Consumers and Complaints Systems

in Health Care

Jan Patterson

A thesis submitted to fulfil the requirements for the Degree of Doctor of Philosophy.

The Department of Community Medicine,
Faculty of Medicine,
The University of Adelaide.

August 1996
CONSUMERS AND COMPLAINTS SYSTEMS IN HEALTH CARE

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>vi</td>
</tr>
<tr>
<td>Declaration and Acknowledgments</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Rotten apples? unrealistic expectations? Or something more?</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Health complaints systems as a public health issue</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Nature and scope of this thesis</td>
<td>9</td>
</tr>
<tr>
<td>1.4 Thesis outline</td>
<td>15</td>
</tr>
<tr>
<td>CHAPTER TWO: COMPLAINTS AND COMPLAINTS SYSTEMS</td>
<td>19</td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>21</td>
</tr>
<tr>
<td>2.2 Theories about complaining behaviour and complaints processes</td>
<td>25</td>
</tr>
<tr>
<td>2.2.1 Exit, voice and loyalty</td>
<td>32</td>
</tr>
<tr>
<td>2.2.2 Naming, blaming, and claiming</td>
<td>37</td>
</tr>
<tr>
<td>2.3 Health complaints</td>
<td>42</td>
</tr>
<tr>
<td>2.4 Patient satisfaction research</td>
<td>49</td>
</tr>
<tr>
<td>2.5 Litigation and health care</td>
<td>52</td>
</tr>
<tr>
<td>2.6 Complaints systems and accountability</td>
<td>61</td>
</tr>
<tr>
<td>CHAPTER THREE: CONSUMERS, THE CONSUMER MOVEMENT AND CONSUMER ORGANISATIONS</td>
<td>67</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>68</td>
</tr>
<tr>
<td>3.2 Consumers, consumerism and consumerist</td>
<td>69</td>
</tr>
<tr>
<td>3.2.1 Consumers</td>
<td>72</td>
</tr>
<tr>
<td>3.2.2 Consumerism</td>
<td>75</td>
</tr>
<tr>
<td>3.2.3 Consumerists</td>
<td>76</td>
</tr>
<tr>
<td>3.3 Consumerism, the public sector and health care settings</td>
<td>80</td>
</tr>
<tr>
<td>3.4 The consumer movement</td>
<td>80</td>
</tr>
</tbody>
</table>
3.4.1 Consumer movement cycles
3.4.2 Theories about the cycles of the consumer movement
3.4.3 The consumer movement and other social movements
3.4.4 The impact and influence of the consumer movement

3.5 Consumer Organisations in Australia
3.5.1 Australian Consumers' Association
3.5.2 Australian Federation of Consumer Organisations
3.5.3 Consumers' Health Forum of Australia
3.5.4 Health Issues Centre
3.5.5 Australian Consumers' Council
3.5.6 International Organisation of Consumer Unions
3.5.7 Australian consumer organisations and consumer organisation theory

3.6 Conclusion: consumers, consumer organisations and complaints systems

CHAPTER FOUR: THE CONTRIBUTION OF THE CONSUMER MOVEMENT IN HEALTH

4.1 Introduction
4.2 Consumer movement in health
4.3 The common elements characterising the contribution of the consumer movement in health
  4.3.1 Promoting the social view of health
  4.3.2 Valuing experiential knowledge
  4.3.3 Questioning information from professional sources and health care practices
  4.3.4 Sharing information about health and health care
  4.3.5 Developing statements of the rights of health consumers
  4.3.6 Voicing consumers ideas about health and health services.
  4.3.7 Participating in decision making about all aspects of health service provision
4.4 Conclusion: the consumer movement in health, consumer participation and complaints systems
6.7 Conclusion: government, public sector managers and handling complaints

CHAPTER SEVEN: THE HEALTH SYSTEM AND COMPLAINTS HANDLING

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Introduction</td>
<td>310</td>
</tr>
<tr>
<td>7.2</td>
<td>Context: restructuring health services and health service provision</td>
<td>313</td>
</tr>
<tr>
<td>7.3</td>
<td>The professions and complaints handling</td>
<td>328</td>
</tr>
<tr>
<td>7.4</td>
<td>Health services and complaints handling</td>
<td>340</td>
</tr>
<tr>
<td></td>
<td>7.4.1 Accreditation of health services</td>
<td>343</td>
</tr>
<tr>
<td></td>
<td>7.4.2 Statements of patients' rights</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>7.4.3 Complaints Liaison Officers</td>
<td>353</td>
</tr>
<tr>
<td>7.5</td>
<td>Central health complaints handling mechanisms</td>
<td>358</td>
</tr>
<tr>
<td></td>
<td>7.5.1 The New South Wales Health Dept. Complaints Unit</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>7.5.2 The Victorian Health Services Commissioner</td>
<td>373</td>
</tr>
<tr>
<td></td>
<td>7.5.3 South Australia: the Ombudsman option?</td>
<td>385</td>
</tr>
<tr>
<td></td>
<td>7.5.4 The Commonwealth Medicare Agreements Act 1992</td>
<td>396</td>
</tr>
<tr>
<td>7.6</td>
<td>Conclusion: the health system and complaints handling</td>
<td>403</td>
</tr>
</tbody>
</table>

CHAPTER EIGHT: LOCAL HANDLING OF HEALTH COMPLAINTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Introduction</td>
<td>409</td>
</tr>
<tr>
<td>8.2</td>
<td>Perspectives on the handling of health complaints at the local level in South Australia</td>
<td>410</td>
</tr>
<tr>
<td></td>
<td>8.2.1 The study</td>
<td>412</td>
</tr>
<tr>
<td></td>
<td>8.2.2 Complaints and complainants</td>
<td>415</td>
</tr>
<tr>
<td></td>
<td>8.2.3 Processes and procedures</td>
<td>417</td>
</tr>
<tr>
<td></td>
<td>8.2.4 Consumers’ experiences of making a complaint</td>
<td>421</td>
</tr>
<tr>
<td></td>
<td>8.2.5 The resolution of complaints</td>
<td>423</td>
</tr>
<tr>
<td></td>
<td>8.2.6 Ideas for improving complaints handling at the local level</td>
<td>426</td>
</tr>
<tr>
<td>8.3</td>
<td>A consumer model for handling health complaints at the local level</td>
<td>429</td>
</tr>
<tr>
<td>8.4</td>
<td>Local complaints handling: ‘collective individuals’</td>
<td>438</td>
</tr>
</tbody>
</table>
CHAPTER NINE: CONCLUSION: CONSUMERS AND COMPLAINTS SYSTEMS IN HEALTH CARE

9.1 The consumer agenda for complaints systems overshadowed 444
9.2 Implications for public health 449
9.3 Health complaints systems in the future 454

Appendices
Appendix One. Consumers Health Forum's Statement of Consumer Rights and Responsibilities 457
Appendix Two. Perspectives on the handling of complaints at the local level in South Australia study interview schedules 460

Bibliography 462
Abbreviations 497

List of Tables

TABLE 1. Models of complaints systems proposed by consumer organisations 197-199
TABLE 2 Combined consumer model for health complaints mechanisms 203-204
TABLE 3 Essential elements of effective complaints handling (from Standards Australia, Complaints Handling) 303
TABLE 4 Organisation type by number of organisations and number of informants interviewed 414
TABLE 5 Health service provider informants by organisation type and position held 414
TABLE 6 Consumer and peak informants by position held 415
TABLE 7 Principle elements of a consumer model for health complaints handling at the local level 438
CONSUMERS AND COMPLAINTS SYSTEMS IN HEALTH CARE

Summary

Systems for handling consumer complaints about various aspects of health service provision have come under scrutiny in the past two decades for complex reasons. As Australia moved into the 1990s, the political climate seemed ripe for a series of legislative changes that would significantly reform and revitalise complaints systems in the health care area. This thesis explores the dimensions of the actions of consumers, governments and service providers influential in contributing to this climate and the subsequent developments.

There are clearly defined consumer models of complaints handling for the health area, ascertainable from examination of the broader context of the development of the consumer movement and consumer organisations; and specifically drawing on the common elements from the contribution of the consumer movement in health. These models have two parts: the individual part concerned with the recognition and acceptance of each consumer's right to complain and to have that complaint dealt with to their satisfaction; and the collective part concerned with the actuality and relevance of consumer experience to the shaping of health services and ultimately better health outcomes. The models have been refined by, and incorporate, elements of the evolving notions of consumer rights and consumer participation. However the history of both weakness and suppression of the consumer "voice" in the health area has contributed to the difficulty in getting the consumer agenda for health complaints systems heard.

For a brief period it seemed that the consumer agenda may be given a voice, fanned by the rhetoric of the new public health, consumer participation, and partnerships between consumers and service providers, and culminating in the Medicare agreements drawn up in 1992. The provision that all states/territories must establish independent complaints mechanisms provided a tangible acknowledgment of the validity of consumer complaints, but even before the Medicare agreements were signed, significant shifts had occurred.
The model of complaints handling which reflects a consumer perspective has been substantially overshadowed by the broader agendas of government restructuring and reform and professional accountability and control. These other agendas have been the more powerful determinants of the nature of the continuing changes to complaints handling and complaints systems. The focus on market choice and customer service, downsizing government and self regulation have been particularly important factors in the recent organisation of complaints mechanisms. While there have been differences between the states/territories and the Commonwealth, common themes prevail. Both governments and service providers have "individualised" complaints and complaints handling, thereby limiting and controlling the consumer voice and channelling it for their own ends. Complaints systems remain on the political agenda, not because of consumer concern, but because they can serve other agendas.

Resolution of complaints at the local level, between consumer and service provider (whether the individual or the organisation), is considered the first step, even where central health complaints bodies exist. The findings of my study of consumer and service provider perspectives on the local handling of complaints, conducted in South Australia as part of the research for this thesis, reveal themes similar to other contemporary studies. The primary concerns of consumers with obtaining resolution and justice contrasts with the defensive responses of many service providers, focussed on investigation, attributing individual blame and based on the assumption that retribution is the driving force behind making a complaint.

From a consumer perspective resolution of individual complaints is crucial. But the individualisation of complaints by current complaints handling practices reduces the potency and value of complaints data to inform change to health service provision and enhance health outcomes. A consumer model for complaints handling at the local level is proposed, based on the notion of collective individuals, for generating a consumer voice from the combined force of health complaints. The implications of health complaints systems reforms for public health policy, and human service provision generally, are discussed.
This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for photocopying and loan.

Signature:........................................Date: 20/1/96

J. H. Patterson
Acknowledgments

Full-time research on this thesis was undertaken with the assistance of a NHMRC Public Health Research and Development Committee Scholarship (two years) and a University of Adelaide, Medical Faculty Scholarship (one year).

My heartfelt thanks go to:

Key informants who gave of their time so willingly to participate in my field study.

Neville Hicks for the intellectual challenge, good advice and encouragement he provided as my thesis supervisor.

Colleagues in the Department of Community Medicine for providing me with a congenial environment in which to work, stimulating conversation and delicious morning teas.

Other friends and contacts who willingly provided assistance with a variety of troublesome matters such as helping me to locate obscure documents, and word processing advice.

Anthea Page for able assistance with editing the bibliography.

Nicole, Tim and Greg Ansell for their love, support and perseverance throughout the long process of completing this thesis.
CHAPTER ONE

INTRODUCTION

1.1 ROTten APPLES? UNREALISTIC EXPECTATIONS? OR SOMETHING MORE?

The topic of complaints and complaints handling is a sensitive one in the health area. The nature of health care during the twentieth century has changed significantly with the advances in scientific medicine and access to the provision of modern health care has been proposed as a 'social' right for all citizens. Intrinsic in the portrayal of modern health care is the idea that the characteristic interventions and treatments, carried out by highly skilled professionals, will be health enhancing, primarily through curing illness and treating disease. Until quite recently, there has been little suggestion that the interventions and treatments provided, may, in turn, cause harm to health.

Complaints challenge the idea that health care is beneficial. They provide evidence of events which, from the perspective of one party (consumers) in the health care relationship, have in some way caused sufficient distress or harm for the consumers concerned to take action. When complaints are made the ministrations of health service providers come under scrutiny. With professional status and reputations at stake, health service providers have tended to dismiss complaints as the problem of a few incompetent practitioners, or a few health services with poor standards, amongst otherwise highly skilled professionals and high quality services; the few rotten apples that can tarnish all the apples in the barrel. By casting out the 'rotten apples', through peer review mechanisms, the competence of the profession or integrity of the service can be maintained. Therefore individual professionals, the 'rotten apples' who repeatedly cause serious harm to unsuspecting consumers, or who discredited the profession through their personal
behaviour, need to be identified and sanctioned. The interpretation of incompetence and negligence remained with professionals, using professionally determined standards, that have not always reflected consumers' concerns.

The 'rotten apple' theory could not be used to explain a number of complaints where the competence of the professional was not necessarily in question, for example when the intervention/treatment had resulted in an adverse health outcome for the consumer, although carried out according to professional standards. Complaints in these cases were dismissed by health service providers as reflecting 'unrealistic expectations' on the part of consumers. Many advanced technological health care treatments and interventions carried risks of some other outcome, that could easily overshadow the benefits gained from the intended outcome. If consumers were more realistic about their situation and the limitations of modern health care, then they would not be disappointed when the expected outcomes were not realised and would not complain about the health service provided. But it was health service providers who usually made the decisions about what were acceptable risks for their patients, often using quite different criteria for making this assessment than the consumers would have chosen. The changes to the ideas and practices of informed consent over the past decade have gone some way to shifting the emphasis to considering risks from consumers' perspectives. Again, many complaints could not be explained away as the result of unrealistic expectations.

Complaints by consumers about aspects of the health care system disclose much more about the interactions between consumers and health service providers than can be attributed to rotten apples or unrealistic expectations, as the evidence in this thesis reveals. The substance of many complaints suggests that questions about professional competence and practices are not just a problem of a few individuals but much more widespread and

1. For an overview discussion about the identification of 'rotten apples' in the medical profession see, for example, the editorial comment by R. Smith, "The Epidemiology of Malpractice", *British Medical Journal*, vol. 301, 29 Sept 1990, pp621-622.

2. For a general discussions of the practice and implications of modern health care see, for example, M. Konner, *The Trouble with Medicine*, Australian Broadcasting Commission, Sydney, 1993.
common; and that quite realistic expectations of consumers are often not met, such as expecting to be treated with respect and dignity and involved in decision making about one's own health. Complaints can provide unique information about the performance of health service providers, and strengthen the idea of greater accountability of health service providers to consumers and the broader community.

The mechanisms set in place by health service providers to deal with complaints have a significant influence on the complaints made and the outcome of the resolution of complaints. In the health area, complaints mechanisms have typically served to minimise the substance of the complaints, cast doubt on the consumers' accounts and defend the health service providers involved. But there has been significant activity in the area of complaints handling over the past two decades in Australia. This thesis sets out to examine complaints handling mechanisms in the health care system, in the context of the developments of the broader consumer movement and the reform of public sector services, with particular reference to consumers' perceptions of complaints handling.

Several terms are used as shorthand throughout this thesis to increase readability. The term 'health consumer/s' is used to describe consumers engaged in matters pertaining specifically to the health area, as distinct from consumers engaged in matters relating to other areas of public service provision. A more comprehensive discussion, in chapter three, outlines the complexity of using the term 'consumer' in relation to health service provision. The term 'health service providers' is used to encompass both individual professionals and organisations involved in the provision of the myriad of different health services that make up the health system.

The term 'health complaints' is used as the shorthand to describe the broad range of complaints made by consumers about all aspects of the health system: health policies and structures, health organisations and professionals and the service/intervention (or lack of) provided. Health complaints are generally based on the experience of individual consumers (or their relatives' or friends' experiences) whilst interacting with, or trying to
interact with, health service providers. Health complaints, in the context of this thesis, do not refer to the medicalised interpretation of ‘complaints’ used to describe an ailment, illness or symptoms of a person seeking medical care, such as a heart complaint or a gastric complaint. Similarly, health complaints mechanisms refer to the services, policies and procedures specifically set in place to deal with complaints by consumers about the health system. Health complaints handling at the local level refers to the handling of health complaints about the health service provider (either individuals or organisations) by the health service provider (predominantly health service organisations).

1.2 HEALTH COMPLAINTS SYSTEMS AS A PUBLIC HEALTH ISSUE

There have always been complaints about the health system. How complaints have been handled and the response to complaints by the respective service providers has varied over time, in line with changing service delivery standards and practices, differing perceptions about the entitlements of citizens to health services and the political climate of the time. Health care provision has often been seen as a privilege, the idea of attending to complaints untenable to those providing the service. For example, in examining the history of the Melbourne Lying-in Hospital in the mid-nineteenth century, Cannon noted that “patients who complained about filthy conditions, poor food, or low nursing standards were summarily evicted”. Complaints are still perceived as a personal affront by many health professionals, challenging the core of their professional being; their specialist knowledge and skills and claim to always act in the best interests of the patient. (See ch7.3 for further discussion of these points.)

For most of this century, the substance of complaints about aspects of the health system have only been taken seriously, that is for some action to be proposed or eventually taken by those in positions to bring about change, when the complaints have obtained some

legitimacy through support and advocacy from citizens in positions of influence. The large number of parliamentary and ministerial inquiries into particular aspects of health services attests to this, often brought about by intense public and political pressure only when scandals could no longer be contained or threatened to erupt. The question then arises: if there had been more effective complaints handling mechanisms in place, resulting in earlier action, would the scandals have been prevented? The two inquiries into psychiatric services in New South Wales and Queensland, reporting in the early 1990s, provide recent examples that suggest that more serious attention to consumers’ complaints may have prevented some of the tragedies from occurring that were uncovered by the inquiries. Public health history resounds in examples where multiple complaints about practices injurious to health have finally led to change, albeit often slowly and belatedly.

These changes are rarely portrayed in the public health literature as action resulting from complaints by consumers about existing services and practices. Rather, they are portrayed as originating from the advancement in health care knowledge and increasing expertise in health service delivery. The picture presented is one of changes driven by enlightened service providers, responsive to new demands and circumstances. It is not surprising, then, that complaints mechanisms in health care are such a little investigated area. Yet the potentially harmful actions of health service providers, and the potential for damage of both a physical and mental nature to persons receiving services from the health system, have been put forward as primary reasons for the introduction of a multiplicity of legislation in the health area, for example, the registration of many health professionals, the regulation of pharmaceutical products and the licensing of hospitals and nursing homes. The need to protect the public from unskilled health workers and sub-standard services through government legislative intervention has been strongly advocated and supported by


Page 5
health service providers. But the dominant health service providers have insisted that they retain control over determining the parameters of this government intervention. The fact that many of these legislative and regulatory interventions in the health area have been shaped and managed by those providing the service/treatment/product is well known to consumers wishing to complain.

As well as significant reform and restructuring of health care services, over the two decades to 1995, a new paradigm for considering the promotion of the health of the public has been advocated by proponents of public health, including many health service planners, health service providers and health department officials. This ‘new public health’ movement, Davis and George suggest, can be described as a social movement generated by an uneasy alliance between various groups with “an interest in a social definition of health and illness”. The need for a new paradigm arose with the increased realisation that the major public health issues confronting affluent populations of the latter half of the twentieth century were significantly different from those of earlier times. The demographic profile of the populations of industrialised countries, such as Australia, had changed by the last quarter of this century, resulting in increased longevity and the presentation of quite different health problems. Epidemiological data revealed that, despite the medical advances and the availability of medical services, preventable or ‘lifestyle’ diseases were increasing, a primary cause of mortality and morbidity and that significant inequalities in the health status between various population groups still existed. As well, there seemed to be no limit to the increasing costs of providing expensive high technology health services that had become an everyday part of modern health care.

Building on the work of the World Health Organisation’s Alma Alta Declaration of 1978 and the later 1986 Ottawa Charter (discussed in more detail in chapter four), the advocates of the new public health ‘philosophy’ began defining alternative approaches to

identifying and addressing the major issues confronting modern societies and health systems. They “widely promoted the recognition of social, economic and environmental determinants of ill health and the adoption of primary health care, health promotion and community development strategies as ways to improve health”. However, the alternative approaches, proposed by groups under the broad umbrella of the new public health, were not necessarily homogeneous or compatible. Rather, they reflected the political orientations of the different groups, ranging from those seeking major social and structural reform through community development and political action, to those focusing on reducing risk factors through education aimed at encouraging individual behaviour change. The common feature of most of the approaches was an increased focus on health consumers, their experiences of health, illness and the health system. Consumer participation in various aspects of health care and health service delivery became a goal, although how this might be achieved was open to wide ranging debate. (See ch4.3.7.) Along with the consumer movement in health, the ideas of the new public health movement placed consumers in a more central position in the health system and encouraged greater recognition of the rights of health consumers to be actively involved in health care decision making. It was in this environment that the handling of health complaints gained some attention.

This attention to complaints handling, by itself, does not necessarily make complaints handling an issue of interest to public health. It is because the substance of complaints provides unique information about the functioning of the health system and indicators of areas for change and improvement that complaints handling becomes important. As demonstrated throughout this thesis, the mechanisms in place to handle complaints influence both the making of complaints and the outcomes of the resolutions of

7. Davis & George, pp380-2.
complaints and it is for these reasons that complaints handling in the health area becomes an issue of significant public health interest. Making a complaint has not generally been perceived as a way of increasing consumer participation in health system decision making. But it is well placed to do this because complaints are directly based on consumers’ knowledge and experience, rather than reliant on expert opinion and assistance. For some consumers it may be the only way they feel able to contribute to a system where ‘expert’ knowledge and expertise are exalted. Alternatively an environment supportive of consumer participation is also more likely to handle consumers’ complaints well.

The injustice and emotion felt; the physical and mental harm caused by complainable events is usually of great consequence to individual health consumers, leaving a marked impact on their future life. But this has been little recognised or acknowledge by health service providers or, indeed, by the broader health arena. It is only very recently that comprehensive studies of adverse outcomes of health care interventions have been undertaken, revealing that the occurrence of adverse outcomes was much more common than had been previously estimated. (For example, the results of the Harvard Medical Practice Study discussed in ch2.5) Although it is not the focus of this thesis, this major cause of ill health can no longer be overlooked in health system policy and planning, in economic terms.

Many barriers exist that make it difficult for consumers to complain and for that complaint to be heard and acted upon. Complaints mechanisms that are ‘consumer friendly’ are better placed to capture the full range of complaints, contributing feedback about the different aspects of the health system that may not be obtained otherwise and acting as an impetus for change. By encouraging consumers to complain, through providing appropriate complaints handling mechanisms, the consumers’ experience is recognised as valid. Without a viable complaints handling system in place the accountability of service providers to the consumers they serve, and to the wider public, who often finance them, is considerably weakened. But health complaints mechanisms
have frequently better served the interests of health service providers, managers and professionals, than consumers.

