Health complaint commissions in Australia: Time for a national approach to data collection

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ABSTRACT

Health complaint statistics are important for identifying problems and bringing about improvements to health care provided by health service providers and to the wider health care system. This paper provides an overview of complaints handling by the eight Australian state and territory health complaint entities, based on an analysis of data from their annual reports. The analysis shows considerable variation between jurisdictions in the ways complaint data are defined, collected and recorded. Complaints from the public are an important accountability mechanism and open a window on service quality. The lack of a national approach leads to fragmentation of complaint data and a lost opportunity to use national data to assist policy development and identify the main areas causing consumers to complain. We need a national approach to complaints data collection in order to better respond to patients' concerns.

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Introduction

This paper examines the type of data published in Australian health care complaint commission annual reports and reviews the extent to which the data allows comparisons over time and across commissions, and their capacity to draw conclusions on complaints management. The context is the trend toward national governance and national reporting and the push to strengthen accountability to the public.

Law and policy governing the safety and quality of the Australian health sector is being transformed by a series of reforms focusing on greater integration (Healy 2011; McDonald 2012) and an increasing emphasis on a national approach to quality and safety as well as professional regulation. A national approach to the safety and quality elements of health governance is perceived to have a number of benefits, including greater consistency. However, little attention has been paid to the functions, operations and organisation of the eight health complaints commissions (HCCs).[1] This is a significant omission given both that the HCCs play an important role in the health governance framework and that it is widely acknowledged that accessing and analysing health complaints data provides an opportunity for data-driven quality improvement (Bismark & Studdert 2010).

All HCCs have a legislative framework governing what can be complained about, who can complain and what happens as a result of a complaint. All eight are independent of their state and territory health departments, having evolved from department administrative units. These HCCs provide a pathway for resolving consumer complaints and depending on the type and seriousness of the complaint identify the appropriate method for managing it. They are an important mechanism for holding health services and health professionals accountable and provide remedy for those dissatisfied with the way the professional registration boards and hospitals handled complaints. The broader context for their maturity over the last decade has been the move to empower health care consumers (Thomas 2002). In addition the focus on patient safety highlighted after studies in several countries, including Australia, showed that patients could be inadvertently harmed by 'adverse events' even in the best of modern hospitals (Wilson et al. 1995). HCCs were consolidated in the late 1990s when the Australian government, under the amended *Medicare Agreements Act 1992,* required the states and territories to maintain independent health complaints bodies.

Recommendations from a series of public inquiries into medical scandals resulted in enhanced powers and resourcing for the commissions, particularly in Queensland and New South Wales, now the two strongest commissions. The Queensland commission was strengthened following complaints in 2005 about incompetence,

[1] The exception is in Western Australia where the complaint entity is called the Health and Disability Services Complaints Office. The health complaint commissions are referred to as HCCs for the remainder of the paper.

inadequate infection practices and inappropriate surgery by Jayant Patel at Bundaberg Hospital, which widened into public inquiries into several Queensland hospitals (Davies 2005). The NSW commission was strengthened after an inquiry in the late 1980s into deaths from deep sleep therapy at a private psychiatric hospital (Slattery 1991), and again after a public inquiry in 2004 into malpractice allegations about surgeons at two Sydney hospitals (Walker 2004).

Reforms to the regulations of health professionals and hospitals

Analyses of complaint statistics by the HCCs and their role in the regulation of health care are timely because the field is being transformed. Governments in many countries in the early 21st century, including Australia, began to overhaul the regulation of health care, moving away from reliance on self-regulation by the health professions and the health industry towards increased accountability to government and the public (Healy 2011). Complaints commissioners were an earlier form of regulatory entity, being established from the 1980s onwards in the Australian states and territories, but since then more bodies have been set up to strengthen the governance of health care and regulate aspects of health care systems.

