successful in ensuring that all key stakeholders received adequate information and assistance in relation to rights and obligations under the Act.

COUNCIL PROJECT – 'BEST PRACTICE GUIDELINES FOR COMPLAINT HANDLING'

As reported last year, the Department of Human Services provided Council with funding for a major project to develop Best Practice Guidelines for Complaint Handling. The Project is now substantially under way and is expected to be completed in early 2004.

The project has involved substantial consultation with key stakeholders. The Council established a working group to monitor implementation of the project, as well as a stakeholders reference group, to ensure adequate consultation with and feedback from groups representing doctors, nurses, health institutions, safety committees, complaints liaison officers and all of those involved in medical health complaints.

Draft Guidelines are currently in the process of a pilot study with key metropolitan and regional hospitals.

Diane Spartels is the Project Officer and Terri Punshon and Kath Kelsey from the Commissioner's Office provide advice and support.

The Guidelines are being developed in an endeavour to assist health institutions to better deal with complaints at source. Better complaint handling will assist consumers as well as reduce the cost, delay and effort required in otherwise dealing with formal complaints if elevated to more formal mechanisms. The resolution of complaints is generally more likely to produce a result acceptable to all involved, at less cost, if dealt with expeditiously and locally.

WORKING WITH THE HEALTH SERVICES COMMISSIONER

The Council continues to work closely with the Commissioner, Beth Wilson and her staff.

Beth continues to attract accolades in the community for her strong public education presence as well as her approachable and common sense manner in dealing with complaints.

Beth is indefatigable in speaking to community groups, industry groups and stakeholders, so as to ensure that the Victorian community is aware of their rights as well as their obligations under the Act.

The Council receives and reviews quarterly statistics on the levels of complaints received by the Commissioner, as well as performance measures in relation to the complaint handling functions of the Commissioner's Office.

It is entirely appropriate that the work of Beth Wilson was recognised with the award of a Centenary Medal for services to health during the year.

THANKS

During the year the Hon Bronwyn Pike was appointed Minister for Health. We are grateful for the support previously received from Hon John Thwaites as former Minister. We appreciate the interest shown by the current Minister in the work of the Council.

We are grateful for the close relationship we have with Beth Wilson, and recognise her great contribution during the year. We are assisted by staff from Beth's Office particularly Susan Herbert and Michael McDonald, and acknowledge their support.

I again congratulate and thank my fellow Council members who give a great deal of time to the work of the Council. The year has been extremely active and work on the Council's project in particular, has required extraordinary commitment. We are fortunate to have such a talented and diverse group as Council members. Their commitment to improving our health system, particularly in relation to prevention and safety, as well as timely resolution of complaints, is strong.

Michael Gorton

President

Health Services Review Council

STATUTORY FUNCTIONS

The Role Of The Commissioner

The OHSC 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* (the Act) 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

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 (Vic) (HRA)

The HSC is also responsible for the administration of the legislation dealing with privacy of an individual's health information. The HRA 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 which relates to individuals, in accordance with the Health Privacy Principles in the HRA, subject to any specific provisions about the management of health information in any other Act.

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

Complaints can be made to the HSC by individuals about an interference with their privacy because their health information has not been managed in accordance with the Act, or who have experienced difficulties accessing their health information. The HSC assesses complaints and, if a complaint is accepted, it may be conciliated, investigated or dismissed. Where a complaint is dismissed, the individual has the right to take action at VCAT.

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 Privacy Commissioner, the Commissioner for Equal Opportunity, the Infertility Treatment Authority 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 conducted 77 presentations, six lectures, five launches and participated in 10 conferences and three hypotheticals in the 2002/03 financial year. 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 in reaching indigenous communities. A summary of her work appears on page 18 of 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, or
2. These circumstances impact on certain population groups, or
3. The complaint is indicative of a systematic flaw or the result of a deficiency in policy or procedures, or
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.

Informed Financial Consent

Health service providers have a responsibility to let their clients and patients know about likely out of pocket costs before undertaking any consultation or procedure. Although health services must set their own fees, there seems to be a culture of reticence to discuss costs on the part of some service providers and consumers. This can sometimes lead to financial hardship and distress as well as complaints to the HSC. Information about costs and refusal of refunds also underlie many complaints about the following services.

Impotency Clinics

The HSC has received a number of complaints from men who say they have been attracted by the promotion of these clinics but are then disappointed with the service they receive. The complainants report telephone consultations and prescriptions from doctors who are not located at the clinic, pressure sales tactics to persuade them to sign up for long term expensive treatments not necessarily suited to their needs and limited or no refunds when the treatment is unsuccessful or the patient changes his mind.

HSC is concerned that the marketing techniques in use by the clinics exploit the vulnerability of their clients and do not provide the expected standard of health care in accordance with the best interests of the patients who seek their help.

Optical Dispensing

Some optical dispensers are creating dissatisfaction within the community by their reluctance to rectify or replace glasses that do not meet the needs or expectations of their clients. It is good business practice to adopt a responsive and conciliatory manner in addressing the complaints made by customers and a large number of dissatisfied clients is not in the best interests of the public nor the business.

Victorian Civil And Administrative Tribunal (VCAT) Civil List - Referrals

When a person is dissatisfied with the costs associated with the provision of a health service and these issues cannot be resolved through the HSC, the complainant can apply for the matter to be heard through VCAT's Civil List. This is a relatively simple and affordable option for complainants in situations where the service provider is not agreeable to resolving the complaint through HSC processes.

Research and Policy Projects

The Unusually Persistent Complainant

In conjunction with Professor Paul Mullen and Dr Grant Lester of Forensicare, research was conducted into the responses of complaints officers to unusually persistent complainants. Experience had shown that a small number of complainants will persist with their complaints for much longer than might be expected, sometimes at great personal costs to themselves and their families. The first part of the research is completed and a paper has been submitted to an international journal.

Rural Consumer's Complaints about Health Services

This research involves collaboration between the OHSC and Professor John Humphreys and Judith Jones of the Monash University School of Rural Health at Bendigo. A de-identified database of 23,866 HSC complaints files was analysed to determine rural-urban differences based on the Remote and Metropolitan classification. Important differences between rural and metropolitan consumers were noted, with rural consumers being significantly under-represented. The findings were presented at the National Rural Health Conference in Hobart in March 2003. Funding from the Department of Human Services Rural Unit will allow expansion of this research in the new financial year.

Respecting Patient Choices - Austin & Repatriation hospital

The HSC has been a member of the Reference Group for this important project on best practice in recording and managing patients' decisions about their care in the case of terminal illness.

Open Disclosure Project (Commonwealth)

The Commissioner was an advisory member of the Commonwealth-funded Australian Council for Safety and Quality in Health Care Open Disclosure project. This important work has developed an Australian Standard for open communication in public and private hospitals, following an adverse event in health care.

Open Disclosure Project (Southern Health, Victoria)

The HSC has been a member of the Reference Group for this research in best practice in communicating with patients and families after adverse events. The OHSC has also assisted with obtaining a volunteer comparison sample of subjects from former complainants, who agreed to assist the research by speaking of their own experiences.

Consumer and Provider Partnership Project (Epworth Hospital)

Terri Punshon, Chief Conciliator chaired the Steering Committee, which was running two CAPPs projects, on Day Surgery and Cardiac Services, concurrently. That committee was comprised of eighteen people, including the Chair and the 2 Project Leaders. There were seven consumers from four organisations, four doctors, two representatives of registered health benefits organisations, the hospital health fund negotiator and the CEO of the hospital, who also represented the Australian Private Hospitals Association.

The structure enabled a strengthening of consumer participation by providing a common ground for the representatives of the different consumer organisations to work together.

Complex Clients Project

The Commissioner was a member of the Working Group on Complex Clients, convened by DHS to respond to people with multiple and complex needs. The Phase One Report and a Client Profile Data and Case Studies Report were completed during the year under review to be launched in July 2003.

Medical Treatment Act Communications Initiative

Concerns by the Public Advocate, the Commissioner and others about the under-utilisation of the *Medical Treatment Act* were canvassed in the media in October 2002. DHS subsequently convened a working group to target general practitioners and the Commissioner participated in this work.

Quality of Care Reports

The Commissioner was one of the judges on the Quality of Care Reports, which is an important DHS initiative providing information to communities about their health services. Dr Norman Swan presented awards for the best reports at Parliament House.

Student Projects

The Health Services Commissioner is happy to talk to students or teaching institutions about the possibility of student placements within the Office. Mutually beneficial projects can be developed to meet the interests of the students as well as the Office.

Anne-Marie Polimeni is a doctoral student in Psychology from Swinburne University. In her placement Anne-Marie surveyed the training and support needs of complaints officers based in Victoria's Hospitals.

Wendy Kimpton is another graduate Psychology student from Swinburne. Wendy is writing a "road map" of the Health Services Commissioner's Inquiry into the Royal Melbourne Hospital. This work will be completed in the next reporting year.

Debbie Miller is an exchange student from the United States who is currently enrolled at the University of Melbourne. Debbie surveyed a sample of Hospitals to conduct an audit of Aboriginal Services provided.

Allison Lusher is a third year Health Information Manager student who completed her 13 week placement with the OHSC. Allison was instrumental in implementing a new records management information system in the HSC.

ANALYSIS OF COMPLAINT TRENDS

2002/2003 Summary

The assessment team receives complaints and general enquiries by telephone, mail and in person. Increasing numbers are also received by email. The majority of these simply require advice or information and are recorded as enquiries.

The HRA came into effect on 1 July 2002 and resulted in a sizeable increase in the numbers of enquiries to the HSC. As well as the 5814 calls to the Office about health services and other general inquiries there were an additional 2093 general enquiry calls related to the HRA. The calls were fairly evenly divided between consumers of health services and holders of health records. This was a total of 7907 enquiries; an increase of more than 40% over the previous year's enquiries.

If a complaint appears to be within jurisdiction of the *Health Services (Conciliation & Review) Act* or the HRA a complaint form will be sent out and the complaint details recorded as a case on the database. There were 2373 complaints lodged for the year of which 164 (7%) were lodged under the HRA. The large number of enquiries about the HRA resulted in only a small number of complaints. A possible explanation may be that once a health service provider's obligations have been clarified, either by a call to or from this Office, the matter is easily resolved and only the more complex cases are forwarded to the HSC.

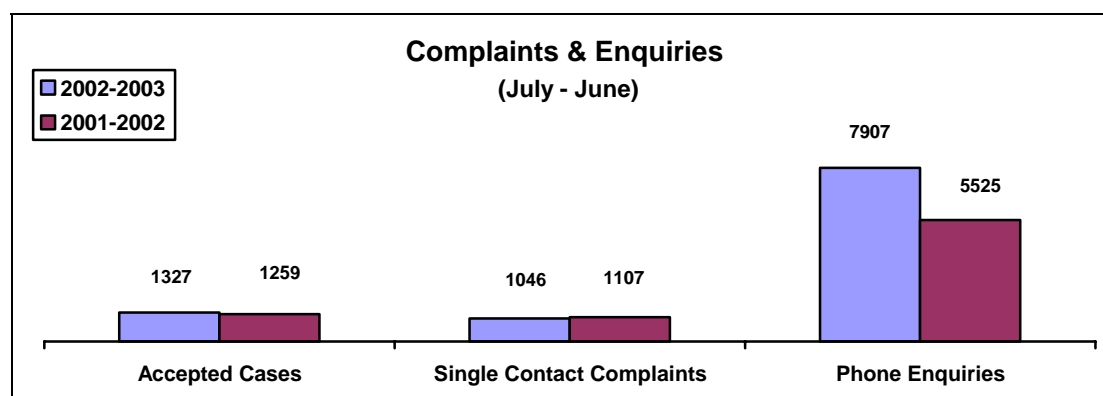
About half of all potential complaints go on to be managed cases when a complaint form is returned. This year 1327 cases (or 56% of potential cases) were received and managed in this way and this is a similar number to that of the previous year.

Table 1 below shows the complaints and enquiries received by the HSC during 2002/2003 and Figure 1 shows a comparison with last year's figures.

Table 1. New Complaints and Enquiries

		Complaints		
Enquires by telephone		Single contact	Accepted Cases	Total
HSC	5814	971	1238	8023
HRA	2093	75	89	2257
Total	7907	1046	1327	10280

Figure 1. Complaints & Enquiries



Enquiries

An enquiry is defined as a contact with the Office. These are often outside of HSC jurisdiction and not considered to be a complaint case. Alternatively, an enquiry can be a request for information or assistance on a vast array of issues. They can often be answered immediately as the caller is given advice or referred appropriately. Below is a breakdown of the types of issues the Office receives enquiries about.

Table 2. Enquiry types

HRA Issues		HSC Issues	
Aboriginal/Torres Strait Islander	6%	Aboriginal enquiry	5%
Access to records	44%	Access to records	3%
Referred to Federal Privacy Commissioner	1%	Fees	15%
Privacy information	22%	Food & environmental health	11%
Referred to State Privacy Commissioner	1%	Health insurance	4%
Referred to FOI Act	4%	Hospital waiting list	4%
Fees	10%	Other	25%
Request for brochure	12%	Referred elsewhere	30%
		Request for brochure	4%
	100%		100%

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

1. **Low:** a phone call, letter or an explanation should easily resolve the problem. 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

HRA	Low	Medium	High	Total	
Access & Correction	34	14	0	48	3%
Anonymity	2	0	0	2	0%
Collection	4	3	0	7	0%
Data Quality	2	1	0	3	0%
Info Available to another HSP	3	0	0	3	0%
Openness	1	1	0	2	0%
Transfer/Closure of HSP	2	1	0	3	0%
Use & Disclosure	26	17	1	44	2%
Total	74	37	1	112	5%
HSC	Low	Medium	High	Total	
Access	164	65	6	235	10%
Administration	48	10	0	58	2%
Communication	180	72	8	260	11%
Cost	98	20	1	119	5%
Not Specified	159	35	10	204	9%
Rights	74	48	17	139	6%
Treatment	475	584	182	1241	52%
Total	1198	834	224	2256	95%
Grand Total	1272	871	225	2368	100%
	54%	36%	10%	100%	

Most complaints received fall within the low and medium ratings (54% and 37% respectively) with only 10% in the high rating.