1.3 Nature and Scope of This Thesis

The focus of this thesis is the handling of health complaints from the perspectives of consumers and the influences on the development of the various health complaints mechanisms that have been introduced throughout the Australian health system, particularly during the decade from the early 1980s to the early 1990s. I have deliberately used data on individual health complaints to enhance understanding of the scope and nature of health complaints handling and to examine why consumers take the time and effort to complain, rather than make an analysis of the complaints a specific end in itself: the focus of my interest is on explanation not counting. The handling of complaints about complainable events and experiences that did not result in substantial physical injury, sometimes called the “lesser complaints” because they are not likely to lead to litigation under present law, are of primary interest.

The questions addressed by this thesis begin with:

What are the components of an ideal mechanism for handling health complaints from the perspectives of consumers?

If these components can be identified, the next question arises:

Why have health complaints mechanisms developed in the way they have?

and

What has prevented the incorporation of these ‘consumer’ components into existing complaints mechanisms?

I concentrate on examining the handling of health complaints at the local level, in order to ask:
Can complaints mechanisms enhance consumer participation activity by encouraging consumers to make a complaint?

and, if so,

What are the elements of a health complaints handling mechanism at the local level necessary to enhance the planning and development of health services by increasing consumer participation?

At the time these questions were proposed in late 1991, only the state of Victoria had established a central health complaints body (in 1988) with a legislative base and formal conciliation. The health complaints unit in NSW, established earlier in 1984, was not protected by legislation, although this had been recommended. Queensland was on the verge of adopting somewhat similar legislation to Victoria, but with a greater emphasis on and link to health rights. Several other states and territories had created special units within their health departments with the specific task of handling complaints and set up working parties to consider the establishment of independent central health complaints mechanisms. Some had circulated draft legislation and discussion papers during 1991. It appeared that Australia was on the verge of a revolution in health complaints handling, particular with the added impetus of the specific clauses relating to central health complaints bodies proposed for inclusion in the new Commonwealth Medicare Agreements Act 1992.8

From the perspective of those involved in the operation of the new mechanisms at this time, it was considered that great strides were being made to improving health complaints handling, particularly compared to the (often non-existent) mechanisms available previously. In the environment of the health arena, where complaints handling by

8. In fact, as the events documented in this thesis reveal, by the end of the research period only three more of the total nine states/territories (Queensland, Australian Capital Territory and New South Wales) had joined Victoria in passing specific legislation establishing the independence and powers of a central health complaints body.
anyone other than professional bodies was viewed with suspicion and the professional culture dominated, the establishment of central health complaints mechanisms as credible bodies was a difficult and challenging task. It required a degree of ‘professionalisation’ of complaints handling and the development of processes where few precedents existed. In a number of individual cases the central complaints handling bodies had demonstrated that they were able to obtain outcomes satisfactory to the consumer complainant and to stimulate some systemic changes in health service provision. At the local level, the idea of complaints liaison officers was taking hold and some of the larger hospitals had created these positions to improve their complaints handling capacity.

From this ‘internalist’ perspective, the reforms necessary for more effective health complaints handling were seen to be well in hand and the central health complaints bodies able to competently take on the tasks assigned to them. However, the vulnerability of the central bodies was evident, through the inclusion of sunset clauses in the legislation in some instances, limited independence and authority in others and restricted availability of resources in most. This made it more difficult for supporters of the concept of independent health complaints handling to criticise the activities of the central bodies, particularly with opposition still strong from some politically influential service provider groups. While the central bodies readily acknowledged their need for stronger powers and more resources, it has been in their survival interests to highlight their accomplishments and the positive benefits to service providers from their complaints handling activities, rather than their limitations. Analysis using this internalist perspective, such as that provided by Donnelly on the way the NSW Complaints Unit gained credibility for its operations, offers important insights into the development of and changes to various aspects of complaints handling in the health sector.

Alternatively, an ‘externalist’ perspective, for example from the viewpoint of consumers, can also be used as the starting point for analysis. The complaints made to the various Ombudsmen about the some of the central units’ operations and the dialogue of
some of the consumer groups suggest that the picture often presented by the central bodies of offering independent and impartial services, while at the time still controlled by the health departments, may not have been complete. Viewing the developments in health complaints handling mechanisms through a different lens from that of the central complaints bodies, while acknowledging the achievements, can provide a more critical view of the activities by placing them in the broader context, in this case the development of the consumer movement and public sector reform, to better understand what may be happening and why. Various consumer groups had been lobbying for reforms to complaints handling in the health domain for many years as consumers have the most to lose from the lack of effective avenues to make complaints and to have the complaints resolved to the consumers’ satisfaction. Already the Victorian experience had shown that the legislation finally passed by the Victorian Parliament was different in many significant aspects from the draft legislation proposed initially. It seemed an appropriate time, with reforms proposed in the other states, to examine in depth what consumers were advocating as the essential features for health complaints handling systems and what might prevent these features from being incorporated into the new mechanisms, at the central and local levels.

This thesis reflects the multidisciplinary nature of both public health and social work, in line with the author’s education and experience; it does not ‘sit’ neatly within one academic discipline but draws on insights offered through the knowledge base of a range of disciplines including political science, law, sociology and more generally the social sciences. The investigation and analysis of the complex relationships between individuals, the broader community and the structures of society have been a focus of public health research and of social work practice. In both disciplines, the study of matters relating to individuals, such as complaints, are not seen as separate from the study of structural matters, such as government policies; both are necessary for an adequate explanation and understanding of each to be obtained. This thesis encompasses discussions about the
theories and practices of complaints handling generally; investigation of individual consumers’ perceptions of the health system and complaints handling; and analysis of the development of the consumer movement and public sector restructuring as the contribution of each part helps provide a fuller understanding of the overall situation. To accomplish this in a logical way, relevant literature is reviewed and included appropriately as the discussion proceeds, commencing with complaints and complaints systems.

The primary source of information for this thesis is the extensive range of documents listed in the bibliography. The collection of this information was arduous, as no easily identifiable hand list of information existed and comprehensive academic research on health complaints handling has been rare. The documents came from a variety of sources including government papers, refereed and non-refereed journals, annual reports and newsletters. In particular, documents that reported primary research elucidating consumer’s views on complaints handling and consumers’ motivations in making complaints were given considerable weight. Those documents which do not focus specifically on health complaints or complaints handling were selected to add depth or breath of understanding, or to validate the overall picture of complaints handling in the health arena in Australia. Some of the most significant documents have been published only during the latter part of the research period, from 1992 to mid 1995. For example, the extensive work by Lloyd-Bostock and Mulcahy on health complaints handling at the local level in Britain was published in mid 1994, the Interim Report of the Professional Indemnity Review and other relevant studies commissioned by the Review were released throughout 1994, the Australian Health Consumers’ Charter was first drafted in 1994 and the approved Australian Standard on Complaints Handling was published in early 1995. As well, the period of research coincided with proposed legislative reform in relation to health complaints handling across Australia and the formation of new bodies to take on health complaints handling more centrally. Primary attention has been given to health consumer group activity in relation to the development of health complaints handling.
mechanisms during the period leading up to the signing of the Medicare Agreements, by the states and territories with the Commonwealth government, in 1993 and in the year immediately following.

A field study was also conducted as part of the primary research for this thesis to gain information about the current complaints handling practices, particularly at the local level, from the perspectives of consumers and service providers. Semi-structured interviews were conducted with a range of individual consumers and consumer groups, service providers and others involved with or having an interest in health complaints handling in South Australia. This study, discussed in detail in chapter eight, further uncovered and confirmed the different interpretations and emphases placed on the various components of complaints handling mechanisms by consumers, government officers and service providers.

A central component of this thesis has been to identify and elucidate the “hidden arguments” underlying the various proposed reforms to complaints handling in the health area (particularly for health service provider complaints handling at the local level) which are generally referred to, in this thesis, as the agendas of the different groups. “Hidden Arguments” was the title of Tesh’s demonstration that identifying the “hidden arguments” underlying health policy debates is necessary for better understanding of the actions eventually taken. Tesh does not argue that values should be “excised from science and from policy but that their inevitable presence be revealed and their worth be publicly discussed”.

The structure of this thesis revolves around three broadly defined groups: consumers and consumer groups; governments, including both the political and bureaucratic arms; and health service providers, including both individual professionals and organisations. While, in one sense, health service providers can be considered to also

---

fall within the second group, because of the focus on public sector services, it is more useful to consider the agendas of the two groups separately here, although this distinction is an artificial and arbitrary one in practice. A substantial part of the discussion is devoted to the first group, consumers and consumer groups, as the least well defined and documented of the three.

1.4 Thesis Outline

This thesis begins by examining the disparate body of knowledge about complaints and complaints systems drawn from the different disciplines, focusing specifically on several major and informative studies, conducted in the 1970s, that still provide important insights twenty years later. The linear model of ‘complaints to litigation’ has been particularly dominant, reducing the study of complaints to the first step in a broader process. In the health area, greater attention has been given to researching the issues of concern to health professionals, such as patient satisfaction and professional negligence, than consumers’ complaints. Studies of health complaints have tended to be limited and related to a specific health service, with the notable exception of Klein, and Australian studies are particularly scarce. Recently, though, Lloyd-Bostock and Mulcahy, based on the findings of their comprehensive research into complaints handling at the local level, have proposed that the making of complaints be considered as an activity in its own right, rather than part of another process. Lodging health complaints are better viewed, they suggest, as processes of calling service providers to account for transgressing complainants’ expectations of acceptable conduct and/or service. The capacity to make complaints, and for complaints to be handled appropriately, have been identified as an integral part of a comprehensive accountability system by a number of authors. The usefulness of complaints as a strategy to increase accountability is largely determined by the mechanisms set in place to handle complaints. Unless the mechanisms are ‘complaints enhancing’, this strategy will be limited.
To identify what might constitute ‘complaints enhancing’ mechanisms from the perspective of consumers requires, first, a more detailed discussion of who are consumers, particularly in the health care context, as outlined in chapter three. The growing influence of the consumer movement provides a fuller understanding of the context in which the notion of consumer rights has gained greater credence within Australian society. As the tangible voice of the consumer movement, consumer groups warrant further examination. The organisation and activities of four prominent consumer organisations, all of which have worked to further the interests of consumers in political and policy arenas, are discussed, highlighting the need for consumer groups to establish their credibility and reliability, despite access to very limited resources, if the consumer ‘voice’, as vocalised by these groups, is to be heard. I conclude that these four organisations can legitimately claim to represent the interests of significant numbers of Australian consumers. All four have been involved in advocating for reform to complaints handling in the health system.

A more detailed understanding of, and insight into, health and health services from the perspectives of consumers is provided by examining the dimensions of the consumer movement in health and consumer participation activity in chapter four. This forms the foundation from which the ‘consumer agenda’ in relation to consumers’ rights and health complaints mechanisms can be ascertained. The broad umbrella of the consumer movement in health encompasses a diverse range of specific social movements, groups and activities, but a number of common elements can be identified that characterise the contribution of the consumer movement in health to health sector debates: promoting the social view of health; valuing experiential knowledge; questioning information from professional sources; sharing information and knowledge about health and health care; drafting statements of the rights of consumers when receiving health care; voicing consumer ideas about the health and health services; and participating in decision making about all aspects of health service provision. Together, these elements have had a significant impact on the way many consumers now view themselves in the health care
relationship. In particular, ideas about consumer participation activity have been promoted by consumers, governments and health service providers alike. However, consumers, governments and service providers perceive the purposes and benefits of consumer participation quite differently, offering further insights into the values and motives underlying the activities proposed by these three groups. While making a complaint has not usually been associated with consumer participation activity, the conditions that are necessary for each to occur are similar for both, and the processes complement each other.

Having established the context in which the consumer organisations have operated and the specific influence of the multiple dimensions of the consumer movement in health and ideas about consumer participation activity, the discussion moves on, in chapter five, to trace the activities of two of the consumer organisations, the Health Issues Centre and the Consumers’ Health Forum of Australia, in advocating for significant reform to health complaints mechanisms. As well, the work towards the development of an Australian Health Consumers’ Charter is discussed and the important connection between statements of consumers’ rights and complaints mechanisms established. Analysis of the documented ‘consumer models’ for complaints mechanisms provides the basis for the development of a more comprehensive framework for a ‘combined consumer model for health complaints mechanisms’, that delineates the components essential to a health complaints mechanism from the perspectives of consumers. The consumer agenda, that incorporates both individual and collective components, is outlined.

However, from the perception of consumers, the health complaints mechanisms in operation around Australia in the early 1990s generally did not reflect these essential components. By examining, in chapter six, the changing context in which governments and public sector managers have developed complaints mechanisms since the mid 1970s, the operation of these complaints mechanisms and the philosophies and ideologies that have shaped complaints handling practices, both the real and potential barriers to acceptance of the essential components become clear. Those parts of the consumer agenda
for complaints mechanisms that have been adopted in reforms to complaints mechanisms are found to be in line with, or to further, the agendas of those already in positions of influence, such as public sector managers. A similar framework for analysis is used in chapter seven, which includes a detailed investigation of the development of central health complaints mechanism in some states, and the impact of the Commonwealth Medicare Agreements Act 1992, requiring all states/territories across Australia to establish independent, statutory based, central health complaints mechanisms and draft charters of consumers’ rights applicable to publicly funded health services. The ‘individualisation’ of complaints and complaints handling by existing mechanisms and the structural limitations imposed on these mechanisms has meant that limited use has been made of the substance of complaints in service planning and to inform change, and subsequently poses little threat to established systems, procedures and practices. In this way, the consumers’ ‘voice’ on complaints handling reform has been controlled and contained.

Health complaints handling at the local level presents specific challenges, discussed in chapter eight. The findings of a field study of key informants’ perceptions of complaints handling at the local level in South Australia are discussed. These findings, along with the findings of several other studies also conducted in the early 1990s (particularly in Britain), and the components of the combined consumer model for health complaints mechanisms, discussed in chapter five, provide ample evidence of the essential elements of a health complaints mechanism at the local level for the mechanism to be considered, by consumers, as ‘complaints enhancing’. For these elements to be accepted and truly reflected by health service providers, complaints and complaints handling cannot continue to be ‘individualised’. A more useful conceptualisation of complaints and complaints handling at the local level is provided by the notion of ‘collective individuals’. The implications of this research for public health and complaints handling in other areas of human service provision are discussed in the final chapter.
CHAPTER TWO

COMPLAINTS AND COMPLAINTS SYSTEMS

2.1 INTRODUCTION

The body of knowledge about complaints and complaints systems has gradually increased, although this development has been dispersed across a number of different disciplines including political science, legal theory and consumer law, business management, sociology and social psychology. The reliance on ‘expert’ advice and decision making, dominant within western society for much of this century, contributed to the stigmatisation of making complaints and the lack of attention given to devising effective mechanisms for handling complaints. By the 1970s, questioning of many of the entrenched, and often discriminatory, practices of industries and public sector services led to calls for the development of more visible accountability processes, including better complaints handling. More recently, the impetus to find ways to increase market share and competitive advantage, and interest in the ideas of quality management, has resulted in a renewed focus on complaints and complaints handling as an untapped area of customer feedback.

The few detailed studies of complaints and complaints handling conducted in the 1970s, such as those by Best, Hirschman, Felstiner and Klein discussed in this chapter, offer important insights into the situation today, twenty years later, for two reasons: many later studies of complaints and complaints handling reported have been limited and specific, rarely building on previous research; and the complaints handling practices and processes of many organisations are still little changed from two decades ago. As well, complaints research has tended to be overshadowed by the more popular, and often less controversial, focus on consumer/customer satisfaction. In the health area, health
professionals concerns about negligence and litigation has directed research attention on these, rather than other areas of complaints.

Theories about complaining behaviour, developed from the 1970s studies, have been influential in the development of complaints handling processes, although not always in the ways the authors had intended. The idea that all complaints could potentially lead to litigation (the linear model of complaints to litigation), has been particularly dominant, reducing the study of complaints to the first step in a broader process. However, Lloyd-Bostock and Mulcahy have proposed that, in regard to health complaints in particular, it is more appropriate to consider the making of a complaint as an activity in its own right, rather than as the early stages of something else.\(^1\) From this perspective, lodging a complaint involves a process of calling for service providers to account for transgressing the complainant’s expectations of acceptable conduct and/or service.

The multidisciplinary contribution to the study of complaints has meant that a variety of terms such as complaints, grievances and disputes have been used to refer to similar processes. The different terms could possibly be defined specifically, according to the language and theories of each discipline but, for the purposes of this thesis, the broadest interpretation is taken so that, in particular, the terms complaint and grievance can be used interchangeably. Birkenshaw and Lewis suggest that

"the difference probably lies in the fact that a complaint is more closely associated with the raising of an objection before there has been any attempt to resolve the matter. Where resolution is attempted and fails - even if it constitutes a simple request to review a decision informally - then it becomes a grievance".\(^2\)

While complaint is the preferred term throughout this thesis, in some contexts, for example when discussing particular authors’ works or the area of administrative law, the other terms, grievance and dispute, seem more appropriate and are used instead.


This chapter concludes with an introductory examination of the inter-relationship between changes to complaints handling mechanisms and the different and changing interpretations of effective accountability processes, particularly for public sector services, a topic that is returned to repeatedly throughout this thesis. For the accountability of service providers to those they serve to be strengthened, it is proposed that ‘complaints enhancing’ processes, from a consumer perspective, need to be identified and used to guide any reforms to complaints handling mechanisms.

2.2 THEORIES ABOUT COMPLAINING BEHAVIOUR AND COMPLAINTS PROCESSES

Developing models for the prediction of consumer behaviour has become a major field of study for business, advertising and marketing graduates, almost always from the perspective of market liberalism. Consumer satisfaction has been identified as an important aspect of marketing practice and various ways of dealing with consumer dissatisfaction have been proposed. Within this field, the specific study of consumer complaints has gathered momentum. This research has often had a narrow focus on the kinds of complaints or the behaviours of complainants; examination of the complaints handling processes has received much less attention. A notable exception to this trend was the study by Best of business complaints handling processes. Through analysis of a series of case studies of consumer problems, as well as a broader survey of “responses to unsatisfactory purchases” in the USA in the mid 1970s, Best highlighted the difficulties experienced by consumers in getting their complaints resolved. For consumers, perceiving that their complaint was likely to be dealt with fairly and that the outcome was likely to be worth the resources expended were, and still are, important factors in making a decision to complain. Best found plenty of evidence that complaints handling processes did not necessarily work towards resolving complaints for consumers. He argued

“Fair treatment of consumer complaints should be recognised as a powerful mode of consumer protection, as valuable as both regulation, which seeks to improve the overall quality of goods and services, and consumer education programs, which aim to provide people with better information about products and services and the ability to use that information”.4

However, as this thesis demonstrates, improvements to complaints handling processes have been slow and incremental, and twenty years later Best’s comments are still relevant.

Best’s research was conducted in the environment of the 1970s where there was an increased interest in and focus on issues of consumer rights and consumer protection; Ralph Nader was acknowledged as an adviser to Best’s project. A detailed article by Ramsay, published in the same year as Best’s book, took up this theme of the relationship between complaints handling processes and consumer rights and consumer protection issues. Ramsay argued that informal complaints mechanisms individualised and trivialised consumer complaints and that the behaviour of consumers in making a complaint was influenced by the widespread “belief that complaining is not desirable and the idea that individuals and not groups have problems and complaints”.5 Ramsay concluded that

“A primary objective of consumer protection must be to ‘reconceptualise little injustices as collective harms’. Only if this objective is achieved will individual consumer redress mechanisms operate effectively”.6

Ramsay’s discussion was focussed on the marketplace of buying and selling products, but similar points are argued throughout this thesis: the individualisation of health complaints by complaints handling practices has been a major factor in controlling and diffusing the impact of complaints in forcing change on the structure of current health service provider systems to make them more accommodating to the consumer perspective.

While overseas research on complaints and complaints handling had been growing, there was still little research that specifically examined the Australian marketplace. It was

not until 1994 that the recently formed Society of Consumer Affairs Professionals in Businesses Australia Inc (SOCAP), with sponsorship from American Express, commissioned a research project to fill the information gap about complaints and complaints handling in Australia.7 Using a postal survey to 15,000 randomly selected households (adjusted response rate 16%), the research findings indicated that almost three quarters of the households had complained about “their most serious problems”. Not knowing where to go to complain and believing that complaining would not do any good or was not worth the time and effort were cited as the primary reasons for not complaining by the other quarter of households. 90% of those who did complain had contacted the business concerned and less than 15% had contacted government or community organisations about their complaint. Over a quarter of complainants had to wait more than a month for the complaint to be resolved and 28% were not satisfied with the action taken to resolve their complaint, a further 40% were only partially satisfied; only 2% of complainants reported that the final outcome had exceeded their expectations.8

A survey of the complaints handling arrangements of 500 medium to large businesses (response rate 21%) was also conducted as part of the SOCAP - American Express study. 65% of the businesses responding to the survey had departments or an individual responsible for handling complaints and, of these, three quarters had annual budgets of over a quarter of a million dollars. The average cost of dealing with an individual complaint was calculated at just over six Australian dollars. Complaints handling clearly involves costs to the organisation as well as the consumer. The study concluded that “effective corporate complaints handling practices can produce significant marketing advantage... [but] only a minority of Australian companies are realising the

benefits associated with complaint handling". The arguments put forward to the business sector that attention to complaints handling can lead to a greater competitive advantage have also become increasingly persuasive in the health sector, with the widespread adoption of corporate management practices explored further in chapters six and seven.

Research interest in the origins and courses of disputing behaviour more generally, which includes complaining, has resulted in studies incorporating anthropological, sociological and/or legal studies perspectives. Felstiner encapsulated the complexities involved in any study of complaints handling processes in his statement:

"the dispute processing practices prevailing in any particular society are a product of its values, its psychological imperatives, its history and its economic, political and social organisation".10

Insights from social psychology have also been applied to disputing and the burgeoning area of research into consumer satisfaction.11 Various theories have been proposed to explain how and why disputes arise, such as relative deprivation theories or how a person’s satisfaction is influenced by comparison with their previous experience or what other people in similar situations have received; equity theories about what people consider they are entitled to; and perceived control theories about different individuals’ perceptions of their ability to influence and control events.12 More recently, attribution theory has been used to expand and offer alternative explanations of the processes leading to disputes and subsequent resolution or non resolution:

"attribution theory holds that people prefer to find order and meaning in the world, and usually develop explanations for why events happen and why people behave as they do... [it] may therefore help to explain... blaming some other for an injury and asserting a claim against that other".13

While the study of complaining behaviour and the different kinds of complaints is important, this knowledge is used to inform the subject matter of this thesis, rather that the object of further investigation. The primary focus in this thesis remains on complaints handling processes and mechanisms.