The HCCs are external regulatory entities set up as statutory bodies independent of the health system. Other external avenues for complaints by the public include civil tribunals and courts, politicians and the media. The professional health boards are also long-standing avenues for complaints by the public (McDonald 2012). In relation to the external scrutiny of hospitals and other health services, Australian states and territories have opted for an independent external complaint entity model rather than the hospital inspector model favoured by other countries.[2]

Recently established national authorities[3] set up to manage the funding of hospitals and to monitor hospital performance indicators are additional external monitories of quality and standards. Hospitals and health services from 2013 will be required to seek accreditation. Internal avenues for complaints about health services have also strengthened with most large hospitals now having internal complaints units. In 2011 the Australian Commission on Safety and Quality in Health Care (ACSQHC) published national standards for public hospitals and other health services to include the right of patients to complain directly to a service provider. An additional standard, criterion 1.15, requires health organisations to have a complaints management system.

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2 The following authorities that can conduct a review/inspection include: the Care Quality Commission in England, the Dutch Healthcare Inspectorate (IGZ), the German Federal Office for Quality Assurance (requires hospitals to report against quality standards) (Healy 2011, p. 207). In addition, many countries have accreditation agencies, whether government or non-government organisations that survey hospitals against accreditation standards. Health complaints commissioners as independent statutory authorities appear to exist only in the Australian states, New Zealand and England.

3 These are the Australian Health Practitioner Regulation Agency, the National Hospital Funding Body, the Independent Hospital Pricing Authority, and the National Health Performance Authority.

This standard will consolidate hospital and health services' internal complaints procedures. National guidelines and a complaints management handbook published by the then Australian Council on Safety and Quality in Health Care (2004, 2005) assist health organisations.[4] In addition most health departments and hospitals have adopted clinical governance policies and practices that seek to hold health care providers accountable for the quality and safety of their services (Braithwaite & Travaglia 2008). Dealing with complaints more effectively is one of many approaches that come under a clinical governance rubric, as are adverse events reporting systems, and disclosure to patients in the case of adverse events or medical injury (Studdert 2009).

The HCCs remain important and distinctive entities for six reasons. First, they act as an independent 'integrity entity' (Transparency International 2009) or 'public watchdog' in making institutions more accountable for improving inadequate services and procedures. Second, the HCCs are important because patients otherwise find it difficult to make themselves heard above other interest groups (Healy 2011), even though the 'voice' of patients is a key indicator of the quality of a health care system (World Health Organization 2000). Third, the HCCs offer a quicker, less daunting avenue for redressing grievances than the courts. Fourth, they have a suite of remedies, including alternative dispute resolution methods for resolving disputes depending on the type and nature of the complaint. Fifth, the HCCs offer an independent avenue for patients to complain about health care organisations. Finally, complaints by patients open a window on the quality of health care, since assessing quality requires not one but many measures and perspectives. More than 10,000 complaints to the eight HCCs and the New Zealand commissioner annually offer a rich database for researching quality (Bismark & Studdert 2010).

In 2005 the Australian Productivity Commission investigated the supply and demand of the health workforce including the supply of, and demand for, health workforce professionals and made recommendations to secure continued quality health care. The commissioners made two groundbreaking recommendations: establish a national health professional registration regime and a consolidated national accreditation regime. The states and territories worked together over five years to create a national registration and accreditation system for Australia. On 1 July 2010 the Australian Health Practitioner Regulation Agency (AHPRA) became the single national oversight agency for health professional regulation.

Under Australia's federal system, the establishment of national boards required 'mirror' legislation in each jurisdiction based on an agreed template law, the *Health Practitioner Regulation National Law 2009* (Qld), followed by parallel legislation in all states and territories. The Act also created independent disciplinary procedures and imposed mandatory obligations on registered health professionals to report professional misconduct or significantly sub-standard performance placing the public

[4] In 2006, the Australian Council for Safety and Quality in Health Care was superseded by the Australian Commission for Safety and Quality in Health Care.

at risk of harm (s.140). Health practitioners registered with the national board now move freely between states and territories, and enhanced powers, such as mandatory reporting and registration checks, provide greater assurance for employers and the community.