Complaints

In the twelve months under review the Office received 2373 new complaints comprising 1046 single contact complaints, where the complainant is encouraged to approach the health service provider to seek a resolution, and 1327 complaints (accepted cases), which were confirmed in writing.

Who Complained?

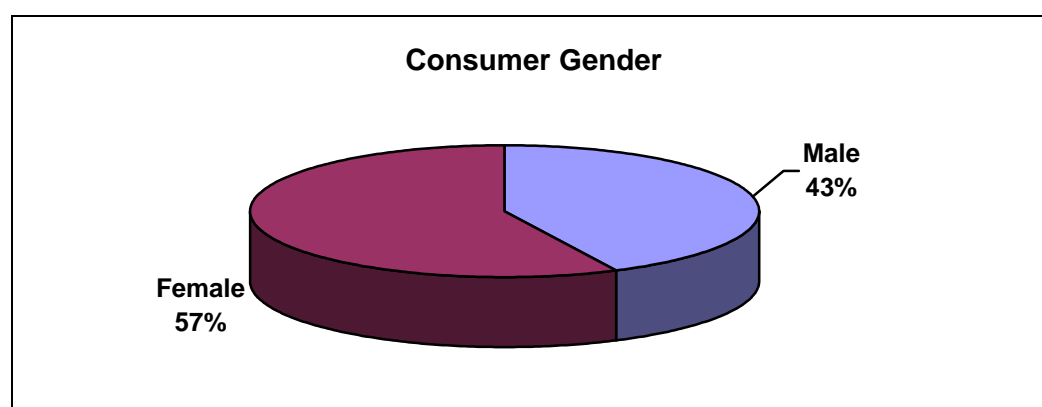
A complainant is defined as the person who makes the complaint. This is most often the patient or user of the health service. Women complained and were nominated as the consumer in complaints more often than men. While it is not known why this occurs it may be because women are more frequent users of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

The age group with the majority of complaints was the 25 to 34 compared with the 45 to 54 group last financial year.

Table 4. Consumer Profile

Age Range	Female	Male	Total
0 to 01	13	15	28
01 to 04	18	20	38
05 to 14	30	23	53
15 to 24	79	52	131
25 to 34	94	50	144
35 to 44	79	43	122
45 to 54	68	48	116
55 to 64	35	55	90
65 to 74	53	41	94
75 +	1	4	5
Unknown	886	666	1552
Total	1356	1017	2373

Figure 2. Consumer Gender



HOW COMPLAINTS ARE MANAGED

The HSC is structured into three distinct teams (see organisation chart p40) with the Assessment and Conciliation teams responsible for managing the complaints received in the Office.

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. 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 hoped that many of the unconfirmed complaints are resolved in this way.

If the complaint is about a health service provider (HSP), 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. The Act requires that complaints made on the telephone or in person must be confirmed in writing. Staff are able to assist in this process.

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 clear explanation from the HSP complained about and, where appropriate, an apology continues to be the most effective means of resolving complaints.

The maximum time a complaint may stay in the assessment stage is 84 days. If a case is not resolved within this time the Commissioner formally refers the case to conciliation. This referral can occur earlier if the case is assessed as being more likely to be resolved in conciliation.

The conciliation process is quarantined from all other processes within the HSC and its aim is to encourage settlement of the complaint by arranging informal, confidential discussions between the parties.

Within two weeks of receiving the referral the conciliator writes to the parties giving details of the arrangements for the discussions. These proceedings are privileged and nothing said or disclosed during conciliation may be admitted in any court action. The process is entirely voluntary; at any stage in the negotiations either party can decide not to proceed any further and this ends the matter in conciliation.

Generally complaints in conciliation fall into two categories. One is the desire for an explanation as to what happened and why. The other is the claim for damages, compensation or remedial treatment. Often they involve elements of both. A claim for compensation is usually negotiated between the parties and their advisors, with the conciliator as the link, without a meeting.

When there is a dispute about a health service provider's liability for a claim then with the agreement of the parties, an independent expert opinion is sought. The

conciliator organises this from an expert in the relevant field. Copies of this opinion go to the parties who use it as a basis for further negotiations.

If a conciliation results in the payment of damages or compensation then normal legal conventions, that is, release documents are prepared.

How Were The Complaints Resolved?

In the year 2002/2003, 2368 cases were closed by the HSC.

The number of files closed varies from the number of files received within any given year, as there are always carry over files at each stage. A more detailed explanation of outcomes is in the following reports.

Table 5: Resolution Stages

Stage of Complaint Process	HRA	HSC	Total	%
Closed in Enquiry (Single Contact Complaints)	61	857	918	39%
Closed in Assessment	62	1061	1123	47%
Closed in Conciliation	1	326	327	14%
Closed in Investigation	0	0	0	0%
Total Cases Closed	124	2244	2368	100%

Enquiry/Assessment Report

In 2002/2003 there were 918 files closed in the enquiry stage because, even though the complaints were probably appropriate under the legislation, the complaints were not confirmed in writing. At the end of the year there were 529 cases open at the enquiry stage awaiting the receipt of complaint forms or other documentation.

During the year 1123 cases were resolved and closed in assessment, the majority of these by receiving some further explanation or information to address concerns. Some of these were referred elsewhere and are discussed separately in the Registrars report. At the end of the year there were 126 cases still open in the assessment stage.

The cases that are approved for assessment are allocated to the four enquiry officers as caseloads. Each officer has 30 to 50 active cases at any one time and will mediate between the parties and collect information to try to resolve the complaints informally. Approximately 80% of accepted cases are resolved in this way without the need for referral to conciliation.

Outcomes achieved in this process include clear explanations of the events that led to the complaint; apologies for distress caused, change in procedures and policies to improve services and sometimes, refunds, further treatment or referrals to other services. Occasionally the Commissioner will decline a complaint. The most common reason for this is that the matter is out of jurisdiction or it happened too long ago or has been the subject of investigation elsewhere, such as with the Coroner.

When this happens the Commissioner will write to advise the complainant of her decisions and invite further communication if there are new issues to consider some time in the future.

Table 6 below shows the broad resolution categories for complaints resolved in the assessment stage.

Table 6. Resolution in Assessment

Outcome	2001/02	2002/03
Apology	2%	3%
Concern registered	6%	5%
Costs refunded	2%	2%
Declined	20%	19%
Explanation offered	48%	56%
Objective Not Obtained	3%	2%
Procedural change	2%	1%
Referred elsewhere	14%	7%
Service obtained	2%	4%
Withdrawn by user	1%	1%

Conciliation Report

A concerted effort by the conciliation team in the year under review has led to the immense reduction of the waiting list that ensued following the previous year's internal restructuring and reworking of the complaint handling process. With the steady increase in complaints coming into conciliation at an earlier stage, finding efficient ways to manage complex and sensitive matters in a timely manner remains a constant challenge.

The Office's additional responsibility of administering the HRA, which commenced in the year under review, has brought new and interesting issues for the conciliation team to grapple with, including the provision of conciliation services to consumers who have been refused access to records under the FoI Act. Although it is early days for this legislation, there is marked concern expressed by consumers when they find their doctor has sold, transferred or closed the practice and their records are inaccessible.

A woman complains that her records have gone missing as a result of her usual specialist transferring the practice to another doctor. Her doctor decided to move overseas and transferred the records without notifying her. At a conciliation meeting the doctor who received the records agreed to reorganise them and notify the patients involved. Two weeks later as a result of this process the woman's records were found.

Although the types of complaints referred to conciliation under the principal Act vary widely, failures of communication between some health service providers and their patients continue to be the most significant emerging issue.

A woman complained that her elderly fragile mother was not cared for adequately by the hospital because the triage nurse had mistakenly written on the admission form that she was there for a painful ankle. Following a number of hours at Emergency Department, the patient was taken to another hospital where she was treated appropriately for a large haematoma that had developed in her buttock following a fall. At a conciliation meeting, the hospital resolved to change its admission procedures to prevent this from happening to anyone else.

Issues about errors in diagnosis are also raised frequently.

A man complained after he presented to hospital with a twisted ankle and in pain. He was informed he may have fractured the leg and as a precaution was given a plaster cast to support the leg and keep the weight off as well as a set of crutches to help him walk.

The following day, not used to crutches, he fell and hurt his wrist. He presented to a second hospital where they reviewed the leg and wrist to find that the leg was fine but the wrist was broken and needed appropriate management. He complained that had the first hospital diagnosed the problem with the leg appropriately, he would not have needed crutches and would have avoided the ongoing problems with the wrist. The complaint was resolved in conciliation.

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 continues to be 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.

Three hundred and twenty seven complaints were closed in conciliation in this period, 96 more than in the previous year. Ninety percent were resolved, one per cent were referred to registration boards from conciliation and the remaining nine per cent were unable to be conciliated.

Table 7. Resolution in Conciliation

Conciliation	2001/02	2002/03
Resolved	92%	90%
Apology given	6%	7%
Change in procedure/policy	1%	1%
Compensation	20%	17%
Explanation/Information provided	65%	65%
Referred to Board	1%	1%
Non-conciliable	7%	9%
	100%	100%

Registrar's Report

The year under review saw the continuation of the excellent relationship the HSC enjoys with the 12 health registration boards in relation to the exchange of complaint information, developing policy and participating in education and training. The co-operation of the Registrars of all of the Boards is appreciated.

Upon receipt of complaints by the respective Boards or the HSC discussions are held between the respective organisations to determine who should deal with the complaint.

A total of 982 complaints were discussed with the Boards. Of these, 613 were about doctors and were received by both the Medical Practitioners Board of Victoria and the OHSC. Dentist complaints totalled 194 and the remaining 175 complaints were about other registered health service providers.

During the review period, a total of 78 complaints were referred formally to the Boards for their consideration. This is an increase of seven on last year with the majority of these referrals (58) being to the Medical Practitioners Board. The Chiropractors Registration Board received the next highest number of referrals with five. No referral occurs without first discussing the complaint with the relevant Board.

The Registrar also attends a bi-monthly Registrars' meeting of all Registration Boards to exchange ideas, network and develop improved methods of complaint management.

The role of the Registrar includes the approval and assessment of new complaints and providing advice and support as a member of the Assessment Team as well as managing the FoI function. Sixteen FoI requests were processed during the year involving 42 files. Although the number of requests saw only a minor increase from the previous year, the complexity of these requests was greater and three resulted in Appeals to the Victorian Civil and Administrative Tribunal.

Table 8. Formal referrals

Formal referrals to Boards	
Chinese Medicine Registration Board	1
Chiropractors Registration Board of Victoria	5
Dental Practice Board of Victoria	1
Elsewhere	3
Medical Practitioners Board of Victoria	58
Mental Health Review Board	2
Optometrists Registration Board of Victoria	2
Osteopaths Registration Board of Victoria	1
Pharmacy Board of Victoria	2
Physiotherapists Registration Board of Victoria	2
Psychologists Registration Board of Victoria	1
	78

Aboriginal Liaison Officer's Report

In the year under review the Aboriginal Liaison Officer continued to make this Office more accessible for Aboriginals and Torres Strait Islander People. Her role involved assisting people with making their complaints, assisting in resolving complaints, conducting information sessions, networking with and visiting communities across the State.

The requirement for a complaint to be made in writing under the Act can make accessing its services difficult for many people and this includes indigenous peoples. Wherever possible, the Aboriginal Liaison Officer is available to assist in formalising complaints in writing, however, she often receives enquiries about matters that fall into the following categories:

- Urgent matters that need to be dealt with immediately.
- Matters of a minor nature that could be easily resolved on the same day the enquiry is received.
- Enquiries that only require information from the Aboriginal Liaison Officer.

During the year under review, the Aboriginal Liaison Officer received 285 of these enquiries. Following is an example of a situation that was serious and urgent, required immediate action and did not need to be confirmed in writing.

A young Aboriginal man had been critically injured and was receiving treatment in the Intensive Care Unit of a public hospital. The young man has a large extended family and friends who were very worried about his condition and visited him en masse at the Hospital. A number of incidents occurred between staff and family members, with family members complaining to the Aboriginal Liaison Officer that some of the incidents were racially motivated, with racist comments being made. A meeting was immediately arranged with the Hospital. The Hospital responded to the concerns, saying the major issue was that it could not accommodate such large numbers of people in the Intensive Care Unit and that this kind of situation was unprecedented. It said there was not enough room in that part of the hospital for such a large number of people. On asking about available room in the Hospital for family and friends to meet, the Hospital agreed to make arrangements for the family to congregate at another part of the Hospital and that this would be cleared with security so they would not be bothered. Apologies were given for the treatment that some family members had received from staff and an undertaking made to prevent it from happening in the future.

The past financial year saw this Office receive 36 written complaints. As in previous years, complaints continue to relate to issues of:

- Accessing services,
- Communication issues,
- Treatment issues.