2.2.1 Exit, Voice and Loyalty

The concepts of exit, voice and loyalty articulated by Albert Hirschman in 1970 have been influential in the development of theories to explain and predict the action taken by dissatisfied customers.\(^\text{14}\) Hirschman proposed that when consumers are dissatisfied with a product purchased or service received they have two options: *exit* and *voice*. He argued that the choice of option is further complicated by the *loyalty* felt by the consumer to the organisation producing the product or providing the service.

When the exit option is chosen the implications for the organisation are that profits or use of the service declines. Management is forced to review its operations to identify those aspects causing concern and implement changes to stop further exit of consumers. However, this will not necessarily happen if new consumers are gained at the same rate as others are lost. Also, the organisation may be ‘insensitive’ to the exit of consumers when it does not rely directly on consumers for revenue. Hirschman argues, though, that the exit option is “widely held to be uniquely powerful” and fundamental to the competition principle.\(^\text{15}\) Where the quality of the purchase or service decreases across all organisations from the same sector, continual exit by consumers, from one organisation to another and another, in the search for better quality will decrease the pressure on all the organisations to improve their quality. Hirschman suggests

“competition in this situation is a considerable convenience to the manufacturers because it keeps consumers from complaining; it diverts their energy to hunting for

\(^{14}\) A. Hirschman, *Exit, Voice and Loyalty*, Harvard University Press, Massachusetts, 1970. Hirschman points out that combining theory from the two disciplines of economics and political science was instrumental in the development of his theories.

\(^{15}\) Hirschman discusses the underlying assumption here that, for perfect competition, consumers have full knowledge of their purchases. Hirschman, p21.
the inexistent improved products that might possibly have been turned out by the competition".\textsuperscript{16}

With the voice option, on the other hand, the consumer endeavours to influence the organisation to change current practices, policies and products which have caused increased dissatisfaction to the consumer.

"Voice is here defined as any attempt at all to change, rather than to escape from an objectionable state of affairs, whether through individual or collective petition to the management directly in charge, through appeal to a higher authority with the intention of forcing a change in management, or through the various types of actions and protests, including those that are meant to mobilise public opinion".\textsuperscript{17}

In using voice the consumer makes the assumption, at least initially, that there is potential for the organisation to make the necessary changes. Hirschman predicts that increasing the number of 'voices' will also increase the effectiveness of that option, but only up to a certain point, after which further protest may stifle rather than assist the change process because organisations need time to respond and make adjustments to their processes.

Voice can both complement and be a substitute for exit. Hirschman suggests that "the decision whether to exit will often be taken \textit{in the light of the prospects for the effective use of voice}".\textsuperscript{18} Consequently, there will be instances where exit is only used after voice has been tried and found to be unsuccessful. In examining the conditions contributing to the use of voice in preference to exit, Hirschman concludes that voice is used when the consumer perceives that the organisation will take notice and the consumer is "willing to trade off the certainty of exit against the uncertainties of an improvement in the deteriorated product".\textsuperscript{19} There are costs involved in using voice, apart from the cost of not using the exit option. The consumer's time and money spent in pursuing the voice option may be considerable: "in comparison to the exit option, voice is costly and conditioned on the influence and bargaining power customers and members can bring to

\textsuperscript{16} Hirschman, pp26-27.
\textsuperscript{17} Hirschman, p30.
\textsuperscript{18} Hirschman, p37, original italics.
\textsuperscript{19} Hirschman, p77.
bear within the firm from which they buy or the organisation to which they belong". Therefore, consumers are more likely to use voice in situations where they have a considerable investment. Voice is also more likely to be considered important by an organisation with few consumers or where a few consumers account for a significant proportion of purchases.

When exit is readily available, the mechanisms for using the option of voice may not be developed. Hirschman postulates that “the propensity to resort to the voice option depends on the general readiness of a population to complain and on the invention of such institutions and mechanisms as can communicate complaints cheaply and effectively”. He cites the establishment of ombudsman offices and consumer advocacy groups and the use of regulatory measures as examples of the institutionalisation of consumer voice. Hirschman suggests that the past experience of using the option of voice, particularly the cost to the consumer and the perceived effectiveness, will influence the consumer's future decisions in choosing this option again. Reducing the costs and increasing the effectiveness are crucial to the development of voice as a viable alternative to exit, hence “voice is essentially an art constantly evolving in new directions”, which can easily be stifled by easy accessibility to exit.

The value the consumer places on the quality of the product or service has an important influence on which option will be evoked when a deterioration of quality is experienced. Consumers who place a higher value on quality, Hirschman argues, are more likely to react to a deterioration in quality than an increase in price, and this is potentially a motivating force for the use of voice. But if a better quality alternative exists, this group will choose exit “which paralyses voice by depriving it of its principal agents” and a further

22. Hirschman, p43.
deterioration of the original product or service will occur, particularly if the organisation is unresponsive to exit.\textsuperscript{23}

Hirschman maintains that in situations when exit is not possible, because of the lack of alternative suppliers, voice is the only option. Analysing the situation where exit is not possible, for example where a monopoly exists, Hirschman suggests that this situation might, in fact, be preferable to that of limited exit if two conditions are present: if exit isn’t effective in changing the organisation and instead results in the most articulate and ‘potentially activist’ consumers leaving, and “if voice can be made into an effective mechanism once these customers or members are securely locked in”.\textsuperscript{24} Organisations with a monopoly may actively provide limited exit so that those who would otherwise use voice will exit. However, just because consumers cannot exit does not mean that grievances about the organisation will be expressed or addressed. Hirschman comments that “voice is not only handicapped when exit is possible, but also, though in quite a different way, when it is not”.\textsuperscript{25}

If the consumer cannot go elsewhere there is greater motivation to express grievances and seek remedial action through using the voice option. Hirschman sees this as providing consumers with power in a seemingly powerless situation. On the other hand, the organisation also has the power to impose sanctions on the consumer using voice, such as expelling the consumer from the group. However, voice is enhanced when the possibility and threat of exit exists, for example in the form of a threatened consumer boycott of an organisation’s products or services. One of the difficulties in using voice is to find “new ways of exerting influence and pressure” on the organisation so that the desired changes are made and this, Hirschman suggests, is one of the reasons why exit will often be chosen before voice.\textsuperscript{26} As well “different organisations are differently sensitive to

\textsuperscript{23} Hirschman, p51.
\textsuperscript{24} Hirschman, p55.
\textsuperscript{25} Hirschman, p55.
\textsuperscript{26} Hirschman, p80.
voice and exit and that the optimal mix of voice and exit will therefore differ from one type of organisation to another”.27

Hirschman argues that the concept of loyalty complicates the choice of exit or voice. Consumers may possess a certain loyalty to an organisation that will result in a decreased inclination to use the option of exit; “as a rule, then, loyalty holds exit at bay and activates voice”.28 The cost to the consumer of using the exit option increases as the consumer’s loyalty to an organisation intensifies. Sometimes this loyalty has been artificially created or reinforced by the organisation, such as imposing penalties for exiting. But there is also a cost to the loyal consumer in using the voice option, possibly postponing the use of voice: recognition and acknowledgment that the organisation to which the consumer has been loyal is no longer satisfactory. While loyalty may delay exit from an organisation it does not necessarily prevent it. Exit by those most conscious of quality, can in itself lead to further quality deterioration. The loyal consumer, by eventually exiting due to quality decline, will contribute to this downward spiral of exit and deterioration.

Loyalty to an organisation can still exist even after a dissatisfied consumer has exited. Where the consumer, with a high degree of loyalty, has made a considerable investment in the organisation, the consumer may continue to use voice by expressing grievances even after leaving the organisation. Hirschman suggests this happens because “the output or quality of the organisation matters to one even after exit” and consequently in this situation “full exit is impossible”.29 He contends that this is the situation with ‘public goods’.30 The whole community will ultimately be affected by a deterioration of ‘public goods’ as complete exit by members is not possible and consequently it is in the interest of all to maintain a certain quality in the provision of the ‘goods’, whether directly

27. Hirschman, p74.
28. Hirschman, p78.
29. Hirschman p100, original italics.
30. Hirschman defines public goods “as goods which are consumed by all those who are members of a given community, country, or geographical area in such a manner that consumption or use by one member does not detract from consumption or use by another”. Hirschman, p101.
using them or not. For example, a deterioration in the quality of services provided by the public health system may lead to poorer health outcomes for the consumers left having to use the service, which may in turn lead to increased usage and cost of health and welfare services to the whole community.

Hirschman offers some words of warning about the effectiveness of both voice and exit: “management will therefore strain to strip the member-customers of the weapons which they can wield, be they exit or voice, and to convert, as it were, what should be feedback into a safety valve”; and that “voice can become mere ‘blowing of steam’ as it is being emasculated by the institutionalisation and domestication of dissent”. Collusion between organisations to accept consumers exiting from their competitors will make them insensitive to exit. As a final strategy for consumers, Hirschman suggests that the option that is least in use at any one time has the most potential impact, whether it be voice or exit.

The terms exit, voice and loyalty and the concepts underpinning them, have become part of the everyday rhetoric of those concerned with consumer relations. Marketing has made considerable use of these ideas as justification for their role in increasing business competitiveness and profits. Sophisticated and fast information retrieval systems have made possible the immediate categorisation of complaints in terms of the ‘value’ of the customer to the business and the likelihood of the customers exiting: complaints by ‘valued’ customers and complaints about matters more likely to cause exit can then be targeted for more attention by personnel dealing with complaints.

However, the promotion of Hirschman’s ideas have not been confined to the business sphere; consumer organisations and consumer advocates also talk about the need for, in particular, the consumer ‘voice’ to be heard.

31. Hirschman, p124.
32. See, for example, Technical Assistance Research Programs, The Nature of Customer Satisfaction, written by J Goodman, President, for the National Quality Forum IV New York, TARP, 1600 Wilson Boulevard, Arlington Virginia, revised 1993.
The difficulties experienced by consumers of health services in exercising the exit option are complex. The health system has not traditionally encouraged 'shopping around' or choice of different services; professional training, etiquette and work practices militate against this. While consumers with money and knowledge can change service providers, the public-private divide does not guarantee different or better quality services. This appearance of choice though, as Hirschman suggests, works to the advantage of service providers by constraining the use of voice, as consumers, likely to be the most articulate, direct their energies into finding other more satisfactory services. Reliance on revenue sources that do not come directly from the consumer, such as current Australian health insurance schemes, according to Hirschman's theories, also decreases the incentive for service providers to take notice of consumer concerns. Using alternative services may include an added financial cost to the consumer, for example consulting a naturopath. Choosing ‘exit’ in the health system may mean, in fact, not receiving a health service at all.

The obstacles to the use of voice by health consumers are also great, as demonstrated throughout this thesis. Health service providers have not typically taken into consideration the views of consumers. The legitimacy of consumer concerns has been measured against compatibility with the ‘expert’ opinions of the professional service providers. The costs to the consumer of using ‘voice’ may be considerable, including direct financial expenses and the possible emotional trauma and ostracism experienced by confronting the more powerful health service provider. As Hirschman points out, the consumer will weigh up the personal costs against the possible gains before proceeding with voice, and prior experience of using voice will further influence this decision. For example, a consumer with previous experience of a complaint being trivialised by the service provider is less likely to complain again. The commitment and ability of consumers to making their views known becomes critical. Bates, for instance, claims
“both the options of exit and voice are readily available only to the educated, articulate and energetic people who are accustomed to protesting if services do not reach standards they feel are acceptable”.

However, Bates does not dismiss the idea that voice is important, arguing that “no matter how health services are organised, voice rather than exit has to be used as the major resource to prevent deterioration of such services”. The challenge is to provide accessible, user-friendly, formally identified mechanisms for consumers to voice their ideas and concerns about all aspects of health services in a way that will be heard and acted upon by health service providers. New complaints systems may prove to be an important mechanism for achieving this.

2.2.2 Naming, Blaming, and Claiming

The expression of grievances or complaints has often been described as the first step in the disputing process that increasingly leads to the use of more formal channels and finally to the ultimate body with the power of adjudication, the courts. In this regard, the study of initial grievances and complaints has been of interest for what might be revealed and predicted about the likely progression of a dispute. A key model used to explain the nexus between the origins and the development of disputes has been the “naming, blaming and claiming” model put forward by Felstiner, Abel and Sarat, in 1981.

In earlier articles, Felstiner had explored the use of avoidance to end interpersonal disputes as a viable and valid alternative to using the processes of adjudication and mediation. Acknowledging the similarity to Hirschman's concept of exit, Felstiner suggested that avoidance did “not necessarily imply a switch of relations to a new object, but may simply involve withdrawal from or contraction of the dispute producing

34. Bates & Linder-Pelz. p164.
relationship". Thus a complainant’s avoidance of a health service provider, to end a dispute, would not necessarily involve searching for a new health service provider offering better quality services. Avoidance did not settle the dispute but, rather, through the changed relationship between those in dispute brought about by minimal or lack of contact, diminished the importance of the dispute to the person initiating the avoidance so that action was no longer required. There were costs, psychological, social and economic, in instituting avoidance both to the individual (internal costs), and to the other party and community more generally (external costs). Felstiner maintained that where the costs of avoidance were considered tolerable by the individual, this option would be chosen. The social conditions that reduced the cost of avoidance also made adjudication and mediation options less feasible and vice versa. Felstiner went on to suggest that the influence of the social conditions in different societies varied the cost of avoidance. For example, the social conditions in the USA were such that the cost of avoidance was relatively cheap, so that avoidance was frequently used as the preferred option, and this reduced the demand for and viability of alternative processes, such as community mediation services.

In developing his argument for the value of avoidance as a disputing process, Felstiner was critical of some of the conditions necessary for using the other options of adjudication and mediation. Adjudication, he argued, relied on established rules for determination of the dispute by a third party and coercion to comply with the outcome. Where the adjudicated decision went against the individual the consequences might be significant: “the effect of losing a dispute is to be told that what you consider as history was either an illusion or a lie... He [the loser] must change either his attitude toward the process or toward his past behaviour”. On the other hand, mediation was a “shared experience” in which the mediator must be able to understand the dispute from the perspectives of the disputants, including the social and cultural context, to be able to

37. Felstiner, 1974, p70, original italics.
facilitate the process. To reach an outcome involved communication and compromise but “mediation may be futile because people are reluctant to bargain away principles and cannot easily compromise on issues that they cannot cooperatively define”. Felstiner’s observations about these processes match the experiences of consumers in pursuing complaints against health service providers, discussed in more detail in chapter seven. But Felstiner’s alternative of avoidance was not without problems. The real cost of avoidance could easily be underestimated, both in terms of the psychological trauma caused to the individual, by leaving the dispute unsettled, and the broader costs to society, in leaving the situation from which the dispute arose unchanged. Difficulties in accessing and using adjudication and mediation processes meant that the costs of avoidance, although high, were still less than using these processes. Again, a well recorded experience of health consumers. The acceptance of avoidance as a normal, if not preferred, course of action, weakened the case for improving existing adjudication and mediation mechanisms and establishing appropriate mechanisms for the handling of specific disputes.

The relationship between how grievances arise, develop into disputes, and the disputing processes chosen to resolve grievances, is complex and unclear. Felstiner, Abel and Sarat proposed a model for describing the social process of the “emergence and transformation of disputes” that begins with the experiences of individuals and finishes with court action. An injurious experience (defined as “any experience that is disvalued by the person to whom it occurs”) may remain unperceived as such by the individual concerned (although it may be know to others, as is often the case with adverse outcomes from medical interventions). The first transformation occurs with the changed perception of the individual, who now perceived the experience to have been injurious. The injurious experience has been named as such. The next transformation, the grievance stage, occurs “when a person attributes an injury to the fault of another individual or social entity”;

41. Felstiner, 1975, p704.
43. Felstiner et al.
Blame has been attached to the injurious experience as normative expectations have been transgressed. Another transformation occurs as the grievance is given voice when the individual, who has suffered the injurious experience, confronts the person/entity thought to be responsible and requests some remedial action. The individual has made a claim in relation to an injurious experience; if this claim is rejected the transformation to a dispute occurs.44

Felstiner and colleagues did not see the transformation from one stage to another as a simple process: “transformations reflect social structural variables, as well as personality traits... they are subjective, unstable, reactive, complicated and incomplete” and a range of factors impinge on each stage of the transformations, constraining their development and preventing settlement of the dispute, such as personal beliefs about entitlements and the causes attributed to the injurious experience, the availability and type of dispute mechanisms and the influence of the professionals involved in the various stages of the disputing processes.45 As the dispute escalates and remains unsettled “the disputant may no longer view the original problem as important, since a central tenet of transformation theory is that a transformed dispute can actually become the dispute”.46

Felstiner and colleagues note that taking action on a perceived injurious experience may not always be desirable and appropriate but went on to conclude: “we do believe, however, that a healthy social order is one that minimises barriers inhibiting the emergence of grievances and disputes and preventing their translation into claims for redress”.47 Their idea was that justice would be served by understanding better the way transformations occurred and how the process could be freed from possible constraints, thereby enabling more people to claim redress, such as financial compensation, for the harm they had experienced. However, the application of this theory in practice has been used for the

44. Felstiner et al, pp633-636.
46. Felstiner et al, p650.
47. Felstiner et al, p654.
opposite effect. The notion of a linear progression through naming, blaming and claiming implied that all injurious experiences named had the potential to eventually become claims, a worrying thought for senior executives in businesses and industries where injurious experiences were suspected, or known, to be relatively frequent, but where claims were minimal, for example in health care. It was in their organisations’ interests that the interaction in the intervening stages prevented, rather than enhanced, the transformation of grievances to the claiming and dispute stages. All grievances, then, had to treated as though the complainant was making a claim and therefore the initial response must not admit liability or jeopardise the organisation’s position in case the claim did proceed; insurers often insisted on this. Defensive and uninformative responses were common but, as understanding of disputing transformations grew, it became evident that this kind of response could, in fact, exacerbate the situation as the transformed dispute included not only the initial grievance but also the way it had been handled. The incentive to find different ways of intervening during the initial grievance stage, for example through improving complaints handling, was to avoid the transformation to claiming, ultimately through the courts. The Australian Complaint Handling Standard, discussed in chapter six, for example, is based on this linear model to some degree. The new rhetoric, that organisations were interested in hearing consumers’ voices, could disguise the underlying motive to thwart any grievances before they reached the claiming stage.

The focus on the expression of complaints as a precursor to litigation has dominated much of the research into complaints and the models of complaints mechanisms. However, more recently, Lloyd-Bostock and Mulcahy have proposed that

“a richer understanding of complaints, and of their potential to evolve further, can be achieved if they are analysed in their own terms rather than primarily as early or embryonic versions of something else”.48

The move away from the linear model to the conceptualisation of complaints and complaining as activities in their own right opens up new ways of thinking about the

handling of complaints and the information contained in complaints. It presents a different perspective on the purpose of complaints that does not tie the purpose of making a complaint so closely to a claim for financial redress but, instead, leads back to Hirschman’s original proposition that the purpose of using voice (by making a complaint) is to seek changes to, and improvements in, the quality of the product/service that are more closely aligned to consumer needs and expectations and could ultimately benefit all who used the products/services. From this perspective, the purpose of handling complaints is no longer focused exclusively on the prevention of claims, but instead takes on quite a different dimension, that of listening to and heeding the consumers’ voice. Lloyd-Bostock and Mulcahy “conceptualise complaints quite broadly as a social process of calling the hospital to account” in their analysis of their research findings into complaints made to and the responses of hospitals.49 The following discussion of complaints mechanisms proceeds from this understanding that the making of a complaint is an activity to be considered in its own right with its own ends, and that an important component of this is the call for the service provider (person or organisation) to account for their violation of the complainant’s normative expectations.

2.2.3 Alternative Dispute Resolution

The range of processes that now fall under the broad banner of alternative dispute resolution (ADR) have been seen as the way forward for the management of disputes.50 The concept of ADR encompass a number of well established processes such as the use of arbitration and the establishment of tribunals, as well as the more informal processes of mediation and conciliation. Formal settlement of disputes through the court system has become renown for being slow, complex, restrictive and costly without necessarily

49. Lloyd-Bostock & Mulcahy, p124. For further discussion of Lloyd-Bostock & Mulcahy’s research see ch2.4 and ch8.3.
50. See, for example, Attorney-General’s Department (Commonwealth), The Justice Statement, Office of Legal Information and Publishing Attorney-General’s Department, Barton ACT, May 1995, p24.
obtaining a satisfactory resolution for any of the disputants.\textsuperscript{51} Since the 1970s, in Australia, the implementation of a series of administrative law reforms has created new mechanisms to deal with disputes arising from the greater acknowledgment of the rights of consumers to question and appeal actions and decisions made by government bodies. Explored in detail in chapter six, the administrative appeals tribunals, other specialist tribunals and the offices of the Ombudsman were established with the intention that they would provide accessible, speedy, informal, fair and cheaper options for dealing with these matters. Many grievances investigated or adjudicated by these mechanisms would have been unlikely ever to have reached the courts. In this way, ADR mechanisms have filled a gap by providing options for the handling of grievances or appeals that would not have been handled more formally otherwise; ADR mechanisms are both alternatives to and additional to the formal justice system of the courts.\textsuperscript{52}

Increasingly, though, mediation and conciliation have become the preferred ADR processes used in Australia, including by the ADR mechanisms already mentioned. The ideas underpinning mediation and conciliation have had a widespread impact on the way disputes are dealt with and complaints handled. While the varying styles and scope of the mediation processes have made definition difficult, mediation may be describe as

"the process by which participants, with assistance from a neutral person or persons, systematically isolate dispute issues in order to develop options, consider alternatives and reach an agreed settlement that will accommodate their needs".\textsuperscript{53}

The role of the mediator, central to the process, is not one of adjudicating or decision making, but of facilitating the disputants in their exploration of the possibilities for agreement. Mediation has the advantage that the outcomes can be decided by the parties to the dispute and are not imposed upon them, allowing solutions and agreements that may not have been possible using other processes, such as adjudication; they also have the


\textsuperscript{52} Astor & Chinkin, pp30-40.

potential to lead to better future relationships between the disputants and to outcomes that are more likely to endure.\textsuperscript{54}

The differences between the processes referred to as conciliation and the processes referred to as mediation are not well defined in Australia. In some instances conciliation, also using an impartial third party, has referred to the process used to obtain agreement about the process to be used to reach settlement rather than facilitating the agreement itself, which becomes the task of the mediator. Alternatively, conciliation may involve greater intervention by the conciliator in assisting the parties towards settlement, going further than what might be expected of a mediator, by meeting the disputants individually and together and pointing out the strengths and weaknesses of each disputant’s desired outcome.\textsuperscript{55} In this model of conciliation, a more interventionist style than usual for mediation, the emphasis is still on a consensual approach and those in dispute must agree to the tasks to be undertaken by the conciliator. Conciliation has been given a specific meaning in health complaints legislation and the conciliator is actively involved in the dual tasks of determining a mutually acceptable process and assisting the complainant and respondent to reach a resolution. All records and actions of the health complaints conciliation process are confidential and cannot be used as evidence in other forums, such as court litigation. (See ch7.5.2.)