While new legislation governs the health professions, the relationship between the HCCs and the national boards in handling complaints about professionals has essentially remained unchanged. While all states and territories joined the national registration scheme New South Wales did not join the scheme for handling notifications (complaints); instead New South Wales retains its existing complaint system involving the NSW Health Care Complaints Commission (HCCC) and the State Health Professional Councils. All other states and territories joined the national notification (complaints) scheme prescribed in the Health Practitioner Regulation National Law.

A Memorandum of Understanding between AHPRA (2011) and each of the complaints commissioners, among other things, requires timely notification of complaints, consultation about their management and the sharing of information. The legislation enables national data on complaints about health professionals to be collected for the first time. AHPRA's annual report for 2010–11 lists national notifications (complaints) data for all professions, mandatory notifications, numbers assessed, investigated, dealt with under health or performance provisions, and numbers referred to a disciplinary panel or to a tribunal. While AHPRA collects national complaint data, with the exception of New South Wales, from the fourteen boards of the registered health professionals, it does not have jurisdiction on complaints about unregistered health practitioners, which remains with the HCCs.

The HCCs are an independent avenue for patients' complaints about health services including many complaints about hospitals. However, the HCCs differ in the balance they strike between the resolution of complaints by individuals and their public watchdog role of identifying and resolving systemic problems with health services. The commissioners all agree, however, that complaint management extends beyond the resolution of individual grievances, since complainants usually want a resolution of their own grievance and an explanation of why the problem arose and what is being done to prevent it recurring (Wilson 1999; Barbour 2007). In addition to offering an independent avenue for resolving complaints about health services, complaints commissions provide an alternative dispute mechanism to the court system. They are 'responsive regulators' in their capacity to respond to complaints with a range of sanctions aimed at improving health services. Regulation is defined broadly here to include strategies ranging from persuasion to enforcement, and so covers any activity, legal, political, social, economic or psychological, the purpose of which is to steer the flow of events (Ayres & Braithwaite 1992). The HCCs thus are important players in the regulation and governance of health service organisations and health professionals.

Table 1. Health complaint entities/commissions (and forerunners) as at January 2012

State	Complaint entity/commission	First est.	Legislation	Inclusions	Time limitation
NSW	Complaints Unit (in Department of Health)	1984	*Health Administration Act 1982* (NSW)	Health complaints	5 years
	Health Care Complaints Commission	1994	*Health Care Complaints Act 1993* (NSW)		
Vic	Office of the Health Services Commissioner	1988	*Health Services (Conciliation and Review) Act 1987* (Vic)	Health complaints	1 year
Qld	Health Complaints Unit	1989	Public sector only	Health complaints	1 year
	The Health Rights Commission	1991	*Health Rights Commission Act 1991* (Qld)		
	Health Quality and Complaints Commission	2006	*Health Quality and Complaints Commission Act 2006* (Qld)		
WA	The Office of Health Review	1996	*Health Services (Complaints) Act 1995* (WA)	Health and disability services complaints	2 years, but commissioner has discretion
	Health and Disability Services Complaints Office	2010			
SA	Health and Community Services Complaints Commissioner	2004	*Health and Community Services Complaints Act 2004* (SA)	Health and community services complaints	2 years
Tas	Health Complaints Commissioner	1997	*Health Complaints Act 1995* (Tas)	Health complaints	2 years, but commissioner has discretion
ACT	Health Complaints Unit (under Community & Health Complaints Commissioner)	1994	*Community and Health Services Complaints Act 1993* (ACT)	Health complaints – but over-arching organisation is Human Rights Commission	1 year
	Human Rights Commission	2005	*Human Rights Commission Act 2005* (ACT)		
NT	Health & Community Services Complaints Commission	1998	*Health and Community Services Complaints Act 1998* (NT)	Health and community care complaints	2 years

Study objectives and methods

The methods used were an examination of enabling legislation for the eight state/territory HCCs and a comparison of statistics from their published annual reports from 2005–06 to 2009–10.