Following is a case study of a written complaint received and dealt with by the Aboriginal Liaison Officer.

An Aboriginal woman complained about communication issues at a medical clinic in a rural town. She complained that reception staff would speak to her loudly in the waiting area as though she was deaf and would reveal personal information that other people could hear. She complained that reception staff did not speak to other people in this way. The woman also complained that family members were given information about her conditions in the course of their appointments with the doctor. The woman was only interested in bringing these matters to the attention of the clinic and wanted to ensure that there was a change of attitude and procedure. She received an apology and an undertaking to ensure better service and was satisfied with this outcome.

This Office was heavily involved in getting the privacy message out to Aboriginal communities in Victoria. This included assisting with the organisation of the "Privacy Laws Protect Our Communities" campaign launch in June 2003, held in co-operation with the Victorian Aboriginal Community Controlled Health Organisation and Privacy Victoria. The Aboriginal Liaison Officer also assisted in providing a design for the promotional campaign.

The Aboriginal Liaison Officer also continued to meet with various communities and organisations across the State on a regular basis. Following are some of the organisations and communities she met with:

- Gippsland & East Gippsland Aboriginal Co-operative, Bairnsdale
- Ballarat & District Aboriginal Co-operative
- Swan Hill Aboriginal Co-operative
- Cummeragunyah, Barmah
- Central Gippsland Aboriginal Health & Housing Co-operative, Morwell
- Lake Tyers Aboriginal Trust

- Goolum Goolum Aboriginal Co-operative, Horsham
- Mildura Aboriginal Corporation
- Gunditjmara Aboriginal Co-operative, Warrnambool
- Aboriginal Community Elders Services, Brunswick
- Victorian Aboriginal Health Service, Fitzroy
- Victorian Aboriginal Housing Board of Victoria
- Victorian Aboriginal Community Controlled Health Organisation
- Indigenous Consumers Unit, Consumer Affairs Victoria
- Moogji Aboriginal Co-operative, Orbost
- Bendigo & District Aboriginal Co-operative
- Koori Health Unit, Department of Human Services
- Privacy Victoria
- Victorian Ombudsman
- Staff from the Office of Health Review, Western Australia
- Health Records Act Implementation Reference Group
- Assisted a student on placement at the HSC from the University of Melbourne

Prisoner Complaints

Two hundred and fifteen complaints were received from prisoners during the year under review. This was a 13% increase over the previous year.

Four metropolitan 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. Complaints were also received in writing throughout the year. As in previous years the focus of complaints remains the same, that is, access to services, including delays in treatment and inadequate treatment. Within treatment issues, medication regimes are a dominant cause of complaint, with many prisoners wanting access to antipsychotic, *benzodiazepines* and pain-killing medication. Prisoners often remain dissatisfied with treating doctors because they are unhappy with medication regimes. They are usually advised in these instances that medication regimes are based on the clinical judgement of the treating doctor.

The introduction of the *Victorian Opioid Substitution Therapy Program* by Corrections Victoria is an important initiative to assist those prisoners identified at high risk of opioid related harm during their imprisonment, or at high risk of relapse to illicit opioids upon their release to the community

The Opioid Substitution Therapy Program also expands current Methadone services to prisoners. Previously only those prisoners with a sentence of six months or less who were already enrolled in a community Methadone program were entitled to enter into a Methadone program within prison. This restriction has now been lifted to include any sentenced prisoner who was previously on a community Methadone program.

Some examples of complaints received from prisoners are:

A prisoner informed medical staff about an infection developing on his lower leg but did not receive treatment for a week. He suffered night sweats and was in considerable pain and discomfort. He believes that due to the lack of treatment the wound could have been a great risk to his health.

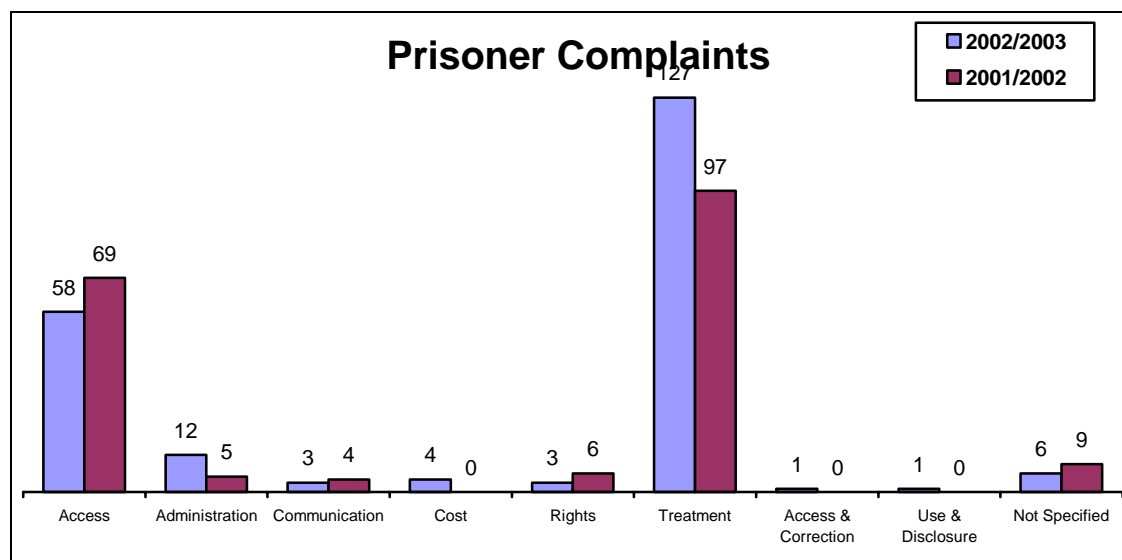
A prisoner complained his diet was inadequate for his insulin dependent diabetes. The prisoner was provided with information about how to manage his diabetes. Extensive discussion and consultation took place in regard to the issues surrounding dietary requirements for the prisoner's

diabetes and the prison agreed to supply him with the special food items as recommended by the doctor.

A prisoner complained about delays in accessing a pain management clinic for his back problem. An appointment was arranged but when he arrived the hospital had no notification of his appointment, nor did they have any knowledge of a previous cancelled appointment. The hospital concerned apologised for the delays and took steps to ensure the procedures for booking and recording appointments was enhanced.

The protocols set up between the HSC, the State Ombudsman and the Prisoner Health care 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. The co-operation between the two Offices is a valuable means of ensuring prisoners' rights are addressed.

Figure 3. Prisoner Complaints



REASONS FOR COMPLAINTS

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

HSC Issue Categories

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;

<i>Cost</i>	refers to information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;
<i>Rights</i>	refers to rights to privacy and dignity, consent to treatment, reasonable access to records; and
<i>Administration</i>	refers to support services for providers such as reception, waiting lists, cleaning services, etc.

HRA Issue Categories

<i>Access & Correction</i>	refers to the right of individuals to access and correct health information held about them, subject to certain criteria;
<i>Anonymity</i>	refers to the right of an individual to not identify themselves when it is lawful and practicable;
<i>Collection</i>	refers to how and when health information is collected;
<i>Data Quality</i>	refers to how accurate complete, up to date and relevant the health information is, having regard to the purpose for which it is held;
<i>Identifiers</i>	refers to the unnecessary use of identifiers, for example the use of a public sector identifier by a private sector organisation can only occur with the individual's consent or if it is required by law;
<i>Information available to another HSP</i>	refers to one HSP making information available to another;
<i>Openness</i>	refers to organisations policies on the management of health information and steps an individual must take to access their health information;
<i>Transborder Data Flows</i>	refers to the transfer of an individual's health information outside Victoria;
<i>Transfer/Closure of a HSP practice</i>	refers to the process to be followed when a practice or business of a health service provider is sold or closed; and
<i>Use and Disclosure</i>	refers to how an organisation has used or disclosed an individual's health information.

Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue.

Primary issues in complaints 2002/2003

Health Services Conciliation & Review Act 1987 (Vic)

In 228 (10%) of complaints an issue was not specified and it is likely that these complaints were not confirmed in writing.

As in previous years, treatment issues were the major component of complaints with inadequate treatment and inadequate diagnosis being the most frequently cited. Underlying all complaints, however, are failures of communication.

This year complaints about treatment accounted for 49% (1157) of all complaints compared with 51% (1205) in 2001/2002.

A family complained a hospital had failed to diagnose and treat an elderly woman who had gone to Emergency Department on three occasions complaining of shortness of breath. She had been told she had a virus and to go home and rest. Shortly after the third visit the woman had a cardiac arrest and was taken by ambulance to the Hospital where she was admitted and provided with cardiac care. The family felt she may not have had the arrest if she had been diagnosed and treated sooner. The Hospital acknowledged the family's distress and explained how they had treated the woman on each of her visits. She had an ECG and blood tests all of which had been normal; she had not shown any symptoms of heart problems in any of the tests conducted. The Hospital then met with the family and discussed changes to protocol that might improve the detection of heart problems for future patients. As the woman made a good recovery and the Hospital had been open in its communication with the family, the complaint was resolved.

Table 9. Treatment

Treatment	49%
Inadequate diagnosis	201
Inadequate treatment	355
Medication	128
Negligent treatment	152
Other	21
Rough treatment	49
Unskilful/incompetent treatment	198
Wrong diagnosis	39
Wrong treatment	14
Total Treatment	1157

Table 10 below sets out the communication issues

Table 10. Communication

Communication	12%
Absence of caring	47
Failure to consult	26
Inconsiderate/undignified service	42
Other	6
Poor attitude/discourtesy	77
Wrong/misleading information	76
Total Communication	274

Again this year communication issues accounted for 12% of primary issues in complaints received with a small drop of nine in the number of complaints. Poor attitude/discourtesy was the most frequently mentioned communication issue. However, wrong/misleading information increased from 58 last year to 76 this year.

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

Table 11. Rights issues

Rights	5%
Access to records	12
Accuracy of records	7
Assault	11
Discrimination	8
No/insufficient consent	21
Other	11
Privacy/confidentiality	24
Refusal to treat	7
Unprofessional conduct	19
Total Rights	120

This year rights issues dropped to 120 (5%) from 199 (8%) last year. This can be accounted for by the introduction of the HRA, which gives specific rights to issues previously recorded here.

Table 12 below sets out access issues raised in complaints

Table 12. Access issues

Access	10%
Communication breakdown	13
Delay in admission	22
Delay in treatment	59
Discharge arrangements	14
No/Inadequate service	72
Non attendance	29
Other	6
Refused admission	11
Transfer	9
Transport	3
Total Access	238

Access issues are about the availability of services and complaints. They have dropped by 3% (61) compared to last year with the biggest being in the 'No or inadequate service' category, which fell by 7% a total of 41 complaints.

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

Table 13. Cost issues

Cost	6%
Amount charged	47
Billing practices	38
Fraud	1
Health insurance	6
Information on costs	24
Other	5
Over-servicing	10
Public/private election	1
Total Cost	132

The 'amount charged' continues to be the biggest issue complained about in the cost category. The total figures dropped 23 overall or a 1% drop.

Table 14 shows the administration issues in complaints.

Table 14. Administration issues

Administration	3%
Advertising	2
Failure to provide certificate	5
Hygiene	5
Management Practices	18
No/inadequate response	8
Other	15
Policy	6
Quackery/legality	1
Total Administration	60

These administration complaints are about the ways services are operated rather than medical or health component of services. They increased from 47 in 2001/2002 to 60 this year.

Health Records Act 2001

The most common issue for complaints made under the HRA is an individual being refused access to private health records about them. Sixty seven complaints were received on this issue and 56 complaints received about health records being disclosed without consent. A total of eight complaints received under the HRA did not have an issue identified

A man complained a health service provider had breached privacy by disclosing information about his health to a support agency. The service responded and confirmed they had passed on information to the agency but only to assist the man to obtain support that had been requested. The service has now developed a consent form for clients to sign to authorise the disclosure of necessary information in finding external support.

Table 15. HRA Issues

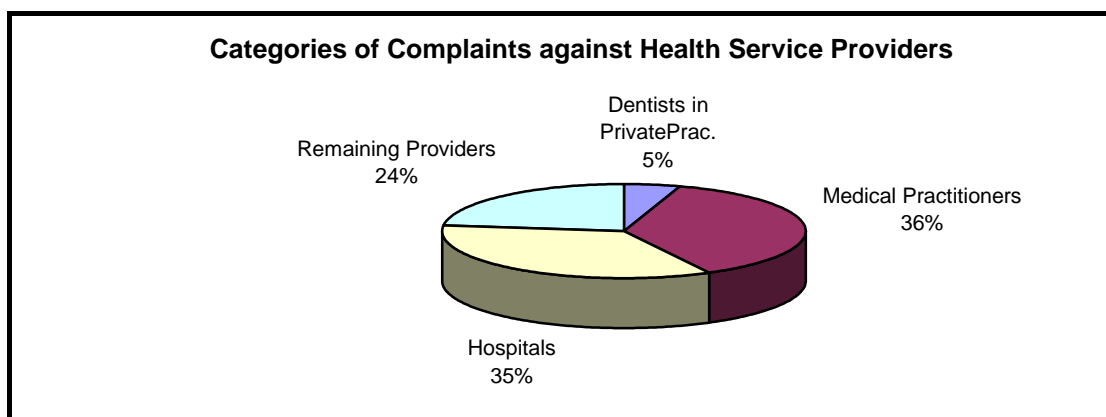
Access & Correction		Info available to another HSP	
Access Refused	67	Excessive fee	1
Inaccurate information not concealed	1	Information refused	1
No written reason for refusal	3	Unreasonable time in delivery	1
	71		3
Anonymity		Openness	
Refusal of anonymity	2	Policies unavailable, unclear or inadequate	2
	2		2
Collection		Transfer/Closure of HSP	
Breach of in-confidence details	4	Inadequate notification	3
Inadequate collection statement	1		
Unlawful/Intrusive collection	1		
Unnecessary collection	1		
	7		3
Data Quality		Use & Disclosure	
Data inaccurate, incomplete or out of date	4	Disclosure – inadequate consent	56
Unlawful deletion	3	Disclosure – inadequate disclosure	4
Unsatisfactory protection	1		
	8		60
Total			164

CATEGORIES OF COMPLAINTS AGAINST HEALTH SERVICE PROVIDERS

Although there was a wide range of other health services that were the subject of complaints, the most frequent were about hospitals (35%) and medical practitioners (36%). As these two groups provide the bulk of health services this result is as expected. There was no significant change from previous years in the number or type of complaints against any group.