The voluntary nature of mediation and conciliation has provided a compelling argument for their use. As involvement in the process is voluntarily agreed to by all parties, the disputing parties are said to retain considerable control over the process and outcome. But the true voluntary nature of the processes may be compromised to some degree by the quasi-legal context in which they are set and “to a greater or lesser extent the parties bargain in the shadow of the law”.\textsuperscript{56} Disputants may perceive considerable pressure

\textsuperscript{55} Astor & Chinkin, pp61-64.
\textsuperscript{56} Astor & Chinkin, p64.
to use mediation or conciliation particularly if access to alternative processes is restricted, unavailable or undesirable. Health consumers, for example, aware of the limited chances of successfully pursuing complaints through litigation or registration boards, may find conciliation to be the only feasible option.\textsuperscript{57}

Numerous other advantages have been claimed for the use of ADR, including speediness and cost effectiveness, but there have also been questions about the process compared to the judicial process. The open, highly structured framework and clearly established legal principles of the judicial system offer a degree of fairness and protection to the position of all the parties using the process. ADR processes, not bound by the rules of evidence and conducted behind closed doors, may not redress sufficiently the power imbalances between disputants, leaving the more vulnerable party in a weaker bargaining position and subject to coercion in agreeing to a settlement. The pressure to reform the justice system, to increase access for the most disadvantaged and vulnerable citizens, may be reduced as ADR mechanisms provide an alternative system, “with only a form of "second class" justice being available for the underprivileged”.\textsuperscript{58} As a cheaper option, ADR may be promoted as the preferred option by governments keen to make cost savings. The private nature of many of the processes of ADR can shield them from outside scrutiny and also hide issues that may be of considerable public interest and concern.

The more recent subtle change in focus of many of the central complaints mechanisms, away from investigation, recommendation and adjudication (except for the most serious cases) to mediation and conciliation has partly been driven by the enthusiasm for ADR notions, but also by new management practices, where caseloads, the number of complaints settled and time taken have been used as measures of the performance of the units, increasingly needed to justify the continued existence of such mechanisms.

\textsuperscript{57} While advocating the increased use of mediation, it was noted in the recent Commonwealth \textit{Justice Statement} that “the Government recognises the inappropriateness of using mediation to resolve disputes in relationships that are tainted by violence and fear”. \textit{The Justice Statement}, p31.

\textsuperscript{58} Access to Justice Advisory Committee. p279.
Complainants, though, usually want their complaints investigated by a third party, who may also have the power to take some action, and the emphasis on settlement and consensual agreement of mediation and conciliation may be seen to advantage the respondent's position over that of the complainant. The lack of access to neutral mechanisms that have the power to adjudicate is in the interests of those already holding power, and the other mechanisms may purely serve as Hirschman's "safety valve", stifling complaints from escalating to uncontrollable proportions. Adjudication, though, is not without its drawbacks, particularly when the standards and criteria used to make judgements are controlled by vested interests. (See, for example, ch7.3.)

The trend towards managing health complaints through mediation and conciliation needs thorough and ongoing evaluation to ensure that real advantages ensue for consumers wanting to complain. Although it has been said that complainants have "nothing to lose" by trying mediation or conciliation first, 'complaints fatigue' may set in, where the energy and resources required to pursue the complaint again in other forums, weighted against the perceived possible outcomes, are considered too great for the individual to continue, leaving only exit or avoidance. Complainants may have difficulty in assessing whether the response given to their "calling to account" has been satisfactory without the assistance of a more experienced third party, particularly if the response is disguised in technical and professional jargon. Felstiner's caution about the need for there to be sufficient common ground to use the mediation process remains particularly relevant in the health area where the schism in the perspectives of consumers and health service providers may be too great for cooperative definition and compromise on issues. The establishment of the central complaints units has been significant for consumers in providing a mechanism for the handling of health complaints that promised impartial investigation and fair consideration of the consumer's position. (See ch7.5.) It is important that this reputation is not lost in the current fervour for mediation and conciliation processes.
Research about complaints and complaints handling in the health area has been limited and intermittent compared to the research about complaints handling in other areas, such as product purchasing. In Australia, research has been undertaken chiefly by officially instigated inquiries into aspects of the health system, health consumer groups and the central health complaints mechanisms, rather than receiving broader academic attention, and much of that research has been conducted in the past decade. This lack of a tradition of research, the difficulty in obtaining even relatively basic statistical information about health complaints, the few articles in the academic and professional literature and inquiry findings often buried obscurely in multiple government reports, has meant a huge gap in knowledge about health complaints and complaints handling across Australia.

The academic and professional literature from overseas, particularly from Britain, has carried a small stream of articles relating to health complaints. Perhaps one of the most detailed accounts stemmed from research undertaken in the early 1970s by Klein into both the nature of complaints and the mechanisms for dealing with complaints relating to general medical practice. Through his examination and analysis of the role of the Executive Councils, designated with the authority to deal with the complaints, Klein maintained that the number of complaints formally lodged was only the tip of the “iceberg”. The way the procedures were implemented influenced the outcome of the complaint; complaints about organisational issues, more likely to be verified easily, tended to be more rigorously dealt with than complaints relating to the “technical competence” of the doctor, more likely to involve issues of professional judgement, but it was the latter that was more commonly the substance of a formal complaint. As relatively few consumers

59. This literature is used through this thesis and so is not detailed here.
60. Although the health finance arrangements and structure are different, Australia has drawn heavily from the British traditions in health care and there have been strong links between health professionals in the two countries, particularly in the medical profession.
made formal complaints, and with the variability amongst the Councils in handling complaints, Klein suggested, it was a matter of chance rather than competence that determined which doctors were called before disciplinary hearings. Consequently the complaints system in place was not a reliable or sufficient way to ensure that professional competence was maintained. Klein noted the “non-evolution” of complaints handling in his area of study, the system remaining relatively unchanged for decades despite “a background of rapid social change and a revolution in the organisation of health care”.63 Administrative and professional agendas dominated attempts to reform the system “in a vacuum of public indifference”.64 Klein outlined the need for greater individual accountability of the health professional to the consumer and, more importantly, greater public accountability of the professions. He proposed the establishment of a “Council on the Professions” with a specific brief to examine “what the professions are doing to evaluate the quality of the services being delivered by their members and to ensure their continued competence”.65 Unfortunately, Klein’s work does not seem to have been replicated in other areas of the health system, although the difficulties in establishing effective health complaints systems that were easily accessible to consumers, in the face of the considerable influence of the medical profession and the numerous bureaucratic requirements, have been a recurrent theme in other literature.66

Analyses of complaints received by specific health services over a period of time have gradually been reported over the past decade. Differing variables such as the reason for the complaints, the frequency of complaints and the validity of the complaints have been examined. Generally the frequency of written complaints received was considered to

63. Klein, p75.
64. Klein, p136.
65. Klein, p162. In Australia it was primarily economic policies that eventually brought to the fore the issues of accountability of the professions, refer chapter six and chapter seven.
be low when compared to the total services provided. While complaints were made about a wide range of issues, the four most commonly reported categories of complaints related to:

- appropriateness or quality of care provided, such as misdiagnosis;
- personal conduct of the health service provider, such as rudeness and lack of respect;
- a failure of communication, such as insufficient provision of information; and
- administrative issues, such as billing practices and waiting times.

However, there appears to have been few attempts to validate or build on others’ work in this area, perhaps because of the small number of studies reported. Some authors have tied their findings to the more extensive consumer satisfaction literature and others have related their findings to management and service delivery practices but the research has tended to be limited and driven by professional concerns.

In Australia, two consumer advocacy groups, the Health Issues Centre and the Consumers’ Health Forum of Australia, have taken a leading role in describing and monitoring health complaints systems from a consumer perspective. The gaps and piecemeal approach to a comprehensive health complaints system which they reveal, the professional and government dominance and the relationship between the recognition of consumer rights and effective complaints handling have been dominant themes in this literature, which is discussed in more detail in chapter five. The other major source of information about health complaints and complaints mechanisms in Australia has been the

---


annual reporting and evaluation of their services by the central health complaints mechanisms. (See ch7.5.) Comprehensive understanding of the nature of health complaints, the issues they raise and the way they have been resolved in Australia, has been severely hampered by reliance on complaints information systems, set up by the individual complaints mechanisms, which have often been inconsistent and incomplete. As Klein pointed out, the complaints mechanisms can be instrumental in determining how a complaint is categorised and handled. The multiple points at which a health complaint can be raised and dealt with, such as direct to the service provider; to a central mechanism; to a registration board; or to the courts, presents a considerable challenge in trying to piece together a complete picture. As the SOCAP - American Express survey showed, there are also a significant number of people who, for various reasons, do not complain, although they, too, had a distressing experience whilst receiving health care, and had justifiable cause to do so.

Overseas research interest in health complaints has been rekindled in recent years. A number of British studies have been published, in the early 1990s, coinciding with a major review of the complaints procedures throughout the National Health Service and the Inquiry of the House of Commons Select Committee into the powers and jurisdiction of the Health Service Ombudsman. The research has focussed on a range of issues to do with complaints and complaints handling, including a personal account of the traumatic effect a complaint can have on the individual service provider, which was exacerbated by poor complaints handling procedures, and the use of informal complaints procedures as part of the quality assurance program in a general practice setting. In particular, the studies in Britain by Longley; Lloyd-Bostock and Mulcahy; and Nettleton and Harding, which include detailed examination of complaints files, provide important insights into health

complaints and complaints handling. (The findings from these three studies are also discussed in ch8.3.)

Longley, reporting in 1992, examined the complaints handling processes of hospitals, area health services and general practitioner services in the period following a major restructuring of English health services that began in 1990.72 Her research included examination of a sample of the complaints files, interviews with complaints officers at the unit and district levels and family health service authorities, interviews with other key health department personnel and community health council representatives, and a small questionnaire survey of a sample of complainants (50% response rate). She grouped the complaints studied into three broad categories: environmental and support services, for example complaints relating to catering and cleaning; care, including clinical judgements and attitude of staff; and organisation, for example complaints about waiting times and visiting arrangements; finding that ‘care’ complaints were the least well handled.

The studies by Lloyd-Bostock and Mulcahy, and Nettleton and Harding both involved detailed examination of letters of complaint to health services. Lloyd-Bostock and Mulcahy, reporting in 1994, examined all the files (399 total) of the formal complaints received by two National Health Service districts, over a one year period 1989/90.73 A sample of the files, which contained the original letter of complaint and details of subsequent correspondence between the organisation and complainant, were examined using content analysis. A smaller sample of complainants were interviewed about their experiences and views of the complaints handling processes. The allegations made in the letters of complaint were placed into thirty five categories, revealing the diversity of consumer concerns about their interactions with health services, and many letters included more that one allegation. Just under a third of the complaints included an allegation


relating to clinical matters. Over a quarter of the total number of allegations made related to communication and behaviour issues. Nettleton and Harding, also reporting in 1994, examined all the files of letters of informal complaints (107), that is the complaint did not proceed to a formal hearing, made to a Family Health Service Authority in 1990. They also found that a number of the letters included more that one issue. Three quarters of the issues identified in the letters related to "inadequate clinical treatment", "practitioner not responding or co-operating" and "personal attributes of the health professional". Similar issues have been reported as the major subject matter of complaints made to the NSW Health Complaints Unit and the Victorian Health Services Commissioner during the early 1990s. (See ch7.5.) The South Australia study of health complaints handling at the local level, discussed in chapter eight, found that the perceived focus of complaints related principally to issues of accessibility and availability of public health services and interactions between consumers and health service providers, including treatment issues.

The different categorisations used by the various studies makes investigation and comparison of the substance of complaints more difficult. However, it is overwhelmingly clear that, while complaints cover a wide range of issues, matters relating to the clinical treatment received (or not received) and the professional conduct and behaviour of health service providers are the primary substance of health complaints in the majority of situations where currently available complaints mechanisms are used. Complaints about these matters cannot be rectified in the same way that complaints about faulty products, for example, can be by simple replacement with new goods. Eventually receiving the correct treatment may not be sufficient to overcome the repercussions on a person's health from mistaken or ill-timed treatment. The experience of humiliation and anger resulting from an incident of unprofessional conduct and behaviour can never be undone even if an apology is made. The primary substance of health complaints suggests that when people complain

about these matters they are possibly looking for resolutions that go further than their individual circumstances to include benefit for others, such as changes to clinical practices or individual service provider behaviour. The research by Lloyd-Bostock and Mulcahy into the desired outcomes from lodging a complaint, as expressed by complainants in their initial letters, found that, while in many letters the desired outcome was not obvious, 20% of letters explicitly included a “request that steps should be taken to put matters right for others in the future”, compared to 15% of letters where complainants specifically wanted something put right for themselves.\(^{76}\)

Further research is needed to better understand the nature and scope of the substance of health complaints. Without further investigation in this area it is also difficult to ascertain the extent to which the substance of complaints may be indicative of what consumers generally perceive to be wrong with health services. The seven common elements that characterise the contribution of the consumer movement in health to health sector debates, identified and discussed in chapter four, provide some evidence that the issues comprising the primary substance of complaints made to current health complaints mechanisms, noted above, are the more specific manifestations of some of the broader issues represented by the common elements. Complaints about matters relating to the clinical treatment received (or not received) can be matched with the elements of questioning information from professional sources; and sharing information and knowledge about health and health care. Complaints about professional conduct and the behaviour of health service providers can be matched with the elements of identification of consumers’ rights; and participating in decision making about all aspects of health service provision. The common elements are more encompassing of broader areas where change is needed than would seem to be indicated by the substance of complaints currently, suggesting that complaints provide an important, but not the only, source of consumer information to inform change within the health system.

\(^{76}\) Lloyd-Bostock & Mulcahy, pp131-132.
For the purposes of this thesis, it is the act of making a complaint and the processes used to handle and resolve the complaint (the health complaints handling mechanisms) that are the focus of analysis, regardless of the subject matter of the complaint. While the substance of complaints may influence the complaints handling processes used because the complaints handler perceives some complaints to be more noteworthy in some way than others, all complaints need to be recognised, acknowledged and appropriately handled.

2.4 PATIENT SATISFACTION RESEARCH

The study of patient or consumer satisfaction with health care has been much more extensive than the study of consumer complaints. This body of literature covers a broad range of research from analysis of consumer satisfaction with specific services and interventions to the development of sophisticated tools to measure patient satisfaction that fit with scientific research criteria of reliability and validity. But patient satisfaction measures do not capture the same information as the study of complaints; people may express dissatisfaction with certain aspects of their health care when specifically asked but do not feel so strongly about it that they find the energy and resources necessary to lodge a complaint or take avoidance action. In fact, satisfaction surveys of health care have generally reported such positive responses that it has been suggested that satisfaction ratings not in the upper quartile of the scale should be of concern to the health service provider conducting the survey!77

Patient satisfaction research has been limited by the “home grown” nature of many of the instruments used and the lack of consumer involvement in the development of these instruments.78 The inclusion of consumers as active participants in the design of

satisfaction research tools and protocols can reveal the different priorities given by consumers, managers and service providers to the aspects of health care considered most important in determining consumer satisfaction. Often, though, patient satisfaction surveys have been limited to the mechanical aspects of patient care, such as the meals and physical surroundings, rather than the more subjective and potentially controversial issues of patient care and staff attitude. Patient satisfaction measures have attracted management attention as possibly useful in helping to gain an edge for their organisation in the increasingly competitive health care provision market. For instance, a recent publication of the American College of Healthcare Executives states

"patient satisfaction measurement can be used to protect or increase patient revenue, conduct sound market research, improve risk management practices, build employee morale, document different levels of job performance, facilitate the performance appraisal process, improve the quality of care and establish performance standards. If used to its fullest potential, patient satisfaction measurement can become a potent organisational development and strategic management tool for health care organisations in the 1990s and beyond".

The focus here is self-centred, on the benefit to the organisation, with the implicit assumption that this will, in turn, be of benefit to the people using the service. As emphasised throughout this thesis, however, real benefits to consumers do not necessarily follow from organisational changes said to be undertaken as a result of consumer feedback. As well, patient satisfaction surveys have sometimes been used to further managerial agendas over professional agendas. (See ch6.4. and ch7.2.)

Other studies of consumer satisfaction with health service delivery have produced mixed results in attempting to link satisfaction to other variables relating to individual consumers, such as health status and consumer values and expectations. Increasing age

80. Westbrook, p77.
and lower education levels have been associated with greater satisfaction but the limited number and extent of the studies leave many questions unanswered. The different items included as aspects of satisfaction in some studies increases the difficulty in making comparisons between studies and in consistent interpretation of results. However, some common threads throughout the satisfaction literature suggest that the 'humaneness' (respect, willingness to listen, treated with dignity), the technical competence, the accommodation of the consumers' wishes, the nature and the quality of the relationships with health care providers are the more important factors taken into consideration by consumers when making an assessment of their overall satisfaction with the service/intervention received. Not surprisingly, these factors correlate with the 'rights' expressed in statements of consumer rights and are the major areas associated with formal complaints.

Interest in the application of total quality management ideas has led some health care organisations to seek out consumer opinion through consumer satisfaction surveys and suggestion boxes, now in more visible places, have multiplied (see ch6.4.2.), but the good intent in obtaining assessments of consumer satisfaction and ideas about the services provided has often been undermined by the lack of importance and priority given to the implementation process, consideration of the results and identification of action to be taken, making the process little more than a transparent public relations exercise. The move towards greater accountability of health service providers, involving the incorporation of consumer satisfaction measures as a basic component of the evaluation of health care services, could result in these measures being taken more seriously and further developed as effective tools.

83. J. Hall & M. Dornan, “What Patients Like about their Medical Care and How Often They are Asked: a Meta-analysis of the Satisfaction Literature”, Social Science and Medicine, vol.27, no.9, 1988b, pp935-939.

Greater acceptance of consumer satisfaction measures, properly constructed and applied, will assist in the legitimisation of consumer feedback, including complaints, as a valid source of important and useful information about health services and service provision. The expression of consumer satisfaction provides information different from the expression of consumer complaints, although the perceptions of consumers about their experiences of health service providers are the starting points for both. In this way the study of consumer satisfaction is separate from, but complementary to, the study of complaints, with the potential for each to offer important insights to the other.

2.5 LITIGATION AND HEALTH CARE

Litigious claims arising from health care received have become a major contemporary concern because of the increased cost of health professional indemnity insurance, the size of compensation payments awarded, the increasing number of compensatory claims made and research that has revealed the high incidence of adverse outcomes from health care interventions that could be potentially compensationable. The concerns of health service providers, professional indemnity insurers, governments and consumers about litigation stem from quite different issues. For the health service provider, proving negligence is the most important issue, as the results can impact on reputations, careers and the future financial viability of the health service provider or to sanctions imposed by their professional registration boards or associations on individual providers. For professional indemnity insurers the issue of funding current and future liabilities sufficiently is paramount, with the desire to set boundaries around this where ever possible, such as limiting the time in which claims can be made. For governments, the impact on health care costs of higher premiums for professional indemnity insurance, the new precedents set about vicarious liability for public health provision and the costs associated with providing extra care as a result of health care injuries are important in a political climate favouring control and containment of health care spending. For claimants,
the desire to find out what exactly happened and why and to receive compensation for the injury or harm suffered are significant.

Illness or injury caused as a result of the medical treatment or intervention given, such as an allergic reaction to a prescribed drug, is a well established and accepted aspect of medical care by health professionals. Although often down played and not fully revealed to consumers, assessment of these possible iatrogenic effects and risks has been taken more seriously, in recent times, when considering which options to use, particularly with the increased legal attention to issues of informed consent. Apart from the known risks, harm or injury can also result from incorrect or inadequate health care provision. The terminology used to describe these incidents has included medical accidents, medical injury, and adverse events. However, the term medical accident has been criticised by consumers and health professionals alike because “‘accident’ conveys a sense that bad outcomes are to be explained in terms of fate and luck rather that a set of understandable, and possibly changeable antecedents”.

The links with issues of professional negligence are clear, but until recently the definition and understanding of “adverse events” was limited by the lack of research in this area. Overcoming numerous difficulties in research design and implementation, Weiler and colleagues conducted the Harvard Medical Practice Study (HMPS), which was specifically designed to illuminate the nature and extent of adverse events and the contributing role of negligence, as well as to gather information about the use of the tort system for redress. In HMPS, for an incident to be termed an “adverse event” the person had to experience some unintended injury that was not part of or the result of the disease process, but the direct result of the medical management provided either through “omission” (failure to diagnose or treat) or “commission” (incorrect treatment). The injury needed to be great enough to cause prolonged hospitalisation or temporary or permanent impairment or disability to the person. HMPS

found that the incidence of adverse events during hospital stays was 3.7%, of which over a
quarter (28%) could be attributed to negligence. While over half the adverse events were
considered minor with minimal impairment, almost 14% were fatal and a further 3.9% of
adverse events resulted in some permanent impairment, 2.8% took more than six months to
recover from and 2.6% resulted in permanent total disabilities. Almost half the adverse
events with serious outcomes involved negligence in the medical management. The
researchers concluded

"while we underscore the need for a balanced interpretation of the results of the
hospital records review, we cannot avoid the stark picture presented of the dangers
in modern medical treatment". 87

HMPS also found that, in New York State, only one malpractice claim was filed for every
7.5 patients who suffered a negligent injury and less than half these claims would be
successful. Other studies have also revealed a different picture of the incidence of
negligence compared to that presented by the number of successful claims brought before
the courts. 88

In Australia, the Review of Professional Indemnity Arrangements for Health Care
Professionals (known as the Professional Indemnity Review, PIR) has been set up by the
Commonwealth government, from 1991, to investigate the current situation regarding
compensation and professional indemnity in health care in Australia and to make
recommendation for future policy directions. An important component of the PIR’s work
has focused on the incidence and cost (financial and social, individual and community) of
preventable adverse patient outcomes and the strategies needed to reduce avoidable adverse
outcomes. The PIR found significant gaps in the information and data available so it
commissioned a series of research projects, including one on the feasibility of a HMPS
style study of adverse events in Australian hospitals. The Australian Hospital Care Study,
incorporating relevant elements of HMPS, was commenced as a result of the feasibility

87. Weiler et al, p139.
88. Review of Professional Indemnity Arrangements for Health Care Professionals, Compensation and
study. Preliminary results released by the Minister for Health, Dr Carmen Lawrence in June 1995, suggested that 16% of hospital admissions in 1992 (the year selected for study) had incurred an adverse event or the admission was the result of an adverse event that occurred earlier. A significant proportion of the adverse events were considered to be preventable. Another study, in Victoria, investigating adult hospital admissions resulting from injuries, found that 32% of these admissions involved health care related injuries, such as complications of medical or surgical care. Although Australian health services have a reputation for high quality care, there appears to be little room for complacency.