Results

Functional differences between the HCCs

The structure and functions of the eight commissions vary depending on the state/territory context, the enabling legislation, ideological preferences, health system structure, history (such as public inquiries into hospital scandals; see Slattery (1991) and Walker (2004)), and public sector culture. The HCCs also vary in staff size and budget, with New South Wales and Queensland the largest. Table 1 lists the HCCs, the relevant legislation, the year each was established, the grounds for complaint covered and the statute of limitations. Four of the HCCs were created out of complaint units located within a state health department (New South Wales, Queensland, South Australia, and Western Australia), while the first statutory commission was established in Victoria in 1988.

An examination of the relevant legislation shows that the HCCs, operating under different legislation, influence complaint numbers and the way complaints are managed. Their jurisdiction covers health services and health professionals, one state also covers hospital standards (Queensland), another includes disability services (Western Australia), and two include community services (South Australia and the Northern Territory). The legislation also varies on the grounds for a complaint (for example, some legislation specifies types of services), the statute of limitations on a complaint (with variation from one to five years), and differences in the information required in reports to respective parliaments.

Enquiries and complaints

Our analysis found that comparisons between commissions were possible only for the most basic data and that there was considerable variability in the matters presented in annual reports. This paper identifies these problems in order to make suggestions about how they might be solved.

Varying definitions in the seven HCC statutes describe common terms such as 'complaint' and 'enquiry'. Some use the term 'complaint' to include a general enquiry, whereas others count a 'complaint' only when a written form is lodged. We first examined the number of reported enquiries. All HCCs (except the Australian Capital Territory) reported increased enquiries between 2005–06 and 2009–10. Enquiries increased by 51 per cent in Queensland and 41 per cent in New South Wales, and while the reasons are unclear, these states did have highly publicised public inquiries during that period. Comparisons between states proved problematic, however, as the annual reports vary in their definition of 'enquiry'. Some count all contacts on a variety of matters, or all enquiries and complaints, while others count only enquiries that do not become formal complaints.

Table 2. Number of total written complaints received by commissions 2005–06 to 2009–10

State/territory commission	2005–06	2006–07	2007–08	2008–09	2009–10	5-year % change
NSW Health Care Complaints Commission	3,023	2,722	3,128	3,360	3,515	+16%
Vic Office of the Health Services Commissioner	1,131	1,170	1,139	1,379	1,316	+16%
Qld Health Quality and Complaints Commission	4,465[5]	2,922	2,675	2,534	2,241	-23% (4-year)
WA Health and Disability Services Complaints Office	321	459	566	265[6]	289	-10%
SA Health and Community Services Complaints Commission	no data available	251[7]	110	97[8]	no data available	–
Tas Health Complaints Commissioner	269	224	235	243	236	-12%
ACT Health Services Commissioner	276	283	228	250	300	+9%
NT Health and Community Services Complaints Commission	97	94	62	84	111	+14%

After talking to commission staff, a person may decide to take up the matter directly with the service concerned, or may decide not to proceed with a grievance. The main finding is that enquiries outnumber actual complaints (approximately double the number). Given variations in the meaning of an 'enquiry', a 'written complaint' is a better measure of community concern, despite some definitional differences among jurisdictions. Most HCCs require a complaint to be in writing (often on a complaints form). Table 2 shows no clear trend nationally with the number of written complaints

5 Combines enquiries and complaints.

6 Annual report not clear on how many complaints were actually investigated—for example, the number of 'written complaints' in 2008–2009 was listed as 449 in the 2008–09 annual report, but given as only 265 in the 2009–10 annual report.

7 Includes community service complaints.

8 South Australian data made up from Table 12 in the 2008–09 annual report, adding together s29 (2), s29 (3), s30, s34, part 6 and part 7.

over the five-year period increasing in some states and territories but falling slightly in others. Two of the most populated states—New South Wales and Victoria—showed a trend of increased complaints with a 16 per cent increase over the five-year period. New South Wales received the most complaints (3,515) in 2009–10, followed by Queensland (2,241) and Victoria (1,316). (Queensland combined enquiries with complaints in 2005–06.) While enquiries to most HCCs rose over the period, this did not automatically convert to an increase in written complaints.