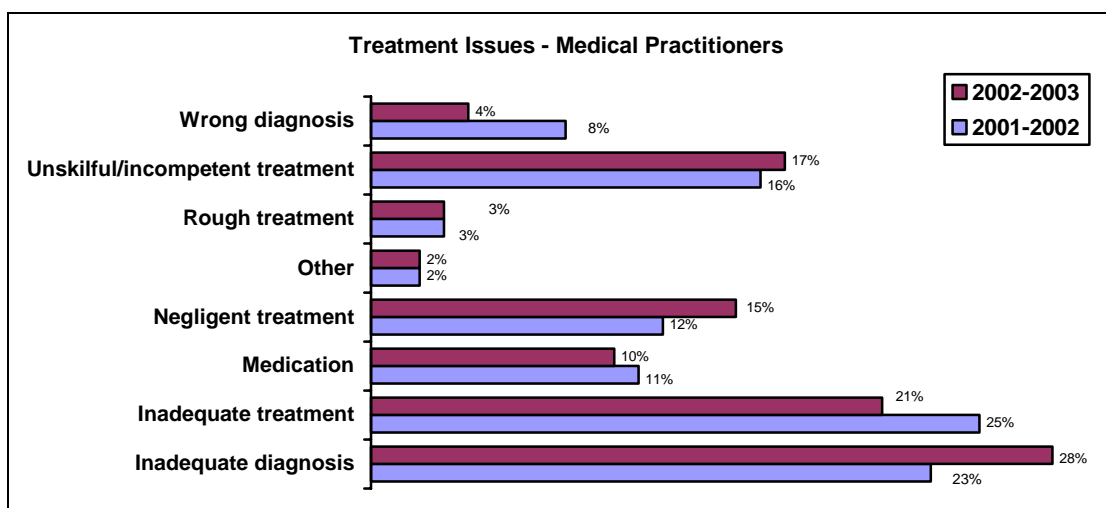
A woman complained a doctor was rude and dismissive when she took her small child for examination because of a persistent cough. She said the doctor barely looked at the child and said it was probably a virus. The child's coughing became worse and another doctor was consulted. X-rays were taken and it was found the child had inhaled a small object and needed an operation to remove this. The family were seeking compensation for the costs of surgery but HSC explained this would have been needed anyway and so was unlikely. The doctor wrote to the woman and said she was very sorry she had not examined the child more thoroughly or ordered an x-ray. The woman was satisfied with the apology and the matter was resolved.

Figure 4. Categories of complaints against health service providers.



Medical Practitioners

Figure 5. Treatment Issues – Medical Practitioners



The category Medical Practitioners includes all doctors whether in specialist service provision or general practice. Appendix 2 lists the number of complaints about individual medical specialities.

The interesting trend to emerge is that inadequate diagnosis has overtaken inadequate treatment as the main issue complained about (see figure 5).

General Practitioners

Although treatment issues dropped 2% from last year they continue to predominate in complaints about GPs. Communication issues increased 5% from last year's figures with access and rights issues reducing significantly since the introduction of the HRA. All complaints, however, include some communication failures ranging from failure to explain diagnoses, patients feeling they were not being listened to and consultations being too rushed.

The types of complaints received about GPs are:

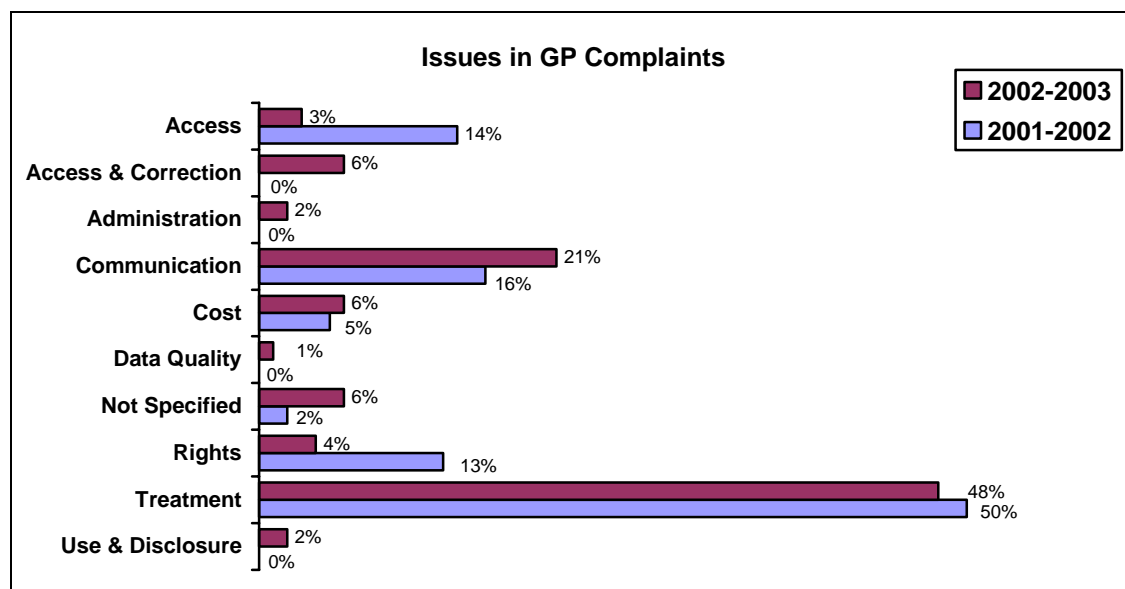
A man with an earache consulted a doctor. Over a four week period he was given pain killers and antibiotics. In the fourth week the left side of his face dropped and the doctor told him that he had Bell's Palsy and again sent him home with pain killers and antibiotics. Following a

second opinion he was admitted to hospital and a mastoidectomy performed. His hearing has been severely affected.

A man complains that a GP misdiagnosed his burst appendix, despite visiting a medical clinic every day for a week with acute stomach pain.

A man believes a general practitioner did not give his late wife the appropriate treatment. The doctor did not refer the woman early enough and her serious bowel condition went undiagnosed.

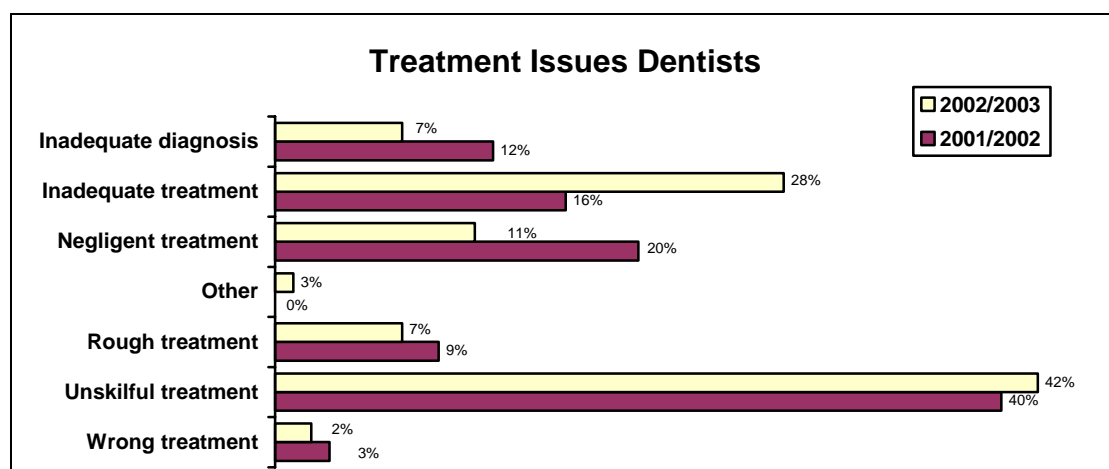
Figure 6. Issues in GP Complaints



Dentists

Figure 7. Treatment Issues Dentists

There were 118 complaints against dentists, eight less than the previous year. Of these 68% (81) were treatment issues continuing previous trends. Most complaints against dentists are resolved in the enquiry/assessment stage of the HSC process.



Treatment is often the primary issue but sometimes there is a secondary issue of cost resulting from patients not being fully informed.

A man complained a dentist left the root of a tooth in his gum when doing an extraction. He paid another dentist to remove the root and sought compensation from the original dentist. After conciliation the dentist agreed to pay the cost of removing the root.

A man visited a dentist because his tooth was aching. In two sessions he was charged in excess of \$1000. He was not informed of the cost or the treatment plan. Another dentist advised the patient he had received inappropriate treatment.

A woman consulted a dentist after a porcelain crown broke and she was told she required dental treatment to the value of several thousand dollars. The dentist commenced treatment by doing a filling, which dropped out the next day. She lost confidence in the dentist and did not want to proceed with further treatment from him and sought a refund for the amount already paid.

A woman presented to a dentist for extraction of a root of her wisdom tooth. The tooth had been extracted a long time previously. The dentist attempted removing the root for an hour without success. He referred her to a specialist who advised any attempt to remove the root should not occur without an x-ray prior to commencing treatment.

Dental Prosthetist

There were seven complaints against dental prosthetists in 2002-2003, which is the same number as last year.

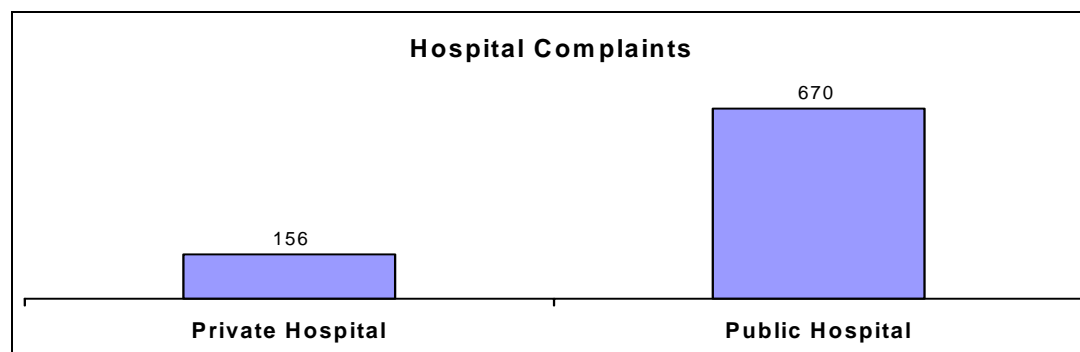
Hospitals

Complaints made to the HSC about hospitals

A total of 826 complaints were made to the HSC about hospitals. This is 35% of the total number of complaints received by the HSC in the 2002/2003 period. Eighty one percent (670) were about public hospitals and 19% (156) about private hospitals. Last financial year there was a total of 799 complaints. There was a 3% increase in private hospital complaints with a corresponding drop in complaints about public hospitals.

All public hospitals have internal complaint handling systems, which means a large number of complaints, are handled in house and do not need to be referred to the HSC. The statistics on these complaints are reported in the section on the Health Complaints Information Program.

Figure 8. Public/Private Hospital Comparisons



PUBLIC HOSPITAL ISSUES

Figure 9 shows the issues that made up the complaints to the HSC about public hospitals. Treatment issues accounted for 56% of all complaints about public hospitals and Access issues comprised 13%, which are comparable with last year's figures of 57% and 12% respectively.

A man complained about various aspects of his care whilst in hospital. He did not receive adequate treatment for an injured arm and facial injury, and has experienced ongoing problems. Surgery was delayed due to the x-rays being lost. The doctor insinuated that he was a junkie and the nursing staff were rude and didn't provide a good level of care. The CLO made enquiries and found the man's complaints were justified and a meeting was held where an apology was given and accepted.