While not all adverse outcomes are preventable or caused by negligence on the part of the health service provider, the difficulties for anyone who has suffered an injury as a result of a health care treatment/intervention in trying to claim compensation using the current system of the law of torts has been demonstrated repeatedly. For example, Neale's review of 100 cases, where he provided a medical opinion on legal claims, showed that an unacceptable standard of care had been provided in 13% of cases; in a further 15% of cases there had been "clinical errors made during otherwise careful practice" but, while he thought three quarters of the clinical faults might have been avoided by better care, he concluded that "the medico-legal process will almost certainly fail to resolve most of these cases". Numerous barriers to proving a claim of negligence have been identified: finding out initially the truth of what happened; refusal by the health service provider to accept responsibility; gaining good legal advice and the cost of proceeding with litigation; the difficulties in proving fault and then causation when reliant on expert witness testimonies

91. See, for example, the Review of Professional Indemnity Arrangements for Health Care Professionals commissioned study, The Health/Medical Care Injury Case Study Project, A Research Paper prepared by The National Centre for Socio-Legal Studies, La Trobe University, AGPS, 1993.
from colleagues of the health care professional; delays in hearings and legal rules that favour the defence; "most of these people [who sue] will abandon their cases because they lack the financial and emotional resources to fight on".93

The push for reform in the area of health care litigation has been driven by disparate concerns; Kinney outlines "first generation" and "second generation' malpractice' reforms in analysing the American situation, and, while caution is always necessary in applying USA analyses to the Australian health care situation, Kinney's dichotomy is relevant to current debates in Australia.94 The first generation reforms, Kinney argues, have been directed at curtailing the frequency and severity of malpractice claims, for example by introducing time limitations on making claims and limiting the amount of damages awarded; these reforms have been promoted by health professionals and professional indemnity insurers, keen for limitations on their liabilities. As Weiler and colleagues suggest, "a tacit assumption running through much of the political debate about malpractice is that American patients (like the American public generally) have an inordinate propensity to bring lawsuits over imaginary injuries and illusory negligence"; therefore reforms have been directed at stopping this assumed practice by reducing opportunities for litigation.95 The idea that Australian consumers too easily follow American trends, in this instance the assumed high use of litigation, has led to claims of a "medical malpractice crisis in Australia" as costs of professional indemnity insurance have risen.96

The second generation reforms outlined by Kinney have been typified by a focus on standards of care and more rational and efficient compensation schemes, not necessarily aimed at a reduction in claims where an injury has occurred. Although second generation

---

95. Weiler et al, p137.
96. Compensation and Professional Indemnity in Health Care. An Interim Report, pp228-229. The PIR concludes that the rise in indemnity costs has occurred for a number of complex reasons, and not just because the number of people receiving compensation has increased.
reforms offer greater potential to compensate victims more fairly, prevent adverse events and increase professional competency, first generation reforms have been more politically acceptable, Kinney suggests, because of the powerful service provider lobby, compared to the much weaker and diverse lobby representing consumer interests. An important component of the health service provider opposition to second generation reforms has been the issue of proving negligence: "reforms that streamline the process for determining physician fault to achieve more expeditious compensation of claimants are likely to arouse physician opposition". 97 Nevertheless some supporters of second generation style reforms caution against rejecting the court system completely, despite its drawbacks: "court proceedings have a number of virtues that have not always been incorporated in the extensive alternative collection of complaints mechanisms that have grown up along side them", namely adherence to the principles of natural justice, power to adjudicate and award compensation, access to legal advice and advocacy, and for the proceedings to be conducted publicly. 98 The findings of the PIR will be an important influence in determining whether reforms mirroring Kinney's first generation or second generation reforms are eventually implemented in Australia; the Interim Report recommendations favour second generation reforms but the rapidly changing political climate prior to the release of the final report, scheduled in late 1995, suggests that more conservative final recommendations, including first generation type reforms, may be made instead.

The law of torts, of which negligence is often an important principle, enables the awarding of monetary compensation for civil harms caused to individuals through the act or omission of another person. 99 Because establishing negligence involves the determination of fault and causation, judgements made can act as a deterrent or stimulus for certain behaviours. Thus the potential for situations to become the subject of litigation has been seen as a powerful motivation to change practices and systems. This has not

97. Kinney, p123.
necessarily been to the advantage of consumers and, in some instances, it may be to their distinct disadvantage, for example with aspects of the practice of 'defensive medicine'. A study on this issue, undertaken for the PIR, found that "fear of litigation appears to have led a significant proportion of doctors to adopt 'defensive medical practices'." While some of the practices were regarded as positive, such as better record keeping and more careful obtaining of informed consent, others may be costly, not essential and involve some risk, such as increased diagnostic testing. The study also found that medical practitioners' fear of being sued was much greater than the actual risk of being sued. As well, the actual experience of being sued, or the subject of a complaint, did not increase the likelihood of the medical practitioner adopting 'defensive medicine'.

Judgements of negligence by the courts has rested on the determination of standards of care, based, until recently, on the advice of other medical practitioners called as expert witnesses, so that "the standard of care expected of a medical practitioner was that of the ordinary skilled medical man exercising and professing that special skill" and the duty of care fulfilled "if the doctor acts in accordance with a practice rightly accepted as proper by a body of skilled and experienced medical men". More recently, there has been a shift towards greater recognition that professions may have adopted professional practices which may not be 'reasonable' from the consumers' perspective, so that standards of care generally regarded as competent by the profession may not be sufficiently so in particular circumstances. Ideas about 'accepted practice' as interpreted by the law, along with the move to develop treatment protocols in many areas of health care provision, will undoubtedly continue to influence service delivery in the future, although the degree to which these will result in individual incompetent practitioners changing to safer practices is still of concern.

For consumers the reality remains little changed: many are not even informed of the adverse outcomes they have experienced as a direct result of a health care treatment/intervention, even fewer are able to make a compensation claim and even fewer still receive compensation. The focus on negligence, so difficult for consumers to prove, has been at the expense of broader notions of accountability, prevention and compensation. Consumers often find that, once they have accepted legal advice, other avenues of complaint are closed to them and they became locked in financially to pursuing compensation to meet further medical, legal and other expenses. Complainants can experience considerable economic and social hardship and emotional turmoil as a result of an adverse event, such as loss of job or family breakdown, for which they can never be fully compensated.

Current barriers to accessing financial compensation have led to proposals for alternative models of compensation to be introduced, such as no fault compensation schemes. Already in place in New Zealand, no fault compensation for adverse health care outcomes would increase the chances of consumers receiving some financial compensation as a result of their injury, without having to prove fault on the part of the health professional. Even with no fault compensation schemes, though, there are difficulties; for example the amount of compensation may be more limited, the need to establish that the injury was caused by the health treatment/intervention may exclude some, and there may be less incentive for health professionals to scrutinise and change damaging practices.

Introducing no fault compensation schemes, without also strengthening other mechanisms to address the issues of accountability and prevention, would not be a satisfactory solution for consumers.

102. Carrier & Kendall, p87.
103. Review of Professional Indemnity Arrangements for Health Care Professionals, The Health/Medical Care Injury Case Study Project.
The relationship between complaints and litigation claims is much more complex than the linear model of complaints to litigation suggests. The idea that to encourage complaints is to encourage litigation or, conversely, that to handle complaints well prevents litigation simplifies the issues and ignores some of the realities of the situation. Complaints systems could become slick public relations exercises aimed at preventing justified litigious action against health service providers, rather than addressing consumers' complaints openly and fairly. For example, health service providers may emphasise providing information to the consumer about the risks involved in receiving health care but without really providing alternative care choices. The HMPS study did find that, for a high proportion (over 80%) of people who actually made claims for compensation through the courts, examination of their clinical records did not reveal clear evidence of negligent adverse events, and it is possibly that this group of claimants may respond to improved complaints handling in the early stages, resulting in fewer claims. On the other hand, Weiler and colleagues point out the very large number of situations where a legitimate claim for compensation could have been made, and a complaints investigation may provide complainants with the necessary information for them to be able to make an appropriate decision about pursuing litigation.

It has been said that medical negligence is the most difficult but important of complaints to deal with and that "medical negligence may provide a good test of the efficiency and fairness of procedures for dealing with all complaints about medical services". From a health service provider perspective, negligence has tended to be considered the most serious type of complaint because of the implications for professional practice but this has also been interpreted narrowly according to standards determined by each profession. Other complaints, deemed 'not serious enough' for consideration by registration boards or other formal complaints mechanisms, are then devalued and attention to the substance of the complaints trivialised, even though consumers have taken the time

and effort to complain. It is not surprising that the complaints information collected by formal mechanisms record complaints about professional behaviour and competence as common; if complaints are not couched in these terms they are not easily heard. As already noted, there has been little consistency in the categorisation of complaints, which in turn may impact on how complaints are handled. Carrier and Kendall suggest that different, but well linked mechanisms, need to be developed to deal with medical negligence and "lesser complaints".\textsuperscript{106} Certainly, health complaints mechanisms, such as registration boards, have not been set up to deal with anything other than complaints categorised as serious by the professions, and their current structures and processes would be inappropriate to the task. This undeveloped area of handling the "lesser", yet equally important, complaints is the primary concern of this thesis.

2.6 COMPLAINTS SYSTEMS AND ACCOUNTABILITY

The nature of the relationship of public sector services to the government of the day and, more generally, to the public has received considerable attention in recent times. The bureaucratic processes of the public sector have been said to overwhelm and stifle the actual provision of services, and the departments, statutory authorities and organisation that made up the public sector have been seem to be unaccountable to anyone other than themselves for the expenditure of significant amounts of public monies. Attention of governments was first directed to establishing greater financial accountability in times of escalating costs. There was also a more general concern, arising in the 1970s, that the supposedly fair procedures devised by the bureaucracies were not always fair, and governments elected on a platform of proposed social reforms were keen to reshape public sector service provision in line with their ideals and to introduce new mechanisms to open up the processes of bureaucratic decision making; the administrative law reforms discussed in chapter six provide a good example.

\textsuperscript{106} Carrier & Kendall, pp67-69.
By the 1980s, another element had been added to the debate about the nature and cost of public sector services; a view became increasingly influential that challenged the role of expanding public sector services. This view, first identified as the ‘new right’, but soon spread across the political spectrum, advocated reducing the areas in which governments, through the public sector, were involved in the provision of services that could be provided by the private sector. This view also offered the incentive that the private sector could provide these services more cheaply and efficiently than the public sector: a much smaller public sector would retain responsibility for assisting governments to set the overall policy direction and monitor industries but only in exceptional cases would the public sector be involved in actually providing direct services. The persuasive influence of this view is readily discernible over the past decade in Australia, resulting in public sector services being contracting out, downsized and privatised. As well, and discussed in more detail in chapter six, the belief in the marketplace as the best mechanism for finding the optimum efficiency of resource usage has led to public sector services being transformed into business enterprises, attributing real costs and the notions of user pays for public services, encouraging choice and competition across the public and private sectors, and a focus on performance indicators and measured outcomes to ensure ‘value for money’.

Making the public sector more ‘accountable’ has been proclaimed, throughout, as both the reason for the introduction of many changes and the proposed outcome of the reforms. Exactly what has been meant by the claim to increase accountability has by no means been consistent or even reflected a common understanding of accountability. As Day and Klein argue, with the increased complexities of modern society, the concept of accountability too “has become an ever-more complex and difficult notion to apply in practice”. They identify different “dimensions of accountability” including the primary ones of political accountability; managerial accountability (which includes fiscal/regularity

accountability, process/efficiency accountability, and program/effectiveness accountability); and, important in the context of this thesis, the dimension of professional accountability.  

Day and Klein maintain that

“accountability, even at its simplest in the relationship between individuals, presupposes agreement both about what constitutes an acceptable performance and about the language of justification to be used by actors in defending their conduct”.  

These two aspects of accountability, control and answerability, are highly relevant to the discussion of health complaints handling, as health complaints often challenge established patterns of control and answerability of professional and managerial or bureaucratic hierarchies by insisting that the views of a third group, consumers, are also considered. At an individual level, a consumer complains when the performance of a health service provider is not perceived to be within the accepted bounds. Obtaining a resolution is often made difficult by the justification offered by the service provider of their conduct that is couched in technical knowledge, professionally determined standards and professional jargon. Throughout this thesis, the implications of different interpretations of accountability are exposed in the discussions of the various contexts in which changes to complaints handling mechanisms have been proposed over the past two decades (to 1995).

The capacity to make complaints, and for complaints to be dealt with appropriately, has been identified as an integral part of comprehensive accountability strategies by a number of authors. Lewis and Birkenshaw argue that “accessible and effective grievance remedial devices are a necessary component of accountability; the errors of decision makers can be corrected, oversights highlighted, abuses rectified, and shortcomings avoided”.  

They maintain that governments have had a long history of involvement in grievance handling and that setting in place “an effective system of redress and justice is a

110. Lewis & Birkenshaw, p27.
state responsibility and an irreducible state responsibility”. Longley argues that “a lack of effective avenues for complaints resolution is in itself an injustice”. She suggests that openness about decision making, policies and procedures are fundamental to achieving accountability and that accountability processes should provide ongoing evaluation and opportunities for improvement; “the hallmark of an accountable public service is thus one which properly and openly plans and evaluates services, monitors grievances and in doing so creates and maintains an institutional record of legitimate decision-making”. Hyman proposes that complaints and complaints handling constitutes a “negative feedback model of accountability” which, instead of focusing on how well something has been done, highlights the failures, where greater efforts are required to rectifying matters and to prevent similar events from occurring.

The increased attention given to the accountability processes of public sector services has aided changing ideas and attitudes towards complaints and complaints mechanisms in a number of different spheres. Birkenshaw, noting the significant changes in political attitudes towards complaints in Britain over the decade between the first and second editions of his book *Grievances, Remedies and the State*, comments that “when a Cabinet seminar (February 1993) approves a statement that “complaints are jewels to be cherished”, whether they believe it or not, something is stirring”. Similarly, in Australia, there has been increased activity in a number of different areas in regard to complaints mechanisms, noticeably with the introduction of the Australian *Standards for Complaints Handling* and the establishment of a number of industry ombudsman positions. Complaints handling has become an acknowledged area in need of improved processes across many public sector services, although not necessarily with the direct benefit to

---

111. Lewis & Birkenshaw, p19.
consumers in mind. The formalisation of numerous organisations’ complaints procedures into written documents has been part of this trend; Seneviratne & Cracknell suggest this is an important step for four primary reasons: people (consumers and staff) are given a clearer idea of how to deal with the problem; the potential for mistakes to be made is acknowledged and a willingness to address the issues fairly and rationally is reflected; a greater openness to listen to and deal with expressions of dissatisfaction is demonstrated by the organisation, particularly where people cannot change services; and overall accountability to the public of the organisation’s activities is enhanced.116

The complaints mechanisms in place are critical determinants of the usefulness of complaints handling as a strategy to increase accountability. The procedures devised to handle complaints, the adoption of priorities about which complaints are to be given preference, the authority to intervene in the resolution of complaints, the independence or otherwise of the complaints handling mechanism, for example, will all influence the likelihood of complaints being lodged and pursued. Day and Klein, from the findings of their study about perceptions of accountability by board and committee members in public service settings in Britain, caution against relying on complaints made, or lack of complaints made, as a sufficient means of accountability in itself because “individual competence is no guarantee of collective competence... [and] because of the assertion by many service providers that only they can define and evaluate competence”.117 They go on to propose, for example, that the current mechanisms based on peer review used by professional service providers need to be opened to greater outside scrutiny “forcing, as it were, the service providers to explain how they police their performance”.118 As examined further in chapter four, a principal argument of the consumer movement in health has been that this outside scrutiny needs to be extended to also include greater consumer involvement in the setting of the standards used as the basis for policing performance and

117. Day & Klein, pp236-7.
118. Day & Klein, p248.
greater consumer participation in health service planning and decision making at all levels, if a true mutual understanding of acceptable performance and conduct is to be achieved between consumers and health service providers.

For complaints mechanisms to be used more effectively to increase the accountability of service providers to those they serve, there must be comprehensive identification of the complaints handling processes that are likely to enhance, or stifle, the making of complaints from potential complainants’ perspectives. Once these ‘complaints enhancing’ processes have been identified, new or revised mechanisms must be set in place that incorporate these identified processes if greater accountability is to be achieved. As the following chapters reveal, a ‘consumer agenda’ for complaints handling can be clearly identified in the health area but the implementation of this agenda has been overtaken and sidetracked by the more powerful managerial and health service provider agendas. In this way the ability of complaints mechanisms to call to account health service providers has been jeopardised, notwithstanding the significant reforms that have been made to, at least, some parts of health complaints handling systems.
CHAPTER THREE

CONSUMERS, THE CONSUMER MOVEMENT AND CONSUMER ORGANISATIONS

3.1 INTRODUCTION

Consumers, the consumer movement and consumer organisations have distinct implications for the articulation of complaints. If their influence on specific matters, such as complaints systems development, is to be identified clearly it is important to examine the ideas and activities associated with and attributed to them. This chapter commences with discussion about consumers, then briefly traces the history of the consumer movement and ends with an examination of the activities and infrastructures of four Australian consumer organisations, relating this to consumer organisation theory. Since even the term 'consumer' needs further definition, to tease out the complexity of ideas and assumptions underlying its usage, an explication of the way 'consumer' and the related terms 'consumerism' and 'consumerist' are used in this thesis begins the discussion.

A brief examination of the history of the consumer movement in Australia, uncovers the cyclic nature of consumer movement activity to date, and, although the earlier activities are not well documented, three different cycles can be identified, each contributing a new dimension to activities that fall within the scope of the consumer movement. While consumer movement activity has often occurred around the same time, and complemented, other social movement activity, for example the civil rights movement and the consumer rights movements in the 1960s, there has been tension within the consumer movement over the extent to which activities should challenge existing social structures in the pursuit of the goals of equity and social justice.

Consumer groups provide tangible 'voices' for the consumer movement, and four prominent consumer organisations are examined: the Australian Consumers' Association,
the Australian Federation of Consumer Organisations (renamed the Consumers' Federation of Australia in 1995), the Health Issues Centre, and the Consumers' Health Forum of Australia. Analysis of their development and organisational structures reveals quite different organisations, established in different time periods and undertaking diverse tasks, but with a common goal, that of furthering the consumers' interests in the political and policy arenas, as well as the marketplace. All four organisations have had to work hard to establish their credibility and reliability, with limited resources and little support from the media. The Health Issues Centre and Consumers' Health Forum specifically deal with matters relating to the health of consumers and the provision of health care services, but a focus on health issues has been a common feature of the work of the other two organisations as well. Two other groups are included in the discussion because of their influence on the Australian setting: the International Federation of Consumer Organisations and the Australian Consumers' Council (previously the National Consumer Affairs Advisory Council).

Theories about consumer groups and consumer group activity caution against generalising the activities of consumer groups to encompass all consumers, and it is important to keep in mind that consumers are not, and never will be, a homogeneous group. However, the extensive activities of the four consumer organisations in relation to health issues, and the diverse membership of the groups, suggest that the organisations can make legitimate claim to represent the interests of a significant proportion of consumers. This chapter provides a better understanding of the context in which the 'consumer agenda' for reforming complaints handling mechanisms in the health area has evolved and the legitimacy of this agenda.

3.2 CONSUMERS, CONSUMERISM AND CONSUMERIST

The increased usage of the terms consumer, consumerism and consumerist by a variety of disciplines and in a variety of circumstances in recent years suggests that the
assumptions underlying these terms must be explored to adequately understand their meaning in the context in which they are used. The current attention to complaint handling and consumer participation is intimately caught up with the notions of consumer, consumerism and consumerist; hence the need to examine these concepts in some detail at this point.

3.2.1 Consumers

In the literature of economics, marketing and management the term ‘consumer’ is used prolifically. In its simplest form a definition of ‘consumer’, as used by economists, is likely to be “persons whose wants are satisfied by production. Raw materials and capital goods are produced only because they help satisfy the wants of consumers”.¹ This definition conjures up images of material goods purchased by individuals but, as managerial ideas developed in and for the industrial sector have gained acceptance in other spheres, it has become fashionable to refer to users of a myriad of services, both private and public, as ‘consumers’.² Health services have not escaped this trend and there has been a gradual introduction of the term ‘consumer’. For example, Index Medicus added the category ‘consumer satisfaction’ in 1968 (which coincided with a period of significant activity by the consumer movement in the USA) and by 1991 Index Medicus had added another five categories under the word ‘consumer’.³ While ‘consumer’ has not replaced the term ‘patient’ in much of the literature pertaining to health care, its acceptance at all is indicative of the changing nature of health service provision that is discussed further in chapter seven.

An alternative term ‘customer’ has gained popularity in recent years, particularly in government management circles, but this term has traditionally been associated with the

---

³. The categories under consumer in the 1994 Index Medicus are consumer satisfaction, consumer advocate, consumer organisations, consumer participation, consumer product safety.
trading of goods and services for direct payment and implies some choice in purchasing the goods or using the services, both in availability and need for the good/service. As users of health services often have little choice about using services, payment arrangements may be more indirect and the relationship between consumer and service provider much more complex than between seller and purchaser, 'customer' does not seem an appropriate term. While the term 'citizen' is popular with some authors to reinforce the idea that people are citizens first and foremost, and that the issues under discussion often reflect underlying debates about citizens' social, if not legal rights, 'citizen' is not so readily used in the Australian literature or by the Australian populace. The use of the term 'consumer' is now widespread and accepted by 'consumer' groups across Australia.