Types of complaints and subject of complaints

All commissions classify the complaints received but categories differ. 'Treatment issues' are uniformly reported, however, as the most common issue for all commissions (except Western Australia where 'quality of care' was the main issue). While the health services literature frequently identifies 'poor communication' as a cause for complaints (National Health and Medical Research Council 2006), 'treatment' consistently outranked 'communication' across all HCCs and years.

Some HCCs such as the Northern Territory include both health and community services data in their figures while others such as Western Australia include health and disability services—which is perhaps why 'quality of care' is the main subject of complaints.

Classification of types of services complained about also differ; for example, 'acute services', or 'public hospitals' are used but may or may not relate to the same place, while 'health services' and 'community services' are general categories. All HCCs receive complaints about medical practitioners, but some code medical practitioners by specialty whereas others use the umbrella phrase 'medical practitioner'.

All HCCs receive complaints about health organisations and health professionals. The pattern was fairly consistent over the five-year period in the type of organisation complained about and the type of professional; Table 3 shows the results for 2009–10. 'Public hospitals' were the most complained about group over the five years and for 2009–10. This is to be expected, as public hospitals are the largest type of health service organisation. Queensland received the highest percentage of complaints about public hospitals (59 per cent) with the remainder of the HCCs receiving between 13 per cent to 25 per cent hospital complaints. While trends in complaints about public hospitals were fairly stable in most places, there was a noticeable decrease in Victoria (from 31 per cent in 2005–06 to 14 per cent in 2009–10) and in the Australian Capital Territory (from 30 per cent to 13 per cent). Whether this was due to better services, improved complaint procedures in hospitals, or loss of confidence in the complaint system cannot be determined.

Table 3 also shows complaints about types of health professionals as a percentage of complaints for 2009–10. Only Victoria, the Northern Territory and New South Wales reported consistently on the type of medical specialty (for example, general practitioner, surgeon, or psychiatrist). Not surprisingly, given their number, general practitioners were the most-complained-about group of medical practitioners. (While nurses are by far the largest health profession numerically, around 5–10 per cent of complaints were about them.)

Table 3. Type of organisation and type of professional complained about (as a percentage of total complaints) for 2009–10 (top three categories, rounded to a decimal place)

State/territory commission	Type of organisation	Type of professional
NSW Health Care Complaints Commission	Public hospital 18% Corrections 4% Private hospital 2%	Medical practitioner 36% Dentists 12% Nurse/midwife 6%
Vic Office of the Health Services Commissioner	Public hospital 14% Corrections health 9% Private hospital 4%	Medical practitioner 24% Dentist 10% Dental prosthetists 1%
Qld Health Quality and Complaints Commission	Public hospital 59% Medical centre 10% Private hospital 9%	Medical practitioner 78% Dentist 15% Dental technician 2%
WA Health and Disability Services Complaints Office[9]	Public hospital 18% Prison health service 15% Other 15%	Data not available
SA Health and Community Services Complaints Commission	No data available	Data not available
Tas Health Complaints commissioner	Public hospitals 25% Correctional health 14% Dept. Health and Human Services 7%	Medical practitioner 25% Dentists 5% Psychologist 1%
ACT Health Services Commissioner[10]	Public hospital 13% Community health 5% Mental health service 5%	Data not available
NT Health and Community Services Complaints Commission	Public acute services 27% Corrections medical services 14% Health services 11%	Medical practitioner 18% Psychologist 5% Dentist 4%

The data show that medical practitioners were the most complained about profession although the percentage decreased from 2005 to 2010; for example, complaints about doctors in Tasmania decreased from 44 per cent to 25 per cent of all complaints and in New South Wales from 61 per cent to 36 per cent.

9 Data relates to both enquiries and complaints combined.

10 The figure is for public providers only.

Complaints management

After a complaint is received in writing, HCC staff assess whether the matter comes under their ambit, its seriousness and appropriate management. All commissions try to resolve the complaint in the preliminary stage either through referring to another body to resolve or manage, including referring back to the hospital or health professional who is the subject of the complaint, or recommending the parties enter conciliation. New South Wales is the only state mandated by legislation to investigate matters that raise significant issues of public health and safety; the health professional boards in New South Wales do not investigate complaints concerning registrants unless the complaint concerns performance or impairment. In all other jurisdictions, the health professional board investigates unless a board refers it back to the complaint entity for investigation.