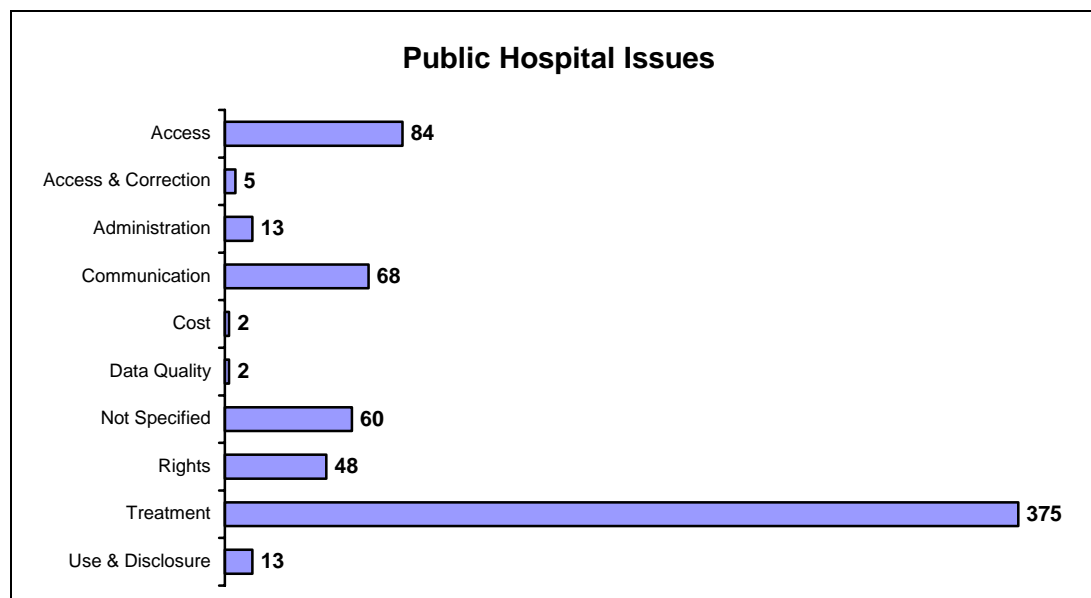
A senior citizen was admitted to hospital for a heart condition. While in the emergency department he fell as he tried to climb back on the trolley. As a result of the fall and associated pain he was unable to live independently as he did prior to his hospital admittance. The matter has been referred to conciliation.

A man complained that he was not warned of the risk of developing deep vein thrombosis post surgery. He developed thrombosis and required admittance to intensive care and took some time to recover. Hospital staff agreed he was not given a warning and apologised which was accepted. The hospital also provided staff training to minimise the likelihood of this occurring again.

A woman complained about an allergic reaction she had whilst in hospital. She said she received no treatment for this reaction despite there being treatments available. The Hospital complaints officer checked the records and agreed the woman had not received adequate treatment. An explanation and apology was given with an assurance that staff had been counselled to prevent a reoccurrence.

A woman complained about waiting several hours in a public hospital with young child who was violently ill. When they finally got to see a doctor and expressed her concern she was asked 'what they wanted him to do about it'. The woman took her daughter home visited a GP who prescribed some helpful medication. The woman considers the public hospital doctor to have been tired, overworked and uncaring.

Figure 9. Public Hospital Complaints



PRIVATE HOSPITALS

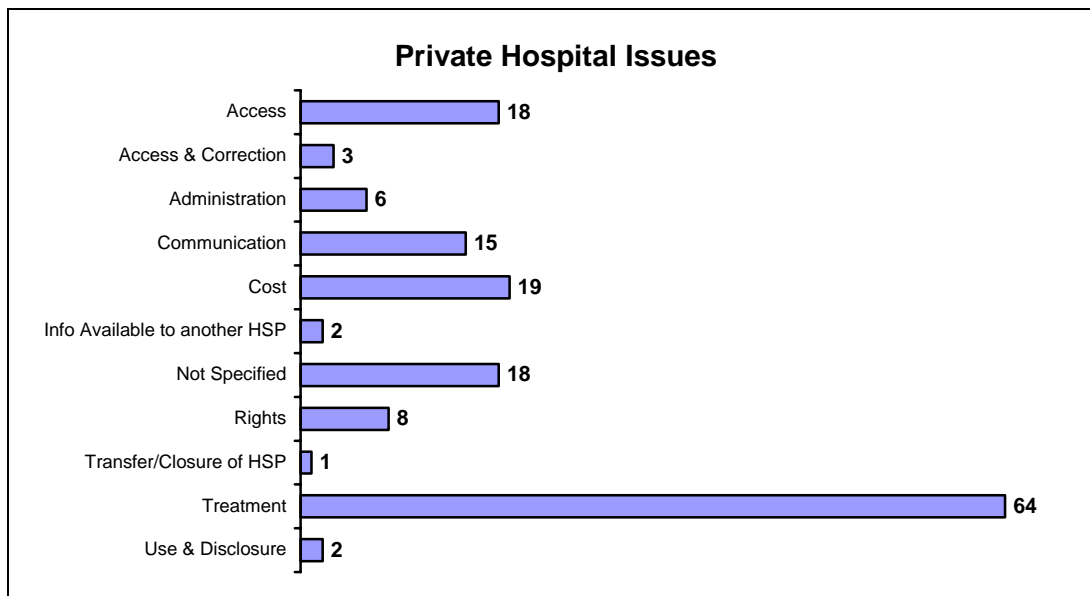
The pattern of complaints about private hospitals is similar to that for public hospitals with 64 (41%) being about treatment and 18 (12%) about access. Costs 19 (12%) are also an issue in private hospitals and usually involve a failure by hospitals to fully inform patients of the full costs involved.

A woman complained about a 'surcharge' for 'incidentals', which she had not been advised about. When she sought clarification what the charges were for and whether the surcharge was new, she was given the response, "I don't know". This is a clear example of poor communication and cost issues and the hospital has taken steps to ensure staff are trained in this area.

A woman who had been admitted to a private hospital was distressed by the behaviour of a staff member. She wrote a letter of complaint to the Hospital but received no reply. The Hospital's inaction led to her contacting HSC for assistance. It was explained to the Hospital the importance of prompt and courteous responses to complaints. The matter was resolved to the woman's satisfaction.

A man who had private health insurance was admitted to a public hospital. There was no room in the public hospital and he was moved to the adjacent private hospital. He was told he would be out of pocket for a small amount. When he was discharged from the Hospital he was told there was nothing to pay. Six months later he received a bill for several thousand dollars. The hospital agreed to him paying monthly installments however he feels aggrieved because he was not correctly or fully informed at the time of admission.

Figure 10 Private Hospital Issues



Psychiatric Services

There was a decrease in the number of complaints made about psychiatric services in the year under review. This continues the trend from 2000/2001, which also saw a slight decrease over the previous year.

Figure 11. Psychiatric Services Complaints

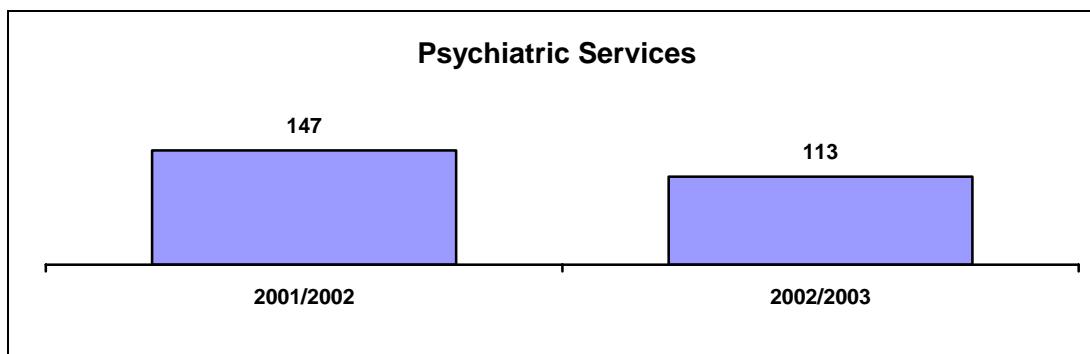
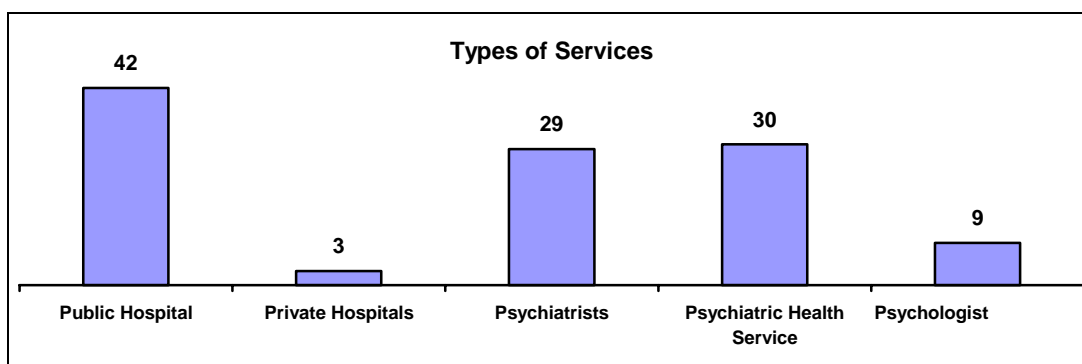


Figure 12 below shows the numbers of complaints made against each type of service.

Figure 12. Types of Service



ISSUES IN PSYCHIATRIC SERVICE COMPLAINTS

Figure 13 shows the primary issues identified in the 113 complaints received in the year under review. This is a slight decrease from the previous year, when a total of 147 complaints were received. Treatment 50 (44%) and patient rights 19 (17%) continue to be predominant. Some of the complaints about treatment are from patients who believe they no longer need to take their medication.

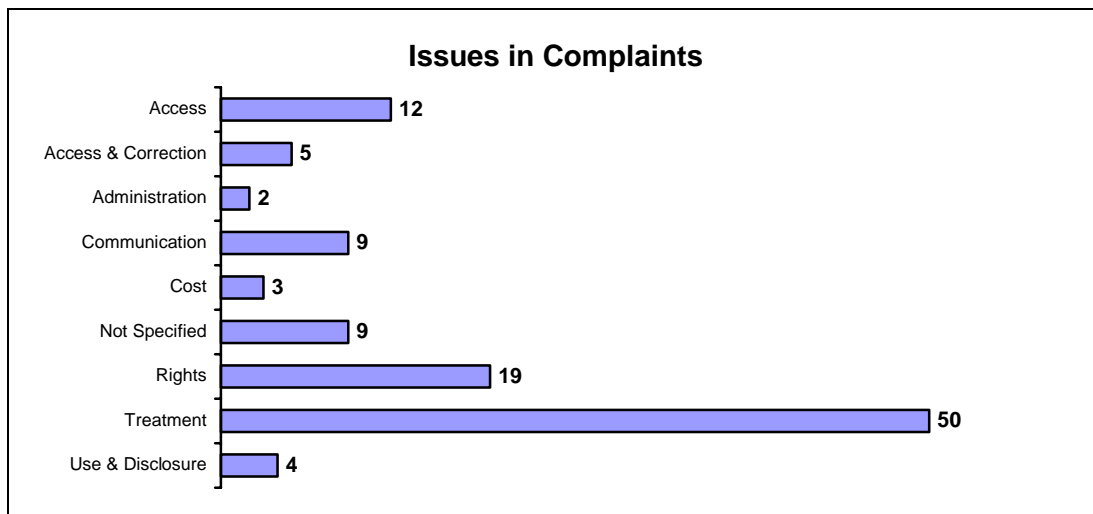
The HSC does not interfere with clinical decisions and is unable to review any decisions on patients' levels of medication. However, the HSC can request the treating psychiatrist to explain the reason for the clinical decision. Psychiatrists are usually happy to do this, thereby enhancing communication and the therapeutic relationship with the patient

If complaints are about involuntary status, the complainants are advised of their right to appeal to the Mental Health Review Board.

A woman was admitted to a psychiatric hospital and says she was treated roughly and her dignity was denied.

A mother expressed concern about the amount of medication her daughter was given on discharge from a psychiatric unit. She was especially concerned since her daughter had overdosed in a short period of time. With the daughter's consent the complaint was accepted and discussions with the mother, daughter and psychiatric service are continuing

Figure 13. Issues in Psychiatric Complaints



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 and provided by them to the HSC. 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 directly with the HSC.

The following trends comprise data provided by 36 public hospitals

WHO COMPLAINED AND HOW?

Forty-six percent of complainants were female and 41% male. As expected, public patients comprised the largest group (95%), private patients (4%) and 1% not specified.

The majority of complaints were made via telephone call (37%) or letter (33%), 17% by personal visit and 13% by other means.