The question of who is the consumer of health services requires further discussion. Simply, it can mean the person receiving the service and/or treatment provided by the health professional, such as a physical examination or taking an x-ray. This person has traditionally been identified as the 'patient'. However Pollitt, who studied trends in the arrangements of public services in England and Wales, suggests this definition does not adequately or accurately reflect the range of people with an interest in what and how services are provided, when talking about health services. A broader definition must be used which includes past service users and potential users in the future. Those indirectly receiving a service, such as parents of young children, relatives and carers, should be included as consumers as well. Finally, Pollitt suggests, the general public, who both provide the resources through taxes and benefit from the 'externalities' generated by the provision of health services, such as a healthier population, also need to be considered.

Although such a broad definition runs the risk of having no value because it is all-encompassing rather than specific, it is important to be aware of the potential for the definition of 'consumer' to include all these groups. As Gilliatt remarks "the under-

5. Pollitt, pp75-80.
conceptualised, little researched and all-encompassing term ‘consumer’ disguises differences in preferences, resources and skills which vary across ethnic, class, age and gender cleavages”.6

Using the broader definition, immediately reveals difficulties over, for example, determining who speaks for the ‘real consumer’. Health workers can claim that they speak on behalf of the consumer, as can professional consumer advocates, who may never have used the services themselves but rely on information supplied to them by others who have. Williamson, in discussing consumer and professional standards in health care, attempts to overcome this problem by limiting the term ‘consumer’ to “recipients of health care”.7 She defines consumers as primarily the patients or users of health services but this can include former and future recipients of the services. Patients’ and users’ close relatives or carers can be defined as consumers, Williamson suggests, only if “they have authority to act on behalf of the patient or user”.8

The interpretation of the term ‘consumer’ used in this thesis lies somewhere between Pollitt’s all-embracing and Williamson’s more specific descriptions. A certain fluidity of definition will be retained, though, because complaints about health services are made by a variety of people, including those who may not be the person identified as the patient or receiving a specified health service. The use of the term ‘consumer’ must incorporate more than Williamson’s description because some consumers, when complaining, are not necessarily acting on behalf of the identified patient but on their own behalf, for example a person who complains about the dirty state of a hospital ward when visiting a hospitalised friend. This particularly applies to carers and parents who may make a complaint about the way they have been treated or the impact the services have had on them, for example a mother who complains that her advice about the best treatment for her

son with a chronic illness was ridiculed or ignored by the treating doctor. Generally in this thesis, the description of 'consumer' does not include health workers acting in their professional capacity, but does include workers specifically employed by consumer organisations as consumer advocates.

3.2.2 Consumerism

The concept of 'consumerism', as described in the 1990s, reflects the increased understanding and interpretations of the development of the consumer movement, consumer research and the influence of economic and marketing theories over the past three decades. In the book *New Consumerism: Selected Reading*, written in the early 1970s, the Editor did not define the term, instead listing a number of descriptions given by influential citizens in the United States, at the time, to explain consumerism. These descriptions emphasised three key ideas: dissatisfaction amongst consumers; a better informed public; and the relationship with consumer protection activity. Several suggested that "the term 'consumerism' was a word originally coined by industry to make the burgeoning consumer movement sound like a dangerous threat". The following twenty years have seen increasing discussion and research about 'consumerism' and the development of a number of theories to explain the components of consumerism, such as the life cycle pattern of the development of consumerism and the two-dimensional theory.

Consumerism, from an economic perspective, has been defined as "concerted action to make firms pursue the interests of consumers, even at the cost of shareholders' incomes. Action can take the form of lobbying parliaments for legislation, protest marches and legal suits".

---

Redressing the imbalance between the provider (traditionally the seller) and the consumer (the buyer) where the provider is seen to have the advantage, is intrinsic to the notion of consumerism. Darley and Johnson suggested three indicators designed to reduce the imbalance as evidence of the existence of consumerism: the prevalence of activities relating to the consumer protection; consumer education; and consumer information.

Marketing literature has placed considerable emphasis on the notion of consumerism. This interest, though, is driven by a desire to influence the consumer so that the ends/needs of the organisation are met, rather than assisting the consumer to influence the organisation to the advantage of the consumer. The idea of attending to consumer dissatisfaction to increase consumer loyalty to the organisation, and therefore maintaining the competitive edge in business and thus profits, is a prominent feature of recent marketing activities. Marketing experts, having defined consumerism as a necessary tool for their own activities, are keen to point out that consumerism should not be confused with the marketing concept. Instead “the marketing concept calls for a customer orientation backed by integrated marketing aimed at generating customer satisfaction as the key to attaining long-run profitable volume”. Consumers become passive recipients of this ‘expert’ interpretation of their needs and wishes that ultimately benefit the organisation rather than the consumer. The impact of marketing concepts on contemporary managerial agendas has particular relevance to the understanding of current activities

13. For example, where the provider is the sole supplier and where the provider holds secret information about the product that may influence the consumer’s choice.
15. For example N. Smith, Markets and Morality: Consumer Pressure and Corporate Accountability, Routledge, London, 1990, examines the use of consumer boycotts to encourage corporate accountability, highlighting the point that marketing is organisation orientated rather than a balance between the consumer and the organisation and as such “consumerism is the ‘antithesis’ of marketing” (p39) but it has been seem as “an opportunity and adopted by business”(p40).
16. For example, an article in The Advertiser, (Adelaide) Tue 2nd Aug 1994 entitled “Consumer service - recovery program vital, says expert”, reporting on the visit of Professor of Marketing from the USA, stated that to build and maintain customer loyalty after a problem has occurred, organisations must resolve the problem to the customers’ satisfaction. Another example was the Society of Consumer Affairs Professionals (SOCAP) workshop Complaints for Profit held on 14 July 1994, attended by the author, where this was a persistent theme of the speakers and the discussion during question time.
aimed at improving complaints handling, as demonstrated in chapter six and seven. The involvement of marketing and public relations personnel in the handling of complaints and their claim that this is their area of expertise have, and will continue to, influence the future direction of complaints mechanisms and the construction of the concept of consumerism, which may be quite different to that offered by consumer organisations.

However, the foundations on which the understandings of consumerism are built are often not explicit or, necessarily an accurate reflection of the true situation. Morrison suggests that “the underlying assumptions of consumerism are firstly that consumers know what they want and secondly that they can articulate these wants by making demands”.18 In health care provision neither of these assumptions are likely to be true for a significant number of consumers, as reliance on ‘expert’ professional advice and skill may limit consumer knowledge and ability to make demands, particularly at times of increased vulnerability, such as during serious illness.

Some writers have suggested that the consumerism of the 1990s is not the active process of the 1970s, and this is a reflection of the move to internally driven management notions of consumers and consumerism away from the earlier externally driven consumer movement concepts. For example Morrison, in comparing consumerism with community work, found that

“consumerism is essentially a passive process...... [it] denies the active role that local people can play...... consumerism is fundamentally non-accountable. It encourages the yes/no choice by the consumer. It fails to allow for the education of taste, or even the possibility of experiment”.19

The existence of two quite different images of consumerism mirrors the current debates about citizenship, particularly in Britain, where the conservative perspective of citizenship highlights passivity and private individual concerns in contrast to the alternative and more radical notion of citizenship as a visible and active process.20 The prevailing influence of

19. Morrison, p212.
the more conservative perspective on the government and bureaucratic context is explored further in chapter six.

3.2.3 Consumerists

The term ‘consumerist’ is directly derived from the notions pertaining to consumerism. Few authors take much interest in discussing the changing usage of this term in any depth, or in elucidating the assumptions underlying its use in a particular context. In a way similar to consumerism, utilisation of the term ‘consumerist’ appears to have moved from referring to those involved in consumer movement activities to referring, now, to those advocating for individual consumer choice but with no connection to or allowance for collective consumer action. The new idea of consumerist conveys a picture of the consumer as an articulate, assertive citizen who is able to identify and demand what services are relevant to their individual needs. Consequently, those who speak loudest maybe able to get more but they cannot be assumed to be the most needy. The current emphasis on reducing surgical waiting list and appointment waiting times while other serious complaints about health service provision remain ignored is a possible example of this; patients’ charters drafted by governments another.

A notable exception to this trend of leaving undefined ‘consumerist’ is Williamson.21 She sees consumerists as the consumer advocates who promote the consumer interest rather than individual consumers’ interests (although she recognises that in many instances this distinction may be a matter of degree). She coins another term ‘proto professional’ to describe health workers who take on and advocate for a user perspective. Williamson provides helpful ongoing descriptions and explanations of her usage of the term throughout her book examining consumer and professional influences on the determination of standards for health care. For example, she comments that

“consumerists believe that people can act in their own best interests, or those of their dependents, from ‘ordinary’ intuitions, feelings and thought, in most

situations. In special situations like sickness, people can still act in their own best interests if they have ‘enough’ information, preferably information from more that one source and more than one perspective... So consumerists uphold consumers’ self determination or autonomy”.22

Because of the differing connotations now associated with the employment of the term ‘consumerist’ and the chance for misinterpretation, its use is avoided wherever possible in this thesis.

3.3 CONSUMERISM, THE PUBLIC SECTOR AND HEALTH CARE SETTINGS

The relevance of the concept of consumerism to public sector services (and, consequently, health services) has received considerable attention within public administration circles in the past decade as governments have introduced economic policies aimed at public sector reform. Hambleton suggests that there are two definitions of consumerism currently in use: one referring to “problems associated with the consumption of ‘high street’ goods and services, and the broader usage applied to problems associated with the use of public services”.23 While the application of the ideas generated by consumerism to the public sector is not new, Hambleton states that “what is new is the political context within which these consumerist ideas are being debated”.24 (See ch6.2.&ch7.2 for further discussion of this point.)

One line of argument supporting the adoption of consumerism by the public sector has been epitomised by Rhodes’ much quoted epigram: “the twin values of caring and citizenship provide the rationale for consumerism”.25 The need to develop a distinctive public service model of consumerism, as opposed to the wholesale adoption of industry models of consumerism, has been debated widely amongst both public administrators and

24. Hambleton, p127.
consumer activists. Potter, in her examination of consumerism in the public sector in Britain, states

"to shift the balance of power in favour of consumers, those representing their interests have isolated five key factors which provide a structural underpinning of consumerism. These are the principles of access, choice, information, redress and representation".26

Potter argues that the application of these principles to public sector services is not necessarily straightforward or clear. How might the principle of choice be applied, for example, when users of some public services, such as psychiatric services or children protection services, may be compelled to use these services by law. Also, Potter suggests it is easy to overlook the interests of people who cannot make choices for themselves and that the choice provided for some may be to the disadvantage of others.27 Accessibility, either in relation to availability of services or geographic location, as well as in regard to specific groups, such as people from non-English speaking backgrounds or homeless people, also presents challenges for the public sector. Information is crucial for consumers to be able to benefit from the services but this must include information about the operation and decision making processes of the bureaucracy if consumers are going to be able to influence change in the operation of the organisation.

The right to make a complaint and to redress, Potter suggests, is important not only on an individual basis but also as a 'quality control' mechanism and hence in increasing the accountability of public sector services (as already noted in chapter two). The difficulties in achieving representation because of the lack of organisation and resources amongst consumers has been acknowledged, to some extent, by the establishment of government funded bodies with the specific task of representing the interests of consumers, such as the Community Health Councils in Britain and the Consumers' Health Forum in Australia. In relation to public sector services. Potter contends, these principles do not go far enough as

they do not allow for discussion of what sort of services should be provided, nor do they define quality and standards of service. She concludes that

"consumerism's primary concern is to place consumers' preferences on the agenda, rather than encourage consumers to take account of the preferences of... Consumerism is fine as far as it goes, but it does not go far enough to affect a radical shift in the distribution of power".28

The interpretations of consumerism currently used by different government instrumentalities has also varied. Pollitt refers to 'brands of consumerism' that can be identified in the public sector "ranging all the way from cosmetic, 'charm school' approaches through improved provision of information to direct consumer participation and power-sharing".29 Much of the criticism about consumerism has focused on the actual implementation of the policies. As Pollitt, writing the Editorial for an issue of Public Administration devoted specifically to consumerism and public sector services, stated "the encouragement of greater consumer responsiveness in a public service cannot be simply a 'bolt-on extra', to be affixed to the most appropriate part of the organisation while all else goes on as before".30

In the health setting, interpretation of the notion of consumerism has been complicated by the unique professional relationship that exists between health service providers and consumers and the perceived life and death nature of many of the services provided. Haug and Lavin, in their study of consumerism in medicine in the USA, suggest that "in simple terms, consumerism in medicine means challenging the physician's ability to make unilateral decisions - demanding a share in reaching closure on diagnosis and working out treatment plans".31 They go on to outline seven areas which, they think, contributed to "the 'rise' of consumerism in medicine": rising anti-authority trends; greater

29. Pollitt, p78.
30. C. Pollitt, Editorial, Public Administration, vol.66, Summer 1988, p121. This journal is produced by the Royal Institute of Public Administration, the professional association of public administrators in Britain, a similar body exists in Australia, the Royal Institute of Public Administration Australia.
consumer education; the increased number of paraprofessionals; increased self care; the focus on medical ethics; the demand for physician accountability; and the greater non-compliance with “doctor's orders”. Similarly, Williamson identifies three elements that have contributed to this rise of consumerism in health care: “the creation of a climate of scepticism, the popularisation of disturbing insights about professionals and institutions and the intense concern of small groups of patients or relatives”.32

Significant consumer driven changes in health services have not necessarily followed from the rise of consumerism, though, as Winkler notices: “there has been no revolution, simply a shift in the way consumerism is defined” and consumerism “is about customer relations, not patients’ rights”.33 She argues that the adoption of the “supermarket model” of consumerism by health services, with its focus on waiting times and presentation, does not allow consumers to become involved with the fundamental questions of service provision, such as what and how services will be provided. Winkler maintains that the notion of consumerism must involve methods other than customer relations, and include the idea of scrutiny of health care organisations from the outside, if it is to have relevance for consumers.34 In particular, she envisages models promoting partnership between providers and users as proving the most useful.

Consumerism remains a rather nebulous notion denoting an array of ideas and activities, some generated by consumers and consumer groups, others by managers and professionals. The consumer contribution to current notions of consumerism can be identified more easily through examine of the development of the consumer movement and the organisation and activities of consumer groups.

32. Williamson, p2.
34. Winkler, p2.
3.4 **The Consumer Movement**

Brief exploration of the development of the broader consumer movement provides an important contextual basis to better understand consumer groups' activities and aspects of the development of the more specific consumer movement in health. The movement has received considerable academic attention, including study as a social movement and for its impact on the consumer affairs agendas of governments. Exactly what constitutes the consumer movement is open to interpretation and highlights the diversity of activity consistent with consumer issues. It has been defined as narrowly as the non-government organisations that are said to represent the ordinary consumer but, also, more broadly to include any activity that has taken place in the public interest, such as consumer protection legislation and the establishment of government consumer affairs bureaux. The movement is, of course, greater than the activities organised by consumer groups, but consumer groups have been instrumental in generating and driving the movement, as discussed in the next section of this chapter. Issues that have an impact on the health of consumers have been a prominent feature throughout the history of the consumer movement. Considerable activity has centred around gaining recognition, and exposing the risks to health, of various business and professional practices, such as the manufacturing processes used in food production and surgical intervention in childbirth.

Ideas about the rights and obligations of citizenship have been central to the consumer movement but activity has usually stopped short of challenging the basic structures of society. In the earliest phase

"the consumer movement arose as a response to the new role of consumption in the common life. It was not a reactionary critique - it did not call for a return to the traditional early industrial economy. It accepted the new advances in industrial technology and organisation, but it insisted that these advances should not be

---

35. For example, S. Brobeck, *The Modern Consumer Movement: References and Resources*, GK Hall & Co, Boston, 1990, limits his definition of the consumer movement to non-profit advocacy groups and individual advocates who seek to advance the consumer interest.
controlled by a wealthy oligarchy, but should be controlled by and used for the benefit of most people”.36

The concept of working for the collective good of all consumers, rather than the individual purchaser, has also been a feature of the consumer movement, although the extent and form in which this has been manifest has differed over the past century.

3.4.1 Consumer Movement Cycles

The early history of consumer activity in Australia has not been documented concisely and some have said that consumers had no formal voice until the formation of the Australian Consumers’ Association in 1959.37 While this may have been true in the sense of a dearth of dedicated consumer organisations, earlier consumer activity can be identified if parallels are pursued with the well documented history of consumer activities in the United States of America. There, three periods of greater consumer activity have been defined: the first around the turn of the century (the Progressive era), the second around the time of the great Depression of 1930 (the New Deal Era), and the third in the 1960s and early seventies (the New Frontier Era).38

The Progressive era was marked by campaigns to pressure governments to introduce legislation regulating the activities of a number of industries, at a time when little government legislation existed dealing with issues such as food production, pharmaceutical goods and working conditions. By the latter half of the nineteenth century, evidence of major social problems, such as poverty and ill health, saw the questioning of the effects of industrialisation and the workings of the capitalist system. A number of groups seeking reform were formed, including groups that identified themselves as consumer groups. In


Page 81
the USA the first Consumers' League was set up in New York City in 1891. One of this group's earliest activities was to prepare "a white list of shops paying minimum fair wages and having reasonable hours and decent sanitary conditions". By 1898, the National Consumers' League had been formed from the federation of local consumers' groups and within five years it spanned twenty states with sixty four branches across the USA. The League often took up issues in conjunction with other activist groups, such as the National Child Labour Association and the League of Women Voters. Consumer leagues were founded in a number of countries around the same time including Britain, France and Germany. As early as 1908, an international conference of the leagues was held, where participants agreed, amongst other things, to pursue and support the issue of a minimum wage. In Australia, women's and trade union groups headed campaigns on similar issues. For example women, as well as trade union leaders, presented evidence to inquiries on the issue of fair and reasonable labour conditions leading to the Harvester judgement and the foundation of the concept of a basic wage in Australia. But a specific consumers' league, along the lines of overseas organisations, does not appear to have been formed in Australia at this time.

Consumer movement activity was not just confined to consumer, women's and union groups, either in Australia or overseas. The popular press printed articles exposing dangerous products and production practices, particularly food production. There was also considerable interest in 'pure' foods and 'secret' drugs during and after the New South Wales Royal Commission into the decline of the birth rate in 1903. Although earlier

41. Seligman & Johnson, p291.
43. If such a group did exist its influence and association with other organisations must have been minimal as there is no mention of its existence in documentation by other associations, for example in Norris.
health acts of the Australian states had included reference to adulteration of food, public
pressure for more stringent action led to some states introducing a ‘Pure Food Act’
outlining more detailed standards for saleable food, the first by Victoria in 1905.45 With
the advent of the first world war, and the following period of affluence and improving
living standards, the consumer movement lost some of its momentum both locally and
internationally.

The increasing array of new consumer goods available in the 1920s, and the
adoption of forceful advertising and persuasive, high-handed sales techniques, made
education of consumers, through information provision to enable consumers to make
prudent choices, seem important, particularly to groups such as the Association of Home
Economists.46 The idea that housekeeping could be performed as a scientific endeavour
adhering to the notions of efficiency and prudence was espoused by popular magazines for
women; the study and teaching of home economics was promoted and housewives
associations were formed.47 Emphasis on judicious purchases and receiving value for
money were important aspects of these activities and helped shape the agenda of the second
period of consumer activity. The notion of ‘scientific consumption’ came into vogue and
scientific testing of products against manufacturers’ claims the method used to achieve
this.48

With the crisis of the depression these ideas gained greater support, and the
emphasis on testing, efficiency and education, rather than protests, social reform or
legislation, highlighted the consumer movement of the 1930s.49 Consumer groups were set
up, in a number of countries, taking on this brief of product testing and education, which

47. K. Reiger, Disenchantment with the Home: The Modernisation of the Australian Family 1880-1940,
Oxford University Press, Melbourne, 1985, p58. Reiger provides a detailed discussion of the influence
of the notion of the ‘domestic economy’ on the role of women and housework.
49. Tiemstra, p11.
still continues today. The Australian Consumers’ Association adopted this role, when it was formed two decades later. (See ch3.5.5.) Consumer groups also began regular publication of journals detailing the findings of their tests on products. Other groups, such as women’s clubs, labour unions, and educational institutions, took up and popularised a variety of consumer issues, for example the lack of technical information available to the consumer to make a wise purchase and the limitations of pure food and drug legislation. The National Council of Women of Australia and the Home Economics Association of Australia Inc, for example, still hold full membership in the Australian Federation of Consumer Organisations.

The New Frontier Era, the third era of consumer movement activity in the USA during the 1960s and early 1970s, was marked by the occurrence of two significant events in 1962: President Kennedy’s consumer message to Congress; and the publication of Rachel Carson’s book, Silent Spring. On 15 March 1962 (now celebrated internationally as World Consumer Rights Day) President Kennedy presented a consumer message to Congress, outlining four consumer ‘rights’:

- “the right to safety, to be protected against the marketing of goods which are hazardous to health or life;
- the right to be informed, to be protected against fraudulent, deceitful or grossly misleading information, advertising labelling or other practices, and to be given the facts needed to make an informed choice;
- the right to choose, to be assured wherever possible, access to a variety of products and services at competitive prices; and in those industries in which competition is not workable and government regulation is substituted, an assurance of satisfactory quality and service at fair prices;
- the right to be heard, to be assured that consumer interests will receive full and sympathetic considerations in the formulation of government policy, and fair and expeditious treatment in its administrative tribunals”.

In more recent years three additional rights have been added by consumer groups: the right to redress; the right to consumer education; and the right to a healthy environment. These

rights have formed the basis for much consumer protection legislation and consumer movement activity around the world since. Shortly after President Kennedy's speech, a new position as Special Assistant to the President for Consumer Affairs was created.\(^5\) The major step in institutionalising the representation of consumer interests within government spheres had been taken, although this was not to happen until almost a decade later in Australia, with the establishment of ministerial responsibility specifically for consumer affairs at both state and federal government levels. (See ch6.5.)