Definitional differences again make the data difficult to interpret. The HCCs categorise assessment decisions differently; for example, New South Wales and Queensland publish comprehensive data only on their procedural decisions (for example, case closed), while Victoria and Tasmania report the outcome for the complainant (for example, apology given). An examination of trend data for 2005–06 to 2009–10 showed fairly consistent patterns of complaint management over the five-year period for each of the HCCs although there are differences between them on how they manage complaints. Table 4 illustrates the management of complaints cases with data from the commissions for 2009–10.

As noted above, most cases do not proceed beyond the assessment stage and are closed (discontinued) in early stages. The annual reports emphasise 'early resolution' or 'assisted resolution', which involves the commission asking the service provider or facility manager to provide an explanation or apology.

In all jurisdictions except NSW complaints concerning registered health practitioners are referred to the professional registration boards for consideration or investigation. Consistent data on the number of matters referred to boards were not available in the annual reports. Queensland referred 4 per cent of complaints to registration boards in 2009–10 but no data was available for the other states except New South Wales. New South Wales, as a co-regulator with the registration boards, is responsible for the investigation and prosecution of disciplinary matters for health professionals before the various panels and tribunals. This is the case even with the enactment of the Health Practitioner Regulation National Law. This new national legislation requires a HCC and the relevant national board to agree on how the notification/complaint should be dealt with. In the event of no agreement, the most serious proposed action must be taken (s.150 (4)). A national board can also refer a matter to a complaint entity for investigation (s.167 (b)). New South Wales, however, opted to retain its co-regulatory model so that the commission remains responsible for all investigations under the *Health Care Complaints Act 1993* (NSW), but is required to inform AHPRA of all complaints.

Table 4. Complaints management by the commissions 2009–10

State/territory commission	Assessment results % of cases (top 3 categories)	Completed conciliations % of resolution (total number)	Number cases investigated
NSW Health Care Complaints Commission	Discontinued 41% Referred externally 23% Assisted resolution 17%	48% resolved 52% unresolved (Total 66)	223
Vic Office of the Health Services Commissioner[11]	Explanation 28% Declined 26% Referred externally 14%	89% resolved 11% unresolved (Total 320)	3
Qld Health Quality and Complaints Commission	Closed 25% Referred for conciliation 5% Referred to boards 4%	67% resolved 33% unresolved (Total 122)	37
WA Health and Disability Services Complaints Office	Data not available	57% resolved 43% unresolved (Total 145)	Data not available
SA Health & Community Services Complaints Commission	Data not available	Resolution not available (Total 12)[12]	18
Tas Health Complaints Commissioner	Explanation 39% Service obtained 9% Apology given 8%	Resolution not available (Total 53)	3
ACT Health Services Commissioner	Data not available	14 resolved 17 unresolved	Data not available
NT Health & Community Services Complaints Commission	Data not available	9 resolved (Total 9)	3

[11] Figures are only for those cases 'resolved in assessment' so do not include how many conciliated/ investigated and so forth.

[12] State in their annual report that they managed 'at least 12' complaints by conciliation.

Conciliation usually involves the two parties to a complaint engaging in face-to-face discussion, facilitated by commission staff as the independent third party, with the aim of resolving the complaint through an explanation, apology or compensation. Several HCCs (New South Wales except for 2009–10, Victoria, Queensland and Tasmania) reported a rise in the number of conciliations between 2005 and 2010. Conciliation procedures vary. For example, conciliation in Victoria may be undertaken between the parties or their advisers without involving commission staff. Conciliation was popular especially in Victoria (320 cases) and Western Australia (145 cases). Western Australia completed 145 conciliations out of 289 complaints received; that is, 50 per cent of all complaints proceeded to conciliation. The NSW commission is unique in that public interest can override the private interests; that is, the commissioner can override a wish for conciliation by the two parties if the complaint raises significant concerns about public health and safety.