The age and gender profile of complainants are shown in Table 16 and Figure 14 below:

CONSUMER PROFILE

Table 16. HCIP - Age analysis

Age	Total
Under 1	29
1 – 4	51
5 – 14	123
15 – 24	160
25 – 34	234
35 – 44	253
45 – 54	242
55 – 64	257
65 – 74	266
75+	304
Not Specified	1682
Total	3601

Figure 14. HCIP – Gender

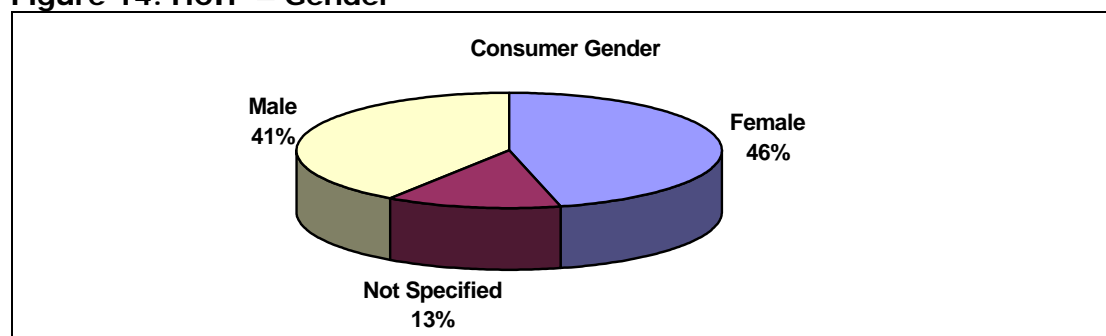
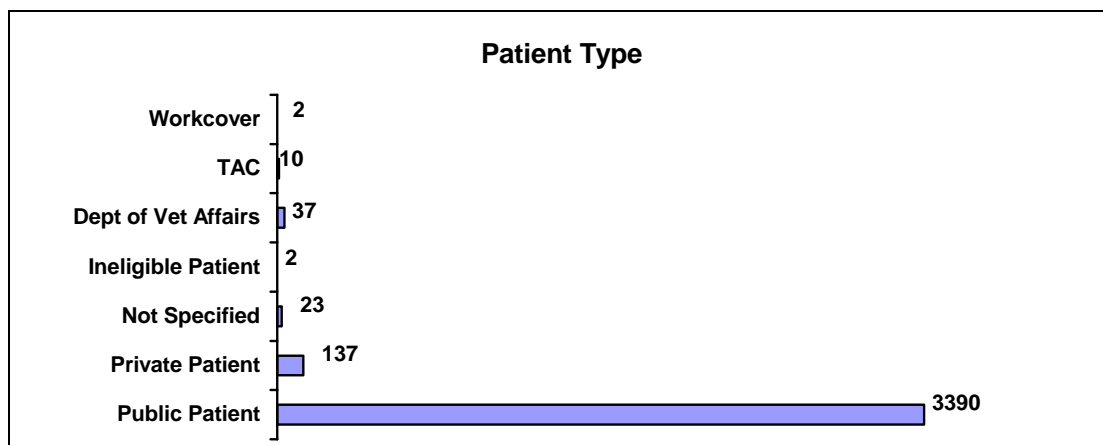


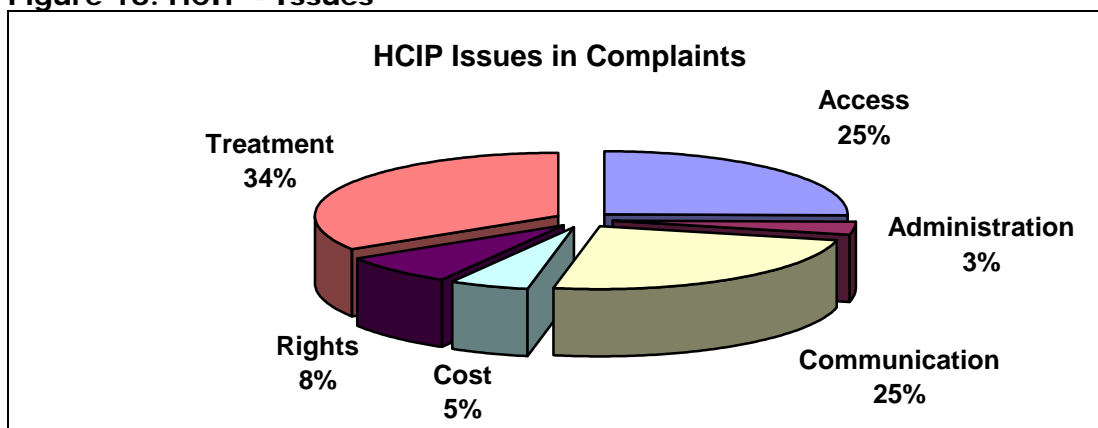
Figure 15. HCIP - Patient type



WHAT WAS THE COMPLAINT ABOUT?

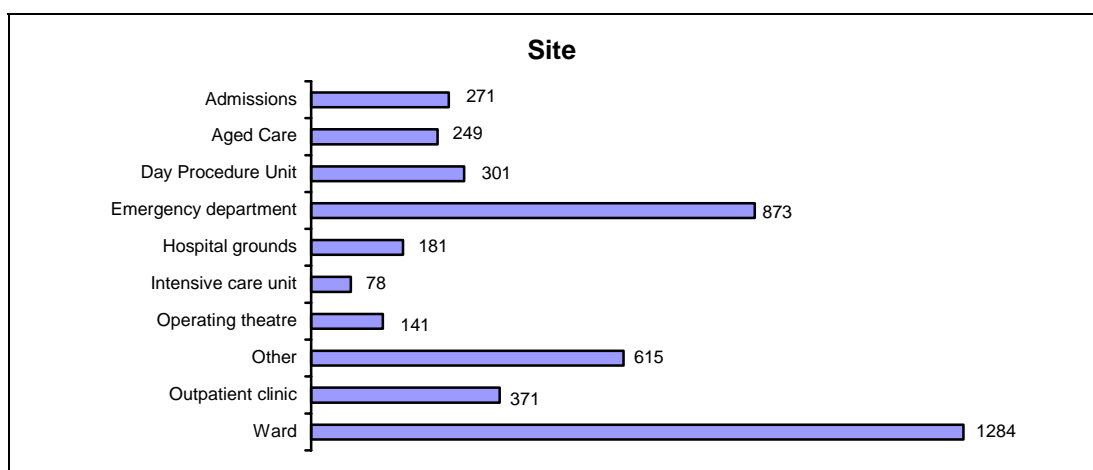
During the period under review hospitals received, and dealt with, 3601 complaints concerning 4364 issues. That is, there was an average of 1.2 issues per complaint received and addressed by the hospital complaints liaison officer (or patient representative). A complaint may be multi-faceted and concerned 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 16. HCIP - Issues



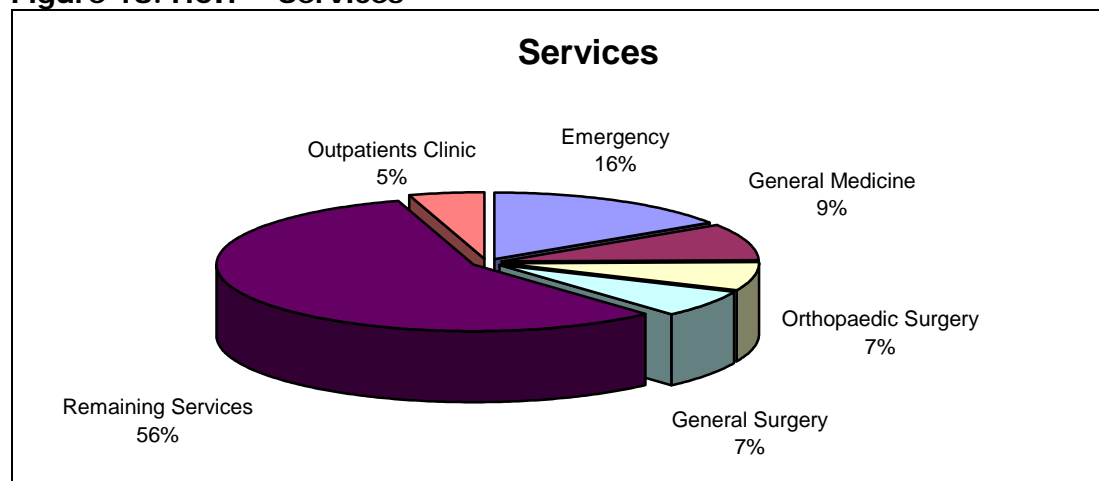
SITE AND SERVICE AT TIME OF COMPLAINT

Figure 17. HCIP - Site



SERVICES

Figure 18. HCIP - Services



HOW SERIOUS WERE THE COMPLAINTS?

Seven percent of complaints were categorised as serious or substantial and 60% as routine. The remaining 33% were listed as either minor or trivial.

WHAT WERE THE OUTCOMES OF THE COMPLAINTS?

Table 17. HCIP - Outcomes of complaints

Stage of Complaint Process	Number of Complaints
Resolved	3425
Lapsed	425
Remedial	89
Referred	255
Not Upheld	170
Total Number of Complaints	4364

If complaints are not resolved internally (which most are) they may be referred elsewhere for example to the HSC or appropriate registration board.

Executive Services

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

HRA

The HRA became operational on 1 July 2002 and despite the enormous amount of work done by the Office of the Health Services Commissioner (OHSC) prior to that date there has and will continue to be a need to:

- consult and educate stakeholders;
- produce and disseminate educational material;
- provide training; and
- offer advice.

The role of educating holders of health information and consumers is a formidable one that is an ongoing process. With the assistance of reference groups we have produced three brochures on the HRA, access to health records and the role of the OHSC aimed at different stakeholders. Over 165,000 brochures have been distributed to more than 530 organisations in the last financial year. Written information sheets have been produced for targeted groups, articles written and presentations given to over 130 groups and our website (www.health.vic.gov.au/hsc) has been redeveloped to assist in the education role.

Information and advice has been provided to many stakeholders including: health service providers, government departments and agencies, local government, holders of health information ranging from employers to kindergartens and the public.

The Commissioner and staff have worked closely with Victoria's Privacy Commissioner, Paul Chadwick. The Privacy Commissioner is responsible for implementing the *Information Privacy Act 2000*. A positive working relationship exists with Privacy Victoria and we have presented jointly to a number of organisations and co-operated on other projects. The co-operation and support of the Privacy Commissioner and his staff is very much appreciated. In particular, the HSC is grateful for the advice and assistance provided by David Taylor, Director, Privacy Awareness, his team and Michelle Fisher who continues to liaise with HSC's legal officer to promote consistency between the two organisations.

Private lives

In March 2003 the Attorney General the Honourable Rob Hulls MP launched the booklet 'Private Lives' a guide to privacy law in Victoria. This collaborative effort between this Office, Privacy Victoria and the Victoria Law Foundation resulted in a plain language guide to 'Privacy' in Victoria available from this Office and also on our website. Thirty thousand of these guides were produced and distributed throughout Victoria.

Infomed

Infomed provides displays of patient information in over 300 medical centres throughout Victoria. The HSC used this method as a way of communicating to patients and doctors information on the HRA and on the role of the OHSC.

Communicating privacy among diverse communities

Privacy Victoria appointed Cultural Partners Australia (CPA) to undertake social research to better understand issues related to privacy among Victoria's culturally and linguistically diverse (CALD) and indigenous communities. One of the recommendations from this research identified communication strategies to be developed for the CALD and indigenous communities.

CALD

The OHSC joined Privacy Victoria in a public information campaign to raise awareness of personal privacy rights and obligations among Victoria's CALD communities. The Parliamentary Secretary for Justice, Jenny Mikakos MP, launched the campaign in May 2003 at the Immigration Museum. It includes brochures, posters, postcards and print and radio advertising targeted at the Arabic, Chinese, Croatian, Greek Italian, Macedonian, Serbian, Spanish, Turkish and Vietnamese communities in Victoria.

Indigenous communities

The campaign to inform the indigenous communities of their personal privacy rights and obligations was launched by Jill Gallagher, Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation and the Privacy and Health Services Commissioners in June 2003. This campaign includes brochures, posters, postcards and print and radio advertising.

Both of the above campaigns include ongoing support, advice and outreach programs to ensure these communities are aware of the privacy message.

DHS training

Privacy Victoria, the Department of Human Services Privacy Unit (DHSPU) and the OHSC developed a training package of 3 modules designed for DHS Managers, Agency Liaison officers and funded agencies. The delivery of this package commenced in February 2003 and finished in June 2003. It covered all DHS regions and 39 sessions were held at 15 separate locations throughout Victoria and were attended by over 1600 DHS staff and agency representatives. The intention of these sessions was to promote further understanding of the respective roles and responsibilities of agencies and DHS in meeting privacy compliance requirements within the partnership framework.

Royal Melbourne Show

This Office joined Privacy Victoria on their stand in the Government Pavilion at the 2002 Royal Melbourne Show. Together we provided information to the public on information privacy in the public sector and privacy of health information in the public and private sectors. Six thousand show bags were distributed containing brochures, information sheets and stress balls. This substantial commitment of staff resources over the 11 days of the Show hopefully gave a large number of Victorians knowledge of their privacy rights.

Other OHSC initiatives

Train the trainer

The Health Records Act team developed a 'train the trainer' package based on Privacy Victoria's successful model. A big thank you to Privacy Victoria for allowing us to use their work. It was designed so privacy and training officers of various organisations could attend and develop their knowledge of the legislation and train staff in their own organisations. Three sessions were held during the financial year attended by approximately 65 individuals representing organisations as diverse as Victoria Police and Turning Point, a Drug and Alcohol counselling service. This package is available on our website. Thanks to Anne-Marie Polimeni who worked diligently on the package and presented two of these sessions.

On Line compliance and education program

The Office employed a project officer, Loretta Hoban, to formulate and manage submissions for an online health privacy compliance and education program. The aim of the program is to educate and test organisational compliance with the Health Privacy Principles as specified in the HRA. DHS Privacy Unit have put to tender a similar project covering the Privacy Principles in general, not only health, and the OHSC will work collaboratively with the successful tenderer to develop our program based on the same IT platform. Thanks to Loretta for her substantial work on this project.

Aged care expo

The Office provided a display at the two day Aged Care Expo held at the Caulfield Racecourse in February 2003. This included an ongoing PowerPoint presentation on the role of the Office and, in particular, the HRA. The various brochures and posters of the Office were displayed and distributed to a large number of providers and consumers in the aged care field.

HRA - A year on - seminar

This was a seminar hosted by the President and Members of the Health Services Review Council in April at the Victoria University. It was an opportunity for stakeholders to discuss the legislation almost 12 months after it became operational.

Key note speakers were Beth Wilson, HSC, and Professor Marcia Neave, Chairperson Law Reform Commission. A panel comprising Jan Donovan - National Prescribing Service, Dr John North, Royal Australian College of General Practitioners and Peter Devine, Association of Independent Schools, Victoria provided reflections on the operation of the Act.

Approximately 90 people attended the seminar and the feedback from participants revealed the HRA appears to have had a relatively smooth transition.