*Silent Spring* detailed Carson’s research into the impact on the environment of the use of chemicals, such as insecticides and pesticides.\(^5\) She highlighted the poisoning of water and food chains by these chemicals and the disastrous consequent effects on the health of human beings. Carson argued for “a complete change in attitude and direction by the citizens of the world in their dealings with the environment”.\(^5\) Carson’s book was sold extensively, widely cited in academic journals and books and the Consumers Union of the US, already concerned with environmental issues, arranged for a special printing of the book for its members.\(^5\) The potential alliances between consumer interests, health and environmental interests were reinforced.

Perhaps the most notable figure of this third era, in both the USA and Australia, was Ralph Nader. His 1965 report on road safety, *Unsafe At Any Speed*, highly critical of the automotive industry, gained publicity when the industry tried to discredit him.\(^5\) Nader’s persistence in exposing practices hazardous to the economic and social well-being and health of the public, and the wide media coverage he was able to attract soon led to his

---


55. Baldry, p85. Baldry’s thesis examines the application of various models of social movement theory to explain the development and influence of the consumer movement in health in Australia, using the Consumers’ Health Forum of Australia as a case study.


57. Tiemstra, p12.
identification as citizen’s advocate on consumer issues. Nader set up public interest advocacy centres across the USA to provide independent research and undertake political campaigns on major consumer issues. His influence on the consumer agenda was considerable and he “made measurable progress on behalf of the consumer on so many fronts that there is scarcely an issue of relevance to the modern consumer on which he has not had an impact”.58 Nader’s work became an inspiration to the consumer movement internationally. His focus on citizen action to demand and achieve change for the greater benefit of all was well known in Australia amongst community development workers involved in community action.59 It was a time when new consumer, self help and community action groups were formed in Australia. In the USA, legislation such as “truth in packaging” and “truth in lending”, passed in the second half of the 1960s, was seen to advance consumers’ rights and added stimulus to the consumer movement.60 In Australia, by the early 1970s, some aspects of consumer protection had been formalised in specific legislation, which included a greater role for government through the new consumer affairs departments that were established. (See ch6.5.2.)

Over the past two decades consumer movement activity has continued although perhaps, generally, it has not been as dynamic or vocal as previously. The newly found concern with environmental destruction and the formation of conservation groups has taken precedence in the public mind. Finch contends that in the third era “concern for the consumers’ rights became an ingrained societal norm”.61 However, as demonstrated in chapter six and seven, the advance in ideas about consumer rights has been within the context of the complex interaction of different agendas, and interpretations of what constitute consumers’ rights are by no means clear or agreed.

3.4.2 Theories about the Cycles of the Consumer Movement

The study of the role of production and consumption as an integral feature of modern society has received considerable attention, particularly during the twentieth century. This interest has not been confined just to the economic sphere, with its concepts of consumer sovereignty and maximum utility that forms the bases for much economic theory today. The notions of ‘the consumer culture’ and the ‘culture of consumption’, for example, have been the subject of sociological inquiry. Simple interpretations of the development of the consumer movement, linked to the idea that people’s perception of their self identity have become intertwined with the consumption of material goods, since the beginning of this century (20th), suggest constraints on consumption have provided the trigger for consumer movement activity. However, detailed study of actual events reveals more complex explanations.

Three recurrent areas of concern have given impetus to the consumer movement cycles according to Herrmann:

1. “ill-considered applications of new technology which result in dangerous or unreliable products;
2. changing conceptions of social responsibilities of businesses; and
3. the operations of a dishonest fringe and the occasional lapses of others in the business community”.

Herrmann suggests that these concerns become particularly relevant in times when increasing prices erode consumer spending power. As well, general concern about the perceived social cost of production can be a mitigating force in generating consumer

---

63. Tiemstra, p9; Finch, pp24-25.
discontent leading to action. A further two relevant factors identified by Mitchell are increasing diversity of choice and a dearth of available information.65

A different analysis of the cycles of the consumer movement is proposed by Tiemstra. He argues that consumer movement activity is connected to the cycles of business mergers and that “increased concentration of economic power that marks the merger movements seem to lead to a decline in the legitimacy of business institutions, which in turn leads to efforts to control their power”.66 These cycles of mergers are characterised by centralisation of business activity and innovation in both production and product technology that, while not necessarily well understood by the general public, can increase consumer expectations. However, with a downturn in economic conditions and when products fall short of consumer expectations, the economic system and, in particular, those business organisations perceived as economically powerful, come under scrutiny and there is a demand for them to become more politically accountable. Tiemstra suggests that it is at the peak of this loss of legitimacy that the consumer movement is most likely to obtain political support.67

Both these analyses offer some insights into the growth in consumer movement activity in the health arena discussed in the next chapter. Increasingly sophisticated technologies have been introduced into medical interventions with the promise of greater benefits to consumers, but disabilities and poor health outcomes remain the reality for many. Calls for revising ways of providing health services, for example the focus on improving medical practitioners’ communication skills, and interest in and use of alternative medicine has increased. Consumers want more information about their medical conditions and proposed interventions than doctors have thought it necessary to provide. Reports of rorting the medical payment system in Australia, or extraordinary high incomes

and the amalgamation of medical practices into major business concerns, in the USA, has left consumers sceptical of the motive of doctors in practicing medicine. As well, increased reporting of medical accidents and negligence has led to questioning of the legitimacy of the doctors’ claim to authority on health matters. The establishment of the Victorian central health complaints mechanism, discussed in chapter seven, provides an example where political support for consumer concerns, to some degree, overrode considerable opposition from established interests.

3.4.3 The Consumer Movement and Other Social Movements

From this short history, it can be noted that consumer movement activity increased at times of other social movement activity and change within society. The first era coincided with the movements seeking universal suffrage and better working conditions leading to the formation of numerous groups supporting these reforms. New notions of how progress could be achieved came to dominate and what has been termed ‘progressivism’, with its emphasis on expert knowledge and direction, was taken up and espoused, particularly by the middle classes. The third era coincided with the well documented civil rights and anti-Vietnam war movements. The commonality of interests and/or issues of the various social movements has been identified as an important aspect for gaining wider public acceptance of the agendas of each movement. This overlap between ‘causes’ has been increasingly utilised by consumer groups to pool resources and work together on joint campaigns particularly over complex issues. Baldry suggests “this interconnection is proving to be a key feature of social organisation during the last two decades of this [20th] century”.68 The question of whether the consumer movement itself can be considered a social movement in its own right remains a point of debate. Baldry argues that this ‘interconnection’ with other social movements, along with attention to the nature and scope of action undertaken, amply qualifies the consumer movement for

---

68. Baldry, p10.
recognition as "one of the large social movements of this era".69 Exploration of this debate, while of academic interest, is not central to this thesis and hence will not be pursued here. However, the interconnection between the consumer movement and other social movements has been an important factor in the development of the different dimensions of the consumer movement in the health area. (See ch4.2.)

3.4.4 The Impact and Influence of the Consumer Movement

The consumer movement at the turn of the century (19th to 20th) was led by ‘the elites’, particularly those versed in the new social sciences such as journalists, economists and social workers.70 This continued to be the pattern for the subsequent waves of consumer movement activity and has been a constant criticism of the movement; that it has been driven by the articulate middle class, primarily concerned with their own issues.71

Although the consumer movement has been associated with campaigns for social reform aimed at improving conditions, particularly for disadvantaged citizens, and as such has challenged those in positions of power and control over the means of production, it has been criticised for seemingly not challenging the basic assumptions that underpin the economic structure of western society. Hornsby-Smith identified five structural factors which he believed were weaknesses of the consumer movement: negligible communication between consumers; inability to mobilise; rejection of effective action; acceptance of existing market arrangements; and ideological support for existing market arrangements.72 This, Hornsby-Smith argued, led to the acceptance of the consumer movement and consumer organisations as necessary components of a democratic society but which government and business, with the backing of greater resources and influence, have often

69. Baldry, p92. Baldry notes that although dealing with the same issue, social action, the literature originating from the disciplines of social work and community work and the literature originating from the sociological investigation of social movements do not appear to have been connected or to build on each others' findings and ideas (pp12-13).
70. Tiernstra, p9.
72. Hornsby-Smith, pp303-304.
managed to censure and minimise the impact on their interests.\(^7^3\) The way consumer representation and consumer consultation has been used by some governments tends to support Hornsby Smith’s argument. (See ch4.3.7 & ch6.4.3.)

Amongst those active within the consumer movement, two ideological groups have been identified: one group, the ‘reformist majority’, seeking to rectify specific consumer concerns stemming from inefficient markets; the other group, the ‘minority radicals’, with broader goals of equity and social justice.\(^7^4\) The two groups advocate different tactics, the former taking a conciliatory path within the system, such as proposing legislative and regulative reform, the latter taking a more adversarial position, through the use of legal suits and consumer boycotts.\(^7^5\) The tension between the two ideologies can be traced through the changing priorities and strategies adopted by consumer organisations. (See this ch3.5.)

Studies of the consumer movement have indicated that, for successful action, three factors must be present: the development of ‘saleable ideas’; access to the media; and credibility in the public eye. To be able to control these factors the consumer movement must be able to draw on sufficient resources.\(^7^6\) Herrmann concludes though “even with these essentials in place, it is difficult to make headway if the political and social climate is not conducive”.\(^7^7\) Similarly, Finch notes that

“characteristics of a meaningful and enduring consumer movement must include: popular support of the movement (not simply support of the cause); the recognition of its activities as constituting a viable and effective force; and the continued/sustained impact of its actions on a substantial segment of the populace”.\(^7^8\)

\(^7^3\) Hornsby-Smith, pp304-205.
\(^7^5\) Friedman, p9.
\(^7^7\) Herrmann, Journal of Social Issues, p128.
\(^7^8\) Finch, p25.
For the consumer movement activities of the 1990s to be sustained, or gather momentum, these are important points to note. The evidence presented in this thesis, reveals how rapidly these factors can change or be overridden by more powerful interests. The nature of the consumer movement in the future remains to be seen. However, Herrmann suggests that

"in the past, the issues with which the consumer movement was concerned often were simple ones, and the solutions it proposed often were correspondingly simple. In the future, the consumer movement will have to deal with increasingly complex issues and develop solutions that can be explained in such a way to win public support".79

Already, significant shifts in government policies, such as the move towards deregulation and mutual recognition of standards in many areas of business and trade and the privatisation of government services, present new challenges in maintaining a focus on consumer issues, despite the rhetoric of consumer focussed services. (See ch6.4.) The ability, or otherwise, of consumer organisations to influence the new agendas for the benefit of all consumers, including the most disadvantaged, will be critical in shaping the impact of the consumer movement of the 1990s. The diversity of activity and the alliances formed by the consumer movement in health in the past two decades, discussed in the following chapter, may prove to be a strength for the movement in tackling the challenges of the future, although it is clear that new strategies for action will need to be developed.

3.5 CONSUMER ORGANISATIONS IN AUSTRALIA

Consumer organisations have a key role in ensuring that the voices of the consumer movement are articulated, and this has been particularly so for consumers concerns about complaints handling. Whether the voices are then heard by governments and planners and providers of services, as explored throughout this thesis, depends on a number of factors, such as the credibility of the organisation, political appeal of the issues being raised, support of those in influential positions and compatibility with other agendas such as

economic policy reforms. By briefly tracing the establishment and activities of the consumer groups that have been most vocal, it is possible to gain a better understanding of the context from which the ‘consumer agenda’ for complaints handling mechanisms in the health area has evolved.

A diverse array of groups with a focus on consumer well-being have been formed, during the past two decades, from local neighbourhood action groups dealing with one particular issue of concern to national organisations with large memberships and tackling a range of issues. While the role of consumer groups as advocates of the consumer interest is important, particularly in the context of this thesis, consumer groups have also provided other services for their members that have sometimes taken priority on the groups’ resources, such as counselling members, providing information about services and even providing the services where gaps are seen to exist.80 In fact, funding consumer groups to provide these services has been one way in which governments have constrained the consumer groups from taking a more critical and vocal stance about government actions (or lack of action).

Four of the major organisations that are commonly identified as having presented a consumer focus on health issues and having advocated for greater recognition of consumer rights by governments and the private sector are examined: the Australian Consumers’ Association, the Australian Federation of Consumer Organisations (renamed the Consumers’ Federation of Australia in 1995), the Health Issues Centre, and the Consumers’ Health Forum of Australia. Each was formed in a different era, with different constituencies and for different purposes. Together, they provide a good picture of the nature and development of consumer groups with an interest in health matters in Australia. Two other groups are also briefly discussed because of their influence on the Australian

---

80. The Schizophrenia Fellowship of South Australia provides a good example of this; the Fellowship has provided a day activity centre and accommodation services, areas where there were perceived gaps in services offered by mainstream providers. Cancer Care Incorporated is another South Australian group with a similar experience.
setting, although they are not consumer groups in the same manner as the four listed above: the International Federation of Consumer Organisations and the Australian Consumers' Council (previously the National Consumer Affairs Advisory Council).

The success of the consumer groups in presenting a united voice and precipitating change has been variable and, as demonstrated in chapter six and chapter seven, often dependent on a range of factors over which the consumer groups have little control. Consumer organisation theory, applied to the Australian situation, provides some further insights into the attributes of the consumer groups that are most likely to indicate, and contribute to, the effectiveness of the groups' activities and in enabling consumers' voices to be heard.

3.5.1 The Australian Consumers' Association

It was not until the end of the 1950s that the Australian Consumers' Association (ACA) was formed. Mrs Ruby Hutchison, a Labor politician from Western Australia, is acknowledged as generating the idea for the ACA, and she joined with other influential citizens with a similar interest in consumer matters in New South Wales, to launch the first meeting of the ACA in the Sydney Town Hall in 1959. The ACA used information from both the United States Consumers' Union and the Consumers' Association (UK) as the basis for the model developed for the Australian association. To establish the credibility of the association, academic support had been sought out and Professor Thorp, Professor of Pharmacology, became the first Chairman of ACA. In line with ideas of the time about 'scientific consumption', testing of products was seen to be a central activity for the new association to undertake, but initially it was reliant on the skills of the members, which, in turn, limited the products tested. For example, Professor Thorp conducted the tests on the

---

82. R. Thorp cited in Halpin, p12.
first product tested, aspirin.\textsuperscript{83} The results were published in the newly created magazine, *Choice*, which was distributed to over 500 members in March 1960. Twenty five years later, there were over 200,000 subscribers to *Choice* and it was widely available in public libraries. Branch committees were set up in other states as ACA grew.

From the outset, there was concern about the potential for such an association to become the captive of particular interest groups and the founding members had tried to overcome this by introducing restrictive membership practices. However, this also proved to be a weakness and, in the 1970s, the Association came under increasing criticism for its exclusive membership and conservative approach. As well, the previously good reputation of *Choice* had been damaged, around this time, by the publication of a series of erroneous information resulting in declining subscriptions.\textsuperscript{84} There was tension between the original agenda of product testing, which “would not rock any boats”, and the newly emerged agenda of public, and potentially political, issues of the 1970s, such as pollution of the environment.\textsuperscript{85} The changing nature of the consumer movements overseas influenced the Australian situation, as the ACA was a founding and active member of the International Organisation of Consumer Unions, and a policy shift to include broader social issues was made. The Association underwent a major restructure of the management of the organisation in 1979, and shortly after membership criteria were expanded. The issue of alignment with other groups remained controversial though. For example, it was considered that alignment with the anti-nuclear movement at that time would result in a significant loss of membership.\textsuperscript{86} The ACA currently operates with a governing Council elected by the voting members and all positions on the Council are honorary. A stipulation still exists that members of the Council cannot hold positions as principals in industry, advertising or sales. ACA describes itself as

\textsuperscript{83} I. Sheahan cited in Halpin, p10.  
\textsuperscript{84} A. Asher cited in Halpin, p21.  
\textsuperscript{85} Wheelright cited in Halpin, p28.  
\textsuperscript{86} Wheelright cited in Halpin, p29.
“an independent, non-profit, non-party political organisation. The Consumers’ Association is funded primarily through subscriptions to its magazines and also from some fee for testing services. We aim to provide consumers with information and guidance about goods and services. In addition we seek to represent and lobby on behalf of consumers to balance the influence of manufacturers and service providers”. 87

Although product testing had taken precedence, the ACA did lobby governments on various consumer issues from its early days. For example, in 1962, the ACA made a submission to the Packaged Goods Inquiry and it was the “first time in Australian history that the consumer had spoken with an organised and united voice”. 88 In particular, two issues were pursued: that of formal consumer representation on government committees and the establishment of government departments or bureaux of consumer affairs. Progress was made in gaining greater consumer representation, although not without considerable resistance, as a comment by Prof Thorp reveals:

“consumer representatives came to be accepted on a limited number of advisory bodies, although the view is often expressed that since everyone is a consumer no special representation is needed!” 89

The important, but often limited, role that consumer representatives are able to play on governmental committees remains an matter of concern for ACA. (See ch6.4.) Persistent lobbying by ACA has been credited as instrumental in persuading the NSW government to set up a consumer affairs council and a consumer affairs bureau in 1969, the first of the state governments to do so. 90

Issues related to consumers’ health, such as food labelling, have always been part of the ACA’s agenda. The broadening of the agenda, in the late 1970s, to encompass social issues more generally led to the ACA becoming much more actively involved in health issues. At the same time, the Medical Consumers’ Association (NSW) began sharing office space with the ACA, and the close liaison highlighted the extent of complaints about

88. Halpin, p52.
89. R. Thorp cited in Halpin, p17. This language is still encountered when consumers’ issues are raised in health circles.
90. P. Holt cited in Halpin, p45.
health services received by both Associations. Subsequently, the ACA became a key player in lobbying the Commonwealth government to support the formation of the Consumers’ Health Forum of Australia. Another major foray into the health area by the ACA was a research project conducted jointly with the Australian Council of Social Services to examine the difficulties consumers experienced with the health system, particularly problems of access, costs, including hidden costs such as transport, and the level and quality of services available locally. Undertaken in 1983, and in the context of the pending introduction of the Medicare scheme, 400 people across Australia were surveyed. The resulting report, *In Sickness and in Health*, contained a series of recommendations, including the call for the development of a health strategy at a national level, greater emphasis on preventive and community health programs and increased consumer representation and formal mechanisms for consumer input at all levels of health services. Through its magazines and journals, the ACA has continued to provide considerable information on health issues for the education of consumers generally.

This emphasis on consumer health issues has continued and, in the internal restructuring of ACA in early 1994, health was identified as one of the three ‘program groups’ along with money (financial issues) and food. The Health Group immediately established three priority areas: health financing and cost, health rights and quality of service; and consumer education about treatments and self management. Consequently, ACA is actively involved in the campaign to develop a charter of health rights with other consumer organisations and maintains a prominent place on a number of national committees on specific health issues.

3.5.2 Australian Federation of Consumer Organisations
(renamed the Consumers' Federation of Australia in mid 1995)

The Interim Committee on Consumer Standards, reporting to the Commonwealth Government in 1973, recommended the formation of an organisation to act as a peak body for consumer groups around Australia.\(^{94}\) The Australian Federation of Consumer Organisations (AFCO) was subsequently set up, with financial support from the Commonwealth Government in 1974. The membership of AFCO were consumer organisations, rather than individual consumers. By 1991, thirty seven consumer organisations were full members of AFCO, a further fifteen organisations had associate member status and two had consultative status. The groups ranged from national groups such as the ACA, Consumers' Health Forum and the Home Economics Association to local groups, such as the Action for Public Transport (NSW), Consumer Credit Legal Service (Vic), and the Non-Smokers Movement of WA Inc.\(^{95}\) In an effort to obtain wider representation of constituent groups, in 1990, the organisational structure of AFCO changed, from that of an elected Executive Committee and co-opted representatives, to a Council of thirteen persons, elected biennially by member and associate member groups.

AFCO’s stated primary role is the representation of consumer groups’ views to governments at all three levels (local, state and Commonwealth) and to industry, by using mechanisms such as organising consumer representatives for various committees, drafting submissions on particular issues and working collaboratively with industry in developing standards. In the AFCO publication, Consumer Action, it is claimed that

“through the Federation the voices of consumers are heard at all levels of decision making. By joining the Federation, groups help raise the volume of that voice and through AFCO are able to have that voice heard more effectively”.\(^{96}\)

---

94. C. Cameron, A Fair Deal for Consumers in Australia, Speech delivered by the Australian Minister for Science and Consumer Affairs at a Meeting with Consumer Representatives in Sydney on 1 August 1975, p4.
The AFCO annual reports over the past decade reveal that AFCO has been active in a number of health related areas. Issues addressed include Medicare co-payments, food processing, labelling and packaging, better health care, home safety and labelling and marketing of pharmaceutical goods. AFCO has also pursued the use of class actions and product liability to obtain better redress for harmful products, for example in relation to passive smoking.

In a similar way to ACA, AFCO has worked on, or combined with, other consumer or social advocacy organisations, to work on issues relating to the health of consumers and advocating for greater consumer participation in health service planning and implementation. AFCO has also maintained a network of representatives on numerous committees, such as the National Health and Medical Research Council. As the ‘peak body’ for a variety of consumer organisations, AFCO has been able to bring a strong, if not always united, consumer voice to a range of government decision making processes, but limited resources in the face of multiple issues has been a major constraint on AFCO’s work.

3.5.3 The Consumers’ Health Forum of Australia Inc.

The history of the formation of the Consumers’ Health Forum (CHF) has been well documented by Baldry, in 1992. With the increasing pressure of health issues on the agendas of the various consumer groups, ACA and AFCO, along with five other community and advocacy groups, presented the Federal Labor Minister for Health, Dr Neal Blewett, with a ‘Petition for Reform’ in May 1985. This petition was critical of the lack of opportunities for consumer and community participation within the policy setting processes of the Commonwealth Department of Health and other health settings. The Minister

received the petition favourably and immediately approved monies for a consultancy to review and make recommendations on community participation within the Department.99

The Report of the Review Committee was completed by December 1985 and the first recommendation called for the setting up of a ‘Health Forum’, to provide a collective peak body for consumers on health issues and comprised of community and consumer groups active in the health area. It was to be independent of the health department or other government agencies, although some core funding was to be provided. A Steering Committee, with dominant consumer groups representation, was funded to oversee the Report’s recommendations implementation including the establishment of the ‘Health Forum’. Consumer organisation representatives advocated for the involvement of a broad range of groups including some not directly consumer based, to strengthen the Forum’s position.100 Thus, the final constituency of CHF “crossed the spectrum of consumer, citizen and community groups in Australia” and was “representative of the women’s, environmental, consumers’ and health movements”.101 The Health Consumers’ Forum (changed to the Consumers’ Health Forum) was incorporated in the following year at the end of 1986.102 Initial activities of the Forum included research on health maintenance organisations, a survey of consumer health groups and an inquiry into the medical workforce and medical training.