Complaints must raise serious issues to be investigated; these are a minority of cases. There is no evident trend for each commission over the five-year period. New South Wales investigates the largest number of complaints—373 in 2007–08 and 223 in 2009–10. All HCCs have the capacity to undertake investigations but only New South Wales is compelled by law to investigate serious complaints. In 2009–10, New South Wales had twice the number of investigations (223) as the other HCCs combined (112). Section 23 of the Health Care Complaints Act requires the commission to investigate a complaint when either the professional health council[13] is of the opinion that the complaint should be investigated, or the Commission believes that the complaint raises a significant issue of public health or safety, or raises a significant question about the appropriate care or treatment of a client, or provides grounds for disciplinary action against a health practitioner. The NSW HCC may investigate a complaint despite any agreement the parties to the complaint may have reached.

The decision to undertake an investigation is not undertaken lightly due to the resources involved. Given this, one might expect that all commissions would have data on the number, type and outcomes of investigations. Most commissions, however, provided little information apart from number of investigations. Only the NSW commission reported the outcomes of investigations, with 60 per cent of investigation cases over the five years being referred for prosecution to the Commission's Director of Proceedings.

Discussion

Our review of the annual report data highlights continuing variations despite an agreement between the commissions that established the National Health Complaints Data Collection as a joint project to standardise the data. The HCCs

[13] New South Wales has created the Health Professional Councils Authority to administer and support the fourteen health professional councils to perform their regulatory and legislative functions under the National Registration and Accreditation Scheme.

agreed in 2000 that the NSW commission's complaint data set would be the national standard but this was later abandoned because of different priorities and limited resources. Section 95 of the Health Care Complaints Act requires the NSW commission to include in each annual report the number and type of complaints made to it during the year, including the sources of those complaints; the number and type of complaints assessed by the commission during the year; the number and type of complaints referred for conciliation during the year; the results of conciliations; the number and type of complaints investigated by the commission during the year; the results of investigations; a summary of the results of prosecutions completed during the year arising from complaints; the number and details of complaints not finally dealt with at the end of the year; the time intervals involved in the complaints process, and the number and type of complaints referred to the Director-General (of Health) during the year and the outcomes of those complaints, as far as they are known.

HCCs are government funded, accountable and open to public scrutiny via the annual reporting mechanism. We combined the different types of data reported by all the commissions to arrive with a list of eighteen pieces of data. Table 5 is a summary of the combined data. This set concentrates on the management of complaints; that is, the information needed to track how complaints are handled across the commissions.

The HCC should also collect systematic and comparable information on who complains, and who is complained about (Bismark & Studdert 2010; Bismark, Spittal & Studdert 2011; Bismark et al. 2011). Information on who is likely to complain would enable better-designed complaints procedures, while information on who is complained about could enable the health professions regulatory bodies to be more active in identifying and remedying problems and disciplining poor performers.

This study began by examining data on complaints and their management in the annual reports of the HCCs. Shared data were reported by the commissions on only four out of the total eighteen combined data items (see Table 5). It is therefore not possible to benchmark complaints, make definitive state-by-state comparisons, or establish best practice in relation to time frames for assessment, conciliation or investigation. Our analysis identified two main problems that restrict the use of complaint data: first, the absence of consistent definitions for key concepts, and second, the lack of consistency within and between the HCCs about what data is published in the annual reports.

The most immediate problem is the inconsistency of definition of terms. Varying definitions described common activities such as 'complaint' and 'enquiry'. Some HCCs use the term 'complaint' to include a general enquiry, others count a 'complaint' only when a written form is lodged. The variation between annual reports means that a national total cannot be calculated. This lack of common understanding of the term 'complaint' prevents the compilation of any comparative or aggregated data about complaints.

The enabling legislation for each HCC defines different ambits for types of complaint and types of health services (and some legislation is broad and some

specific). This makes it difficult to determine how much difference the statutory definitions make to complaints management practices, or whether there is some commonality in the complaints dealt with by each commission.