Human Resources

During the 2002/03 financial year Suzie Aron, the Commissioner's Executive Assistant successfully obtained a promotion to the Department of Natural Resources and Environment. Irene Villis acted in the position until it was advertised and filled permanently by Susan Herbert. Alex Crozier a Conciliator returned to, the warmer climate north of the divide, Wangaratta and Mark McPherson commenced in the conciliation team.

Other new starters during the year were Angela Palombo, Policy & Legal Officer who replaces Fahna Ammett who is working in the Department of Human Services Privacy Unit. Loretta Hoban, Project Officer working on the on line compliance and education project and Joe Barczak who worked with Allison Lusher, a third year Health Information Manager student in implementing a new records management system. Thanks to Joe and Alison for all their work in implementing the new system.

Merit and Equity Employment

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

Staff by gender at 30 June 2003 was 18 women and seven men.

Occupational Health & Safety

An OH&S consultant was employed to review the workstations of all employees and provide a report. All recommendations were acted on.

Whistleblowers Protection Act 2001

Section 104 of the above legislation requires public bodies to prepare an annual report of operations including a copy of current procedures for dealing with disclosures under the Act. (see Appendix 6)

For the year under review the OHSC reports:

a. Number of Disclosures

No disclosures of any type were made to the Office.

b. Public Interest Disclosures Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman for determination as to whether they were public interest disclosures.

c. Disclosures Referred to the Board

No disclosures of any type were referred to the Office by the Ombudsman.

d. Disclosures of Any Nature Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman to investigate.

e. Investigations Taken Over by Ombudsman

No investigations of disclosed matters of any type were taken over from the Office by the Ombudsman.

f. Requests Under Section 74

No requests were made under section 74 to the Ombudsman to investigate disclosed matters.

g. Disclosed Matters Declined to be Investigated

There were no disclosed matters of any type that the Office declined to investigate.

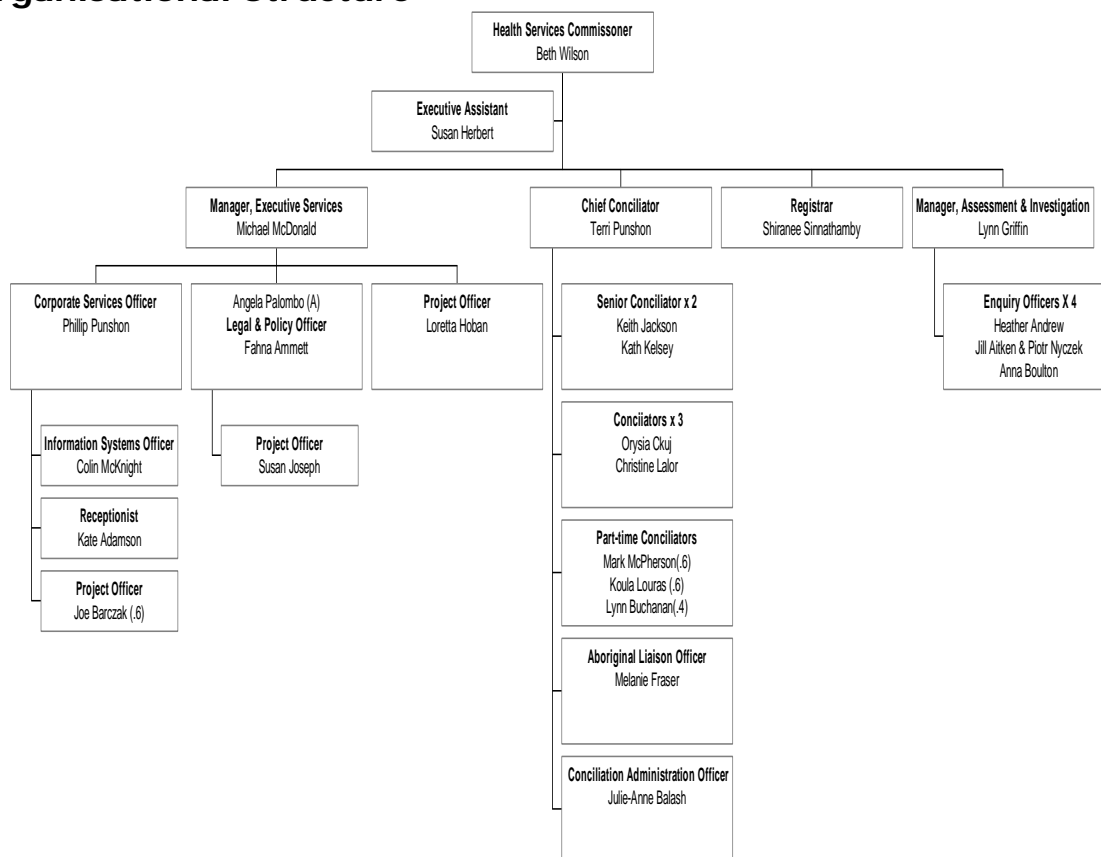
h. Disclosed Matters Substantiated on Investigation

No disclosed matters of any type were investigated, or substantiated on investigation.

i. Recommendations by Ombudsman

No recommendations were made by the Ombudsman under the *Whistleblowers Protection Act* relating to the Office.

Organisational Structure



Training

During the reported year staff attended various training opportunities including the seminar series on Medicine & Surgery for Lawyers, a conference run by the Centre for Law and Genetics and the 4th National Health Care Complaints conference held in Canberra attended by 10 staff from the OHSC.

Lunchtime presentations were conducted for staff by Rosemary Barker from the Department of Human Services on the Whistleblower legislation, David Brown from the Public Records Office, David Lescun and David Howell from the Metropolitan Ambulance Service. Charles Khoo presented an overview of cultural awareness training and Eva Wakim, Cuc Lam and Ron Murray presented specific training in relation to the Arabic, Vietnamese and Aboriginal communities to staff.

Staff also received refresher training in Cardio Pulmonary Resuscitation and the basics in first aid.

Information Technology

The Office installed 25 new computers and flat screen monitors that meet current DHS standards. The computers are cheaper to operate and more environmentally friendly requiring only 20 watts compared to 200 to operate. They are also more ergonomically correct for staff.

A scanner was purchased for the Office to enable electronic storage and transfer of information.

A program called Quick Address System (QAS) was loaded on to the complaints information database. QAS is an address program that validates contact details of complainants by correlating suburbs, streets and postcodes against Australia

Post's postal address files. It assists staff in identifying inconsistent address details, reduces input time and unifies the standard entering and storing of address details.

The major priority for the IT area in the OHSC in the last six months of the year has been the development of a new complaints management database to replace RAEMOC which was unable to meet the demands of the Office. Our Information Systems Officer, Colin McKnight developed the new database to be loaded on to a SQL server that should be operational early in the new financial year.

Customer Feedback

Evaluation Survey

The OHSC sends evaluation survey forms to all complainants and providers at the conclusion of a complaint. The information provides the OHSC with indicators on how we are performing and often contains useful suggestions for further improvement and where follow up action may be required. The form asks for responses to the following:

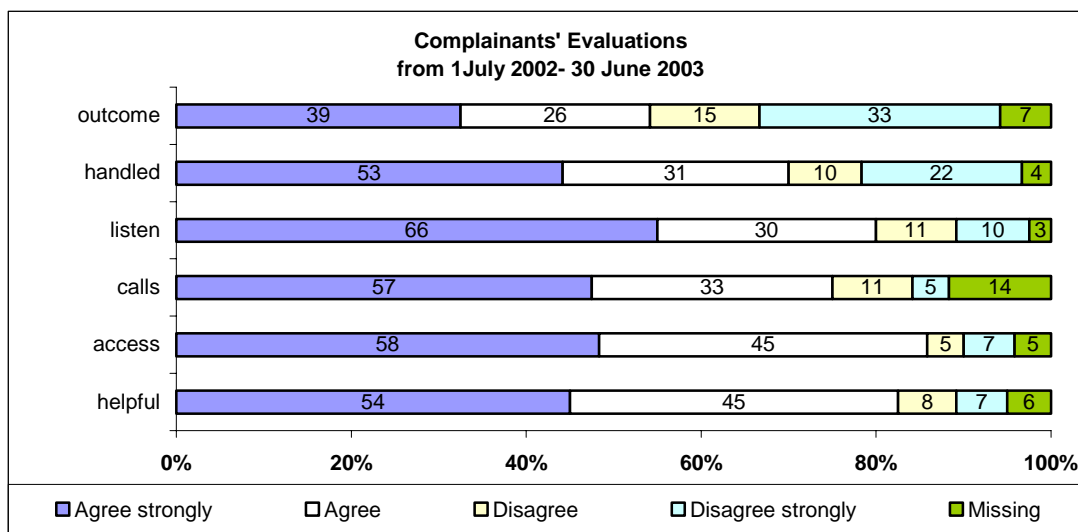
1. HSC staff were helpful in explaining the complaints process
2. I was able to speak to HSC staff when I needed to
3. HSC Staff returned my calls within 24 hours
4. I felt HSC staff listened to what I had to say
5. I was satisfied with the way the complaint was handled
6. I was satisfied with the outcome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

Respondents were asked whether they Strongly Agreed, Agreed, Disagreed or Strongly Disagreed with the statement. The aggregated responses received are tabled:

Complainants

Complainants who responded were very happy with the service provided by the OHSC. Over 82% said that the staff were helpful, they were able to access staff who listened to them and returned calls promptly. Seventy per cent were satisfied with the way the complaint was handled and 54% were satisfied with the outcome of the complaint. Obviously not all complainants receive the outcome they want with 45% not satisfied. It is clear, however, the majority believe their complaint was handled appropriately.

Response total = 120 from 692 (17% return)

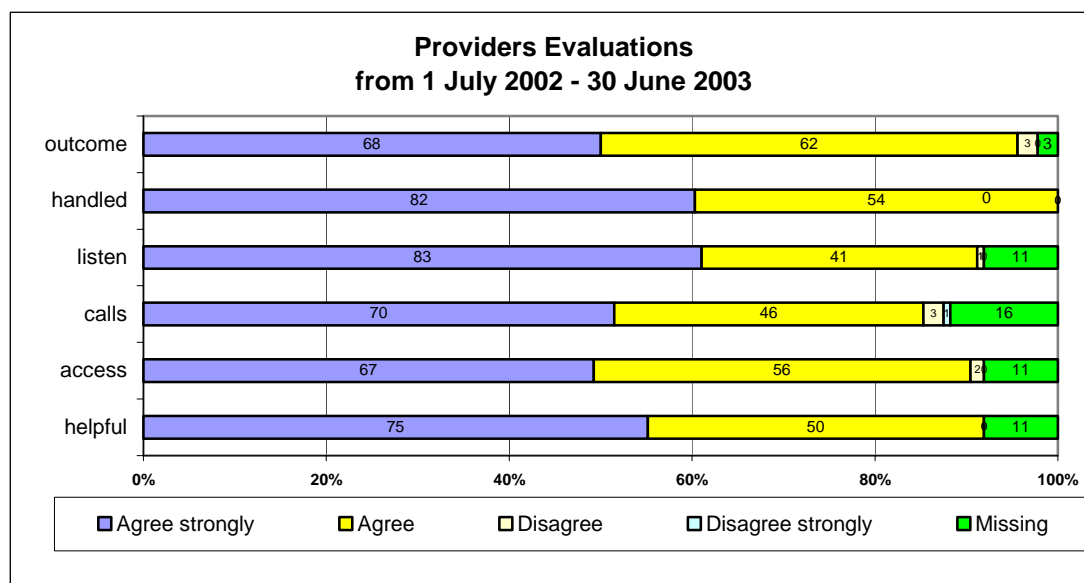


Providers

Provider responses were also very positive. Ninety five per cent of providers who responded indicated they were satisfied with the outcome and 100% satisfied with how the complaint was handled. Ninety one per cent of providers agreed the staff were helpful, they were able to access staff who listened to them and 85% agreed their calls were returned within 24 hours.

Sometimes parties to a complaint evaluate the outcome according to whether or not they have had a 'win' or feel they have been vindicated. In fact this is not the way HSC conducts its business as emphasis is placed on resolution and quality improvements rather than blaming one side or the other.

Response total = 136 from 692 (19% return)



Website

The Office website was most popular in 2002/03 with an average of over 2000 unique visitors averaging over 18,000 hits per month. The following table is for the period 1 July 2002 to 30 June 2003.

	Month	Hits	%	Sessions	Visitors	Pages
1	Jul	19,257	8.20%	2,465	1,702	2,328
2	Aug	20,924	8.91%	2,981	2,103	2,491
3	Sep	26,411	11.2%	3,968	2,769	2,446
4	Oct	20,124	8.56%	3,297	2,430	1,988
5	Nov	18,200	7.75%	2,889	2,179	1,953
6	Dec	14,152	6.02%	1,996	1,514	1,500
7	Jan	15,458	6.58%	2,393	1,829	1,670
8	Feb	17,315	7.37%	2,667	1,982	1,809
9	Mar	22,308	9.49%	3,516	2,572	2,139
10	Apr	19,241	8.19%	3,140	2,325	2,362
11	May	21,078	8.97%	3,356	2,471	2,486
12	Jun	20,075	8.54%	2,991	2,111	2,518
	Average	18,074	7.69%	2,748	2,003	1,980
	Totals	234,543	100%	33,744	9,500	25,690

Finance

Budget

The Budget for the 2002/2003 financial year was increased appropriately to resource the successful implementation of the HRA. The OHSC was allocated \$1,846,000 (excluding indirect expenses) and expended \$1,879,000 being 101.8% of its total allocation resulting in a deficit of \$33,000.

Financial Statements

	Allocated	Actual
Operating Expenses	\$435,900	\$370,117
WorkCover	\$14,326	\$14,326
Salaries	\$1,384,700	\$1,409,183
Sub Total	\$1,834,926	\$1,793,626
Capital Expenditure	\$10,800	\$85,044
Total	\$1,845,726	\$1,878,670

Expenditure

Direct Expenses

Salaries		\$1,409,183
Administrative stationery & operating supplies	\$17,553	
Advertising, publicity & information	\$54,619	
Books/publications/subscriptions/memberships	\$18,397	
Contractors	\$7,166	
Graphic design & editing	\$22,115	
Furniture, fittings & equipment	\$13,496	
HSRC payments & expenses	\$14,212	
Information technology costs	\$14,992	
Interpreter Services	\$3,807	
Legal expenses	\$4,281	
Maintenance	\$2,256	
Medical reports	\$49,239	
Miscellaneous	\$8,316	
Postal /courier	\$4,063	
Printing	\$69,579	
Staff development, seminars & training	\$10,811	
Telephones	\$24,711	
Travel-Airfares, Taxis, Personal Expenses	\$30,461	
Vehicle	\$43	
Sub Total		\$370,117
Workcover		14,326
Capital Expenditure		\$85,000
Total		\$1,878,426

APPENDICES

APPENDIX 1 - Providers by Type

Dentists in Private Practice	118
Hospitals	826
Medical Practitioners	883
Remaining Providers	
Aboriginal Health Worker	1
Alcohol & Drug Service	4
Alternative therapist	12
Ambulance Service	13
Beauty Therapist	2
Business	1
Chiropractor	8
Community Health Centre	32
Community Support Agency/Service	6
Corrections Health	215
Counsellor	8
Dental Prosthetist	7
Diagnostic Service	32
Dept of Human Services	7
Family Planning	3
Government	2
Health Insurance	3
Health Retreat	2
Infant Welfare Centre	1
Locum Service	1
Not a health service provider (individual)	7
Not a health service provider (organisation)	29
Nurse	1
Nursing Home	5
Nursing service	2
Occupational therapist	1
Optical Dispenser	30
Optometrist	7
Osteopath	1
Pharmaceutical supplier	10
Pharmacist	1
Pharmacist	13
Physiotherapist	4
Physiotherapy Service	1
Podiatry Service	1
Psychiatric Health Service	30
Psychological Service	5
Psychologist	4
Radiographer	8
Radiology Service	12
Social Worker	1
Supported Residential Service	6
Not specified	7
	546
Total	2373

APPENDIX 2 - Medical Practitioner Specialities

Specialty	Total
Anaesthetist	13
Cardiology	6
Dermatology	16
Ear, Nose and Throat	16
Emergency Medicine	1
Gastroenterology	4
General practice	226
General Surgery	135
Infectious diseases	1
Locum	5
Neurology	3
Not specified	308
Obstetrics/Gynaecology	39
Oncology	8
Ophthalmology	15
Orthopedic Surgery	7
Pathology	2
Pediatrics	4
Physical medicine	7
Plastic Surgery	23
Psychiatry	29
Radiology	3
Rehabilitation medicine	2
Respiratory medicine	1
Rheumatology	1
Urology	7
Vascular Surgery	1
	883

APPENDIX 3 - HCIP Issues

Access		Treatment	
Absence of caring	138	Absence of caring	60
Delay in admission	53	Inadequate diagnosis	82
Delay in treatment	176	Inadequate treatment	349
Discharge arrangements	94	Inadequate nursing care	182
Discharge/transfer	34	Medication omission/error	62
No/inadequate service	88	Negligent treatment	46
Non attendance	7	Other	498
Other	212	Rough treatment	51
Refused admission	16	Unskilful/incompetent treatment	31
Refused to refer	1	Unexpected outcome	84
Service busy	33	Wrong diagnosis	27
Transport	99	Wrong treatment	10
Transfer unsuitable	8		
Waiting list	146		
	1105		1482
Communication		Rights	
Absence of caring	94	Accuracy of records	15
Conflicting information	63	Access to records	23
Communication breakdown	220	Assault	5
Failure to consult	56	Discrimination	31
Inadequate information	190	Failure to provide an interpreter	2
Other	122	No/insufficient consent	14
Poor attitude/discourtesy	272	Other	69
Undignified service	32	Property	86
Wrong/misleading Information	26	Privacy/confidentiality	52
		Refusal to treat	6
		Unprofessional conduct	37
	1075		340
Cost		Administration	
Amount charged	48	Failure to provide a certificate	2
Billing practice	24	Incorrect. Documentation	25
Information on cost	7	No/Inadequate response	14
Other	118	Other	59
Private health insurance	5	Policy	15
Public/private election	20	Public health standards	13
Unnecessary treatment	2	Treatment Cancelled	10
	224		138
		Total	4364

APPENDIX 4 - HCIP Service Provided at time of Complaint

<i>Services</i>		<i>Services</i>	
Accommodation Services	54	Neurology	95
Administrative Services	57	Neurosurgery	99
Admissions	63	Nursing Home	4
Aged Care	22	Nutrition	4
Alcohol & drug Services	4	Obstetrics	67
Anaesthetics	22	Obstetrics/Gynaecology	67
Audiology	13	Occupational Therapy	4
Awaiting admission	17	Oncology	57
Car Parking	86	Operating Theatre	45
Cardiac Surgery	31	Ophthalmology	121
Cardiology	96	Orthopaedic surgery	310
Chaplaincy	1	Outpatients clinic	201
Colorectal	16	Paediatrics	68
Day procedure	66	Pain services	1
Dentistry	16	Palliative care	3
Dermatology	9	Pathology	19
Ear, Nose & Throat	93	Patient Services	39
Emergency	693	Pharmacy	15
Emergency Triage	42	Physiotherapy	17
Endocrinology	26	Plastic surgery	67
Environmental services	19	Podiatry	3
Finance & Administration	20	Prosthetics/Orthotics	4
Food Services	16	Psychiatry	45
Gastroenterology	76	Radiology	86
General medicine	384	Reception/Administration	33
General practice	42	Rehabilitation medicine	39
General surgery	284	Renal/Nephrology	49
Gerontology	9	Respiratory Medicine	57
GP support Res. Services	1	Rheumatology	6
Gynaecology	20	Social work	15
Haematology	23	Speech therapy	6
Home Care	22	Specialist Medical	22
Hostel	4	Specialist Surgical	31
Infectious diseases	4	Spinal Injuries Unit	19
Intensive Care Unit	96	Telecommunications	4
Interpreter Services	3	Unknown	108
Medical administration	12	Urology	36
Medical technician	1	Vascular surgery	32
		Total	4364

APPENDIX 5 - HCIP Outcomes

Resolved		Remedial	
Agreement reached	108	Censure or Reprimand	3
Apology	1419	Remedial action	80
Compensation Paid	13	Caution or warning	6
Explanation offered	1010		89
Fee waived or reduced	19	Referred	
Fee refunded	7	Outcome in Referral	256
Frivolous/vexatious	0		256
Information Provided	236	Not Upheld	
Misunderstanding resolved	77	Complaint not upheld	74
No further action required	0	No action possible	96
Service/facility provided	236		170
Users view acknowledged	290	Lapsed	
Waiting Time Reduced	9	Insufficient detail	115
	3425	Allowed to lapse by user	93
		Not confirmed	77
		Unsubstantiated	115
		Withdrawn by user	25
			425
		Total	4364

Appendix 6

Reporting procedure guidelines under the *Whistleblowers Protection Act 2001*

September 2003

Contact: Michael McDonald

Executive approval 9 September, 2003

Manager, Executive Services
Phone: 8601 5222

Guideline No. 0302

Prepared by Michael McDonald

These guidelines are for all employees of the Office of the Health Services Commissioner (OHSC) and are available to all members of the public free of charge.

They can also be viewed at the OHSC website www.health.vic.gov.au/hsc

Whistleblowers Protection Act 2001

These guidelines are made in accordance with the *Whistleblowers Protection Act 2001* (the Act), which came into effect on 1st January 2002. Consistent with the Act, the policy of the Health Services Commissioner is to encourage and facilitate the making of disclosures, where these are supported by reasonable grounds, related to alleged improper or corrupt conduct.

A staff person or member of the public, who has reasonable grounds to believe improper or corrupt conduct has occurred, is occurring or is about to occur is encouraged to disclose this in accordance with these procedures.

Introduction

(a) The aim of these procedures is to establish an objective system to encourage and provide support to persons making disclosures ("whistleblowers"), to investigate disclosed allegations of improper conduct, or detrimental action against the person making the disclosure and to enable appropriate action to be taken.

(b) A disclosure may be made about improper conduct by a public body or public official.

Improper conduct means conduct that is corrupt, a substantial mismanagement of agency resources or conduct involving substantial risk to public health, or to safety or to the environment. The improper conduct must be sufficiently serious to establish (if proved) a criminal offence or reasonable grounds for dismissal from employment.

Corrupt conduct includes conduct by any person (not necessarily an employee) that adversely affects the honest performance of the functions of a public body or a public officer; an employee performing their functions dishonestly or with inappropriate partiality; conduct by an employee or a former employee that amounts to a breach of public trust, or a misuse of information or material acquired in the course of performing their official functions; a conspiracy or attempted conspiracy to engage in corrupt conduct.

(c) Detrimental action is action taken or threatened against a person disclosing alleged improper conduct and includes action causing injury, loss or damage, intimidation or harassment, discrimination, disadvantage, or adverse treatment to a person's employment, career, profession, trade or business and includes the taking of disciplinary action because of the fact of a disclosure of alleged improper conduct.

Procedures for handling disclosures

The OHSC has established the following procedures to facilitate the making of disclosures, investigation of disclosures, and for the protection of persons making disclosures from reprisals by the Health Services Commissioner, or any other employee of the OHSC. A disclosure may be made to the Manager, Executive Services of the OHSC or to the Victorian Ombudsman.

The following procedures apply where a disclosure is made to the OHSC:

1. A disclosure of alleged improper conduct shall be made direct to the Manager, Executive Services (or specifically nominated delegate). Alternatively, the disclosure may be made to the Ombudsman.

2. On receipt of a disclosure, the Manager, Executive Services (or specifically nominated delegate) shall assume the role of the Protected Disclosure Coordinator (PDC) and shall promptly:

(a) Meet with the person making the disclosure (unless it is provided anonymously) to ascertain the details of the disclosed matter and invite the complainant to provide a detailed written statement on an "in confidence" basis.

(b) Impartially assess the disclosure to determine whether it amounts to a protected disclosure:

i. If not, the PDC will explain to the complainant what other remedial action can be taken in the circumstances;

ii. If so, the PDC will explain to the whistleblower the protections that s/he receives under Part 3 of the Act and will offer the whistleblower welfare management. Thereafter, the PDC will move to step (c).

(c) Determine whether the protected disclosure amounts to a Public Interest Disclosure (PID) within Part 4 of the Act:

i. If not, the PDC will explain what remedial action can be taken in the circumstances and that the whistleblower has the right to request that the protected disclosure be referred to the Ombudsman for a review of the PDC's determination. Where the whistleblower is satisfied with the proposed remedial action the PDC will give effect to such action subject to the protection, that the whistleblower enjoys under the Act;

ii. If so, the PDC will refer the PID to the Ombudsman for a formal determination as to whether the protected disclosure amounts to a PID.

(d) If the Ombudsman determines that the disclosure is a protected disclosure, the Ombudsman may refer it back to the Manager, Executive Services to be investigated.

- (e) If it is referred back to the Manager, Executive Services, the PDC shall promptly assign an investigator (who may be a senior employee or external solicitor/consultant) to investigate the disclosure and report direct to the PDC who will refer the report to the Ombudsman.
3. If the disclosure relates to the Manager, Executive Services, the disclosure should be made directly to the Ombudsman.
4. Disclosure and investigation material will be treated with the utmost confidentiality and security. Such material is only to be accessed by the Manager, Executive Services as the PDC or by the investigator. Disclosures made under this policy will be investigated swiftly, professionally and discretely.
5. The OHSC is required to include in its annual reports material including the number (if any) and types of disclosures made to it.
6. Where an investigation of a PID reveals that the improper conduct occurred, the PDC will:
- i. Report the findings of the investigation to the Minister;
 - ii. Take all reasonable steps to prevent the conduct occurring in the future;
 - iii. Bring disciplinary proceedings against the person responsible for the conduct;
 - iv. Refer the matter to the appropriate regulatory body for further consideration.
7. It is a criminal offence:
- (a) For a person to take detrimental action against a person in reprisal for a protected disclosure (\$6,000 fine or two years imprisonment or both)
 - (b) For a person to reveal confidential information received in the course of or as a result of a protected disclosure except as provided for under the Act (\$6,000 fine or 6 months imprisonment or both)
 - (c) For a person to willfully obstruct, hinder or fail to comply with a lawful requirement of the Ombudsman (\$24,000 fine or two years imprisonment or both)
 - (d) For a person to knowingly mislead or attempt to mislead the Ombudsman (\$24,000 fine or two years imprisonment or both)
 - (e) For a person to knowingly provide false information to the OHSC's Manager, Executive Services intending it to be acted on as a disclosed matter (\$24,000 fine or two years imprisonment or both).

The OHSC is committed to the highest standards of ethics and probity in the performance of its duties and the delivery of its services to the community.

The Ombudsman has published a set of detailed guidelines and the agency will follow these in dealing with a disclosure. A copy of these guidelines is available from the OHSC or can be downloaded from the Ombudsman's website www.ombudsman.vic.gov.au



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