Table 5. Summary of data reported by each HCC against a 'combined data set for all HCCs'

Number of total enquiries	No – not collected by all
Number of total complaints received	No
Type of organisation complained about	No
Type of individual health care provider complained about	No
Type of specialty	No
Types of complaint matter complained about	Yes – collected by all
Number of complaints resolved at assessment	No
Number of complaints referred for conciliation	Yes
Number of complaints referred for investigation	Yes
Number of completed conciliations	Yes
Number of completed investigations	No
Outcome of assessment	No
Outcomes of completed conciliations	No
Outcomes of investigations	No
Complaints referred to a registration board	No
Complaints referred for disciplinary action	No
Types of health professional referred for disciplinary action	No
Outcome of disciplinary action	No

The second broad problem is lack of consistency; for example, some commissions give only percentages on some measures while others give numbers. The type and amount of data presented in annual reports often varies: for example, the SA HCC presents little data in its annual reports. Some commissions explain the reasons for data changes; for example, Queensland presented little data in 2005–06 as the commission was restructured that year. In most reports there is no explanation as to why certain types of data are presented and others not.

Differences in annual report content raise the question as to the intended audience and the reporting responsibilities of the HCC. Each commission is governed by distinct legislation so it is not surprising their reports show differences, some significant and others less so, in functions and procedures. The different statutory requirements increase the variance in data collection across jurisdictions.

Notwithstanding this variation, one would expect each jurisdiction to have similar accountability and transparency requirements in relation to public reporting.

Conclusion

Australia has an enviable track record of responding to community concerns and, in recent years, of making health professionals and health care services more accountable. The state and territory governments have shown that they can work together to develop a national health practitioner regulatory scheme for all Australians. Growing numbers of enquiries and complaints to the health complaint entities suggest that patients and their families are overcoming their reluctance to complain, perhaps because complaints avenues now are better publicised and easier to access.

The advent of a national approach to the regulation of health professionals and to national standards for health services makes it all the more compelling for the HCCs to agree on a standardised data set and to build links to the new governance networks. The commissions all collect data about the type of complaints, who is making them and how the complaints are resolved, but their varied taxonomies currently cripple comparisons and national analysis.

Over the eighteen-year history of the statutory HCCs, research attention has focused upon grievance procedures rather than upon their impact on improving health systems. Research underway by the authors explores the impact of HCC recommendations on improvements to service delivery. This research aims to establish whether health services voluntarily comply with commission recommendations stemming from patient complaints, or whether stronger legislative provisions are required to legally oblige health facilities to implement recommendations. Preliminary results of this study show that hospitals take seriously recommendations from complaint entities and support their role in complaint management. In addition, research is underway to examine complaints management about health professionals under the NSW complaint system compared to the new national system. Research on how complaints are managed and resolved will enable evidenced-based policies to emerge for the benefit of health professions, health care services and the community.

Complaints are not an end in themselves; they are often an indicator of problems in the health system (Walton 2001). When the HCCs were established, the capacity to analyse national complaint data or to benchmark commission activities against other similar commissions may not have been a priority, but now eighteen years on, it is reasonable to expect commissions to agree on a taxonomy and complaint data set. A national complaint data set would add to the suite of improvement tools urgently required to improve health care and minimise harm to patients. Complaint data can identify where consumers are having difficulties and alert health facilities to problem areas. We can learn from them. The establishment of the Australian Health Practitioner Registration Agency will provide national data on registration; it is now time to agree upon a national data set for complaints.

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LEGISLATIVE SOURCES

Community and Health Services Complaints Act 1993 (ACT)

Health Administration Act 1982 (NSW)

Health Care Complaints Act 1993 (NSW)

Health and Community Services Complaints Act 1998 (NT)

Health and Community Services Complaints Act 2004 (SA)

Health Complaints Act 1995 (Tas)

Health Practitioner Regulation National Law Act 2009 (Qld)

Health Quality and Complaints Commission Act 2006 (Qld)

Health Rights Commission Act 1991 (Qld)

Health Services (Complaints) Act 1995 (WA)

Health Services (Conciliation and Review) Act 1987 (Vic)

Human Rights Commission Act 2005 (ACT)

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