Following wide consultation with the membership of the CHF in 1992, a strategic plan was formulated based on three broad principles:

99. Baldry argues that the ready acceptance of the petition by Dr Blewett was partly due to “Blewett’s and his Department’s continuing attempts to popularise and establish the notions of Health for All and preventive health, needed the support of community and consumer groups”. Baldry, p149. Earlier in 1985, the Policy and Planning Division of the Department of Health (Commonwealth) had published a report that included significant support for the concept of consumer involvement, as well as highlighting the unavailability of complaints mechanisms. Commonwealth Department of Health, Health Care and the Consumer. A paper prepared by the Policy and Planning Division, AGPS, Canberra, January 1985.
100. R. Brown cited in Baldry, p151.
102. As the acronym HCF was already in use by the Hospitals Contribution Fund, a health insurance agency, the name was subsequently changes to the Consumers’ Health Forum. Baldry, p153.
to reduce inequalities in the health status of Australians, to promote universal access to health services for all Australians and to protect and enhance the health care consumers".103

In a similar position to AFCO but specifically focused on health matters, key activities of the Forum have been identified as providing consumer representatives to national health committees; enhancing networking between member organisations and sharing knowledge and resources on issues of common concern; and promoting consumer research and evaluation.104

Support for the work of the Forum is provided by a Secretariat, based in Canberra, with core funding from a grant from the Commonwealth government. An Executive Committee of five and a General Committee of representatives from thirteen organisations, elected biannually by the full members, determine the direction and priorities to be undertaken by the Secretariat.105 Full membership of CHF is open to organisations with “aims and objectives that represent consumer views and interests” while associate membership is available both on an organisational and individual basis for those with an interest in consumer health issues.106 The Forum uses Task Forces “to work on major issues and develop policy and discussion papers which provide a foundation for workshops, lobbying and research”.107 Of particular relevance to this thesis is the work of the Consumer Rights Task Force, the third task group set up.108

CHF produces the quarterly journal, Health Forum, and a more irregular update newsletter for members. Perusal of the articles featured in Health Forum, during the triennium 1991-93, gives an indication of the issues taken up by CHF, which included consumer rights; pharmaceutic products; women’s health; and responses to major issues and reviews arising in the health industry at that time, such as the General Practice

104. Health Forum, no.31, October 1994, inside cover.
105. Health Forum, no.31, October 1994, inside cover.
106. Health Forum, no.31 October 1994, back cover.
108. The first two task forces were on rational drugs policy and health care financing, Baldry, p173.
Evaluation Program. As CHF had been successful in gaining a three year grant to fund small scale research by consumer health groups, the outcomes of a number of the projects were reported in Health Forum during that time.\textsuperscript{109} CHF performs a community education role by holding conferences, workshops and consultations on assorted topics of consumer interest.\textsuperscript{110} CHF has made available an increasing list of publications, several of which have particular relevance to this thesis including \textit{Legal Recognition and Protection of the Rights of Health Consumers} (1990), \textit{Making Health Rights a Reality} (1991), and \textit{A Consumer Perspective on Health Complaints Mechanisms in Australia} (1992), discussed in detail in chapter five.

CHF has worked in tandem with other consumer groups and has not necessarily taken the lead on all health matters. Early in its life, CHF made a decision not to pursue some health related consumer issues, for example the issue of smoking and advertising, as other consumer groups, in this instance ACA and AFCO, were already heavily involved.\textsuperscript{111} Partly because of this decision, and as a relative newcomer to the field of consumer advocacy, the CHF has taken time to establish itself and gain the credibility necessary to be identified as a major ‘voice’ for consumers’ perspectives about issues in the health domain.

3.5.4 Health Issues Centre

In 1979 a group of health workers and academics in Victoria, concerned about cuts to public sector health services at the time, formed the Community Health Coalition. They managed to publish a small series of pamphlets presenting an alternative analysis of the impact of the cutbacks to that provided by politicians, health departments and health service providers. However, limited resources prevented the group taking a greater role in

\textsuperscript{109} This grant was received from the Public Health Research and Development Committee of the National Health and Medical Research Council.

\textsuperscript{110} For example, the issue of financing of health services was the focus of the 1992 Conference \textit{Paying for Health: Consumers and the Australian Health Care System} and consumer research through the CHF Consumer Research and Development Project workshops with a dual purpose to gather material for a resource manual and to establish consumer research networks.

\textsuperscript{111} Baldry, pp167-8.
health debates and they were forced to restrict their brief to monitoring changes to federal health care arrangement under the name of “Healthwatch”. The need for independent analysis of the issues confronting health services was apparent to the group and the idea of a Health Issues Centre was conceived. An Interim Committee, with a strong academic presence, was formed to pursue the idea. At the end of 1983, the Interim Management Committee, with support from the Victorian Council of Social Services, employed a project officer to develop a detailed implementation proposal. The justification for the new centre included the perceived lack of opportunity for ordinary consumers to make comment about the increasingly elaborate health system, the considerable influence that health service providers had in decision making, and the lack of focus on access and equity issues and preventing health problems.\(^\text{112}\)

By the end of 1984 the first Management Committee of fifteen had been appointed. Initial funding was secured from four private trusts and two staff members were employed, joined shortly afterwards by two administrative staff members. The first Annual Report, in 1985, described HIC as

"an independent, non-government health policy analysis and advocacy organisation. Its \textbf{overall aim} is to help create a more equitable health care system which is more responsive to users, particularly those who are disadvantaged by current arrangements".\(^\text{113}\)

It also reported that membership had grown to 300, with over 150 organisational members, and subscriptions have remained a small, but significant, part of the HIC budget. Although HIC began with funding independent of government, core funding was received from the Health Department of Victoria for some years, until the election of a conservative Liberal/Coalition government in 1992, when the government grant was reduced and eventually withdrawn. Throughout its life, HIC has been able to attract other grant monies to undertake specific projects.

\(^{112}\) S. Solomon, \textit{Proposal to Establish a Health Issues Centre}, 290 Wellington St, Collingswood Victoria, May 1984, p1.

The HIC annual reports define three areas of activity for the Centre. The first area of activity, public education, includes the production of the quarterly journal *Health Issues*, presentations to conferences and community groups, publication of other reports and submissions, and media coverage. The HIC has also taken on an information clearing-house function and provides support and resources to community groups and the public. Shortly after its establishment, the HIC received funding from the Victorian Health Department to provided a telephone health information and complaints service until the establishment of the Office of the Health Services Commissioner (Victoria) in 1988. The HIC subsequently set up a Consumer Rights Standing Committee to monitor the implementation of the new health complaints legislation in Victorian and the focus on health complaints systems has continued. (See ch5.2.)

The second area of activity, policy work, covers a range of issues and projects including women’s health, organ transplantation and more recently health technology and mental health. HIC has taken up topical health issues as they arise to ensure the consumer perspective is presented, for example with the introduction of casemix. The third area of activity, research work, is seen to be a crucial for HIC to gain and maintain credibility. The themes of consumer protection and consumer participation are common throughout all three areas of activity. In particular, complaints systems have been examined in some detail and a number of reports and articles have been devoted to this issue.

HIC makes good use of its networks and many HIC projects reflect a collaborative effort with other groups, for example the project *Chronic Illness: Whose Responsibility?* was undertaken with the assistance of members of several self help groups. Like the other consumer organisations, HIC provides representatives, who will promote the consumer interest, on various committees and working parties, for example the National

114. HIC describes *Health Issues* as “a major vehicle through which the Centre provides analysis from a consumer perspective on our health system at both the federal and state/territory levels”. Health Issues Centre, *Annual Report 1992-93*, HIC, 3rd Floor, 148 Lonsdale St Melbourne, p7.

3.5.5 Australian Consumers’ Council

\footnote{D. Harland, “Early Work of NCAAC Reviewed”, \textit{AFCO Quarterly}, no.14, June 1979, p9. Prof. Harland was the Chair of the Council and also a council member of ACA.}

\footnote{For example, manufacturers’ liability, petrol consumption, packaging and labelling and credit legislation. Harland, pp9-10.}

\footnote{Harland, p12.}

(the National Consumer Affairs Advisory Council until 1993).

With the introduction by a Labor government of the Trade Practices Act in 1974, the Commonwealth government became more actively involved in consumer affairs. The Trade Practices Act Review Committee, set up by the incoming Liberal government in 1976, recommended that an advisory body to the Minister for Consumer Affairs be established, similar to the committees that already existed at the state level. In June 1977, the ministerially appointed membership of the first National Consumer Affairs Advisory Council (NCAAC) was announced.\footnote{In 116. Health Issues Centre, \textit{Annual Report 1992-93}, HIC, 3rd Floor, 148 Lonsdale St Melbourne, 1993, p10.}

The Council was given the brief to advise the Commonwealth Minister on consumer affairs issues, either generated by the Council, or referred to it by the Minister. Its function was seen to be different and broader than that already provided through the national consumer groups. The membership of the Council was diverse and included members with commerce and industry experience, as well as others active in consumer groups, although it was stressed in NCAAC documentation that individual members did not represent particular groups or organisations.

NCAA examined a diverse range of consumer issues.\footnote{For example, manufacturers' liability, petrol consumption, packaging and labelling and credit legislation. Harland, pp9-10.} Consumer representation was identified as a priority issue: “the Council sees the development of more effective mechanisms whereby the consumer interest can be represented and heard in the governmental decision making process as a very important and complex question”\footnote{Harland, p12.}.
more recent years, the NCAAC has continued to promote the consumer interest at the Federal Ministerial level. While the major focus has been on consumer issues such as product liability, the financial industry and telecommunications, other issues such as consumer rights of the aged, concerns of consumers living in remote and isolated locations and consumer affairs administration have also been addressed.\textsuperscript{120} In a discussion of the proposed Insurance Ombudsman Scheme it was stated that the Council had “advised the Minister that any proposal for a complaint review mechanism should be developed in consultation with the consumer movement” and went on to note the principles of accessibility, fairness, accountability, efficiency and effectiveness that need to be met if the scheme is to be successful.\textsuperscript{121}

At the end of 1990, the Minister for Justice and Consumer Affairs requested that the NCAAC consider how to ensure consumer input into the development of the National Health Strategy and to identify “strategies for health systems that are more consumer driven and responsive to consumer needs”.\textsuperscript{122} To this end informal consultations and a two day colloquium were held in 1992. Central themes of the colloquium were “the rights of consumers and involvement in their own health care and consumer perspective and participation at all levels of health policy and of the health care system(s)”.\textsuperscript{123} The ensuing report from this process, *How We Feel: a Consumer Prescription to the Health System*, released in December 1992, recommended, amongst other things, that “strong complaints mechanisms need to be developed in every State along with consumer participation on health registration bodies”.\textsuperscript{124} The report also stressed the need for the principles of consumers’ rights and professional standards to be enshrined in all health legislation.

The Council was reformed and renamed the Australian Consumers’ Council (ACC) in 1993: “a more compact organisation with a more direct role in the development and evaluation of consumer strategies... It concentrates primarily on the empowerment of consumers in the areas of communications, financial services and health”.  

In a similar way to the previous Council, appointment to the Council was by the Commonwealth Minister for Consumer Affairs and the ten members do not represent any particular organisations. The new Council sponsored a series of workshops to produce a training manual for consumer representatives as one of its first tasks. The new Council also identified facilitating the development of a Health Consumers’ Charter as a priority projects. To this end, ACC sponsored a two day workshop in mid 1994, to explore the concept of a charter for health consumers in Australia and to discuss a draft charter; which the ACC had commissioned the Public Advocacy Interest Centre (PIAC) in Sydney to prepare. (See ch5.4.) It was intended that the final draft, and recommendations for its implementation, would be presented to the Federal Minister for Consumer Affairs for tabling at the Consumer Affairs Ministerial Council and for referral to their counterparts, the Commonwealth and State/Territory Ministers for Health, for action. The fact that a focus on health issues is written into the mandate of the new ACC is interesting and important. Scrutiny of one sector of government by a body from another sector, and with a special relationship to a different Federal Minister, for anything other than financial matters, is both unusual and untested. Health service provision, in particular, has been seen to be the province of the health sector, under the guidance of the dominant health service providers. The ideas of ‘healthy public policy’ envisaged greater input from the health sector to other sectors of government activity but it was not necessarily anticipated that this involvement might be reciprocated! Whether the new ACC will have any greater success in influencing health policy and health service provision to better reflect consumer


interests, than consumer organisations already working within the health arena, remains to be seen. But the traditional division between sectors is likely to present a major barrier to the ACC aspirations in the health area.

3.5.6 International Organisation of Consumer Unions

Although the International Organisation of Consumer Unions (IOCU) is not, of course, an Australian consumer organisation, Australian groups have been involved with the IOCU since its formation and the two way flow between these organisations has, in turn, had an impact on the Australian consumer movement. Of particular importance was the expanding of the vision of the IOCU to better accommodate the concerns of developing countries. IOCU was formed by the consumer associations of UK, USA, Holland, Belgium and Australia at a meeting held in The Hague in 1960. In line with the activities of the founding member organisations at that time, the original IOCU charter emphasised product testing and technical information sharing. The charter also included representing consumer issues at the international level and IOCU representatives attend the United Nations. An important item in the charter was that IOCU would provide support for the establishment of consumer groups and this was actively pursued.

By as early as 1966, the focus of IOCU’s activity had shifted to begin to address the basic rights and social issues facing consumers in developing countries, such as water

127. At the first conference, held later that year, and financed by the USA Consumers’ Union, forty delegates from eleven countries attended. Halpin, p.31.
128. The IOCU charter listed the following aims:
   - to promote international cooperation in the comparative testing of consumer goods and services, exchange of information on methods of testing and in all other aspects of consumer information, education and protection;
   - to provide a specialised source of information on technical, legal economic and other aspects of consumer affairs;
   - to constitute an international forum for the discussion of all kinds of consumer problems;
   - to represent the interests of the consumer at the international level;
   - to encourage the formation of new consumer organisations by supplying advice and information to individuals who are concerned about consumer problems and are interested in forming a consumer group. Halpin, p.30.
129. Baldry, p.69. In 1974, a regional office of IOCU was established in Penang, Malaysia, to support and promote consumer activity in the Asia Pacific region.
pollution, air pollution and poverty. These changes provided impetus for the consumer groups in Australia to broaden their activities to encompass consumer rights and social issues. A set of basic consumer rights, generated by the IOCU, but incorporating the rights outlined in President Kennedy’s 1962 consumer message, has been used as a model by consumer groups around the world, including Australia: the right to information; the right to basic services and to choice; the right to representation; the right to redress; the right to consumer education; the right to a healthy environment; and the right to safety. The IOCU also identified consumer responsibilities: developing critical awareness through questioning the quality of goods and services provided; being prepared to take action to ensure a fair deal; recognising social responsibilities by sensitivity to the impact on other citizens particularly disadvantaged groups; recognising ecological responsibilities through reducing harmful effects on the physical environment; and solidarity through cooperation with other citizens’ groups. The emphasis on “ethical, ecological and equitable production” remains central to the IOCU’s activities. Viewing consumer issues in the international context helped Australian consumer organisations develop an understanding of consumer issues that went further than a focus only on the purchasing of goods to one which encompassed the welfare and rights of all aspects of consumers’ lives.

3.5.7 Australian Consumer Organisations and Consumer Organisation Theory

A number of researchers have made observations about the organisation and activities of consumer groups that are pertinent to an analysis of the Australian scenario. Traditional social movement organisation theory suggested that supporters or members of groups were motivated chiefly by self interest, that they combined forces with other like minded consumers in groups and were dependent on members to volunteer time and resources to achieve the groups’ aims. However, this theory did not sufficiently

130. For example the Consumer Interpol was set up to give early warning of the hazardous waste dumping of materials in other countries. Baldry, p70.
131. Haplin, p34.
differentiate between the beneficiary base and the member base of a group.\textsuperscript{133} The later ‘resource mobilisation theory’ contended that supporters of particular movements may not necessarily directly benefit, or expect to benefit, from the activities and thus they were a “conscience constituency” rather than a “beneficiary constituency”.\textsuperscript{134} A consumer group based on a conscience constituency works on issues that benefit all consumers, rather than just the members of the group. The resource mobilisation theory also emphasised the importance of linkages between groups, already mentioned in the earlier discussion of the consumer movement.

Drawing on this theory Herrmann, studying the leadership of consumer organisations, identified four ‘types’ of consumer organisations, and all four are prevalent amongst health consumer organisations.\textsuperscript{135} The first is the volunteer-led organisation with beneficiary constituencies, where membership of the group is specifically designed to be of benefit to the members through achieving a common goal or sharing resources, information and advice. This is the typical structure of many local issues/illness based consumer groups, such as the Parks Clean Air Group and the Cystic Fibrosis Association in South Australia. These groups often aspire to the second type, the professionally led organisation with a beneficiary constituency, by requesting funding to employ paid workers to take over some of the work of the group and complement the voluntary work of group members. Many of the larger self help groups with their paid coordinators, executive officers and secretarial staff fall into this category, for example the Schizophrenia Fellowship and the Nursing Mothers’ Association. The third type, the volunteer-led organisation with a conscience constituency, for example the Medical Consumers’ Association of South Australia, is often limited in the role it can take on by the amount of volunteer time available to it. The final type, the professionally led organisations with conscience

\textsuperscript{133} Herrmann, \textit{Journal of Social Issues}, p120.
\textsuperscript{135} Herrmann, \textit{Journal of Social Issues}, pp119-133.
constituencies, for example the Health and Social Welfare Councils in South Australia, have the advantage of paid worker time to research and lobby issues more intensely, but also run the risk of the paid staff controlling the direction of the group's activities. Often the distinction between beneficiary and conscience constituencies may not be well defined and many of the consumer organisations' memberships encompass both, for example the Australian Consumers' Association. Herrmann maintains that the agendas of the four types of organisations differ, as do the scale and extent of strategies used, partly because access to and the kind of resources available to the groups also differs. For example, the professionally led organisations with beneficiary constituencies are more likely to have access to, and use, technical expertise, whereas the volunteer-led organisations with conscience constituencies are more likely to try to obtain the patronage of well known community figures. These differences can be seen amongst the activities of the myriad of health consumer groups.

The evolution of different organisational types of consumer groups has also been related to the three eras of consumer movement activity noted previously. At the turn of the century (19th to 20th), the volunteer-led organisations with conscience constituencies were the most common; for example the women's groups. In the second era, of the 1930s, consumer organisations emphasising product testing, with paid staff and supported by consumer subscriptions were established; the professionally led organisations with beneficiary constituencies; for example, the ACA initially. In the 1960s, the public interest groups set up by Ralph Nader provided another alternative form of consumer group; the professionally led organisations with conscience constituencies; for example HIC.

The idea of a 'peak body', although not a new concept, is one of the 'forms' of organisation used in the last two decades; AFCO and CHF are examples of this type of consumer organisation. Peak bodies, representing organisations rather than individual members, provide a focal point for consumer issues for member groups and outside bodies.

such as government agencies. They usually have a small operational staff but have a large
constituency (both beneficiary and conscience) in the membership of the individual groups.
Advocating on behalf of member groups present challenges to the peak bodies because of
the diversity of interests amongst member groups, and the involvement of the full
membership in activities of the peak bodies activities may be limited. The restructuring of
the General Council of AFCO, for example, was an attempt to obtain greater participation
from a broader range of member groups. Baldry describes the CHF as providing a
necessary ‘mediating structure’ between the complexity of government organisation and
the public. She goes on to suggest that the CHF is “a new style health consumer
organisation with characteristics of both government and non-government organisations”.137
Peak bodies often relate to, and are reliant on, funding from the relevant
government sector and as such have been criticised for taking on some of the features of
the bureaucracy they work with and this, in turn, has limited the effectiveness of this type
of organisation. Indeed the peak body must appear attractive to a public service managed
on increasingly corporatist lines. (See ch6.4.)

Availability of resources, credibility and access to the media are instrumental to the
success of consumer organisations, in similar ways to that noted for the consumer
movement. In some ways, professionally staffed organisations “capable of dealing with
relatively complex issues and providing relatively sophisticated services” are likely to
achieve greater success than volunteer dependent organisations because of the difficulties
faced in acquiring the time and resources needed for effective action.138 However, the
majority of consumer groups employing staff have been constrained by limited and
insecure funding and reliant on often static, or decreasing, government grants. Consumer
groups have been pitted against each other to compete for a share in an already small

137. Baldry, p144.
bucket of funds in some instances. \(^{139}\) Dependence on government funding for survival can compromise the ability of an organisation to determine its own agenda and decrease willingness to criticise government policies and action. Part of the strength and credibility of the ACA can be attributed to its independence from government funding.

The credibility of all of the four consumer organisations discussed has been, and will repeatedly be challenged by, in particular, business and service provider groups. Two important criteria that must be met for consumer organisations to maintain credibility are: the ideas they propose must have merit; and they must be seen as the legitimate representatives of consumers. \(^{140}\) Putting forward unworkable solutions to consumer problems, or shoddily researched reports can quickly lose support that has taken years to build up, as ACA found in the early 1970s. A significant component of the work of all the organisations discussed has been the drafting of submissions which contain well developed recommendations to the frequent reviews and inquiries conducted in the health field. As well, the consumer groups have lobbied for and provided numerous consumer representatives on various committees, particularly government committees, and assisted these representatives with training to increase their potential effectiveness. Apart from work of the peak bodies, there has also been considerable interlinking between consumer organisations, in Australia, through representation on each others’ boards and committees of managements and the movement of individuals across key positions. \(^{141}\) While this has contributed to the interchange of ideas and the greater understanding of the work of each group, it may also have restricted the diversity of issues raised and acted upon.

The assertion by consumer groups that they speak on behalf of significant proportions of consumers still remains open to debate, particularly as members of consumer groups tend to be well educated, articulate and with close connections to others.

\(^{139}\) For example state government grants to self-help groups in the mental health area are to be decided in this way from 1995 in South Australia.

\(^{140}\) Herrmann, _Journal of Social Issues_, p129.

\(^{141}\) For example, Louise Sylvan, founding Executive Officer of the CHF moved to ACA in 1989, and several years later was appointed ACA’s Chief Executive Officer.
in leading positions in the community. Members of the General Council of the ACA, for example, display an impressive list of qualifications. The Interim Committee for the HIC was composed predominantly of academics (this did change with the first Management Committee). Claims that the agendas of consumer organisations have reflected this group of consumers' ideological and political concerns, and the often comparatively small membership of the groups compared to the total number of consumers, have been leveled against the groups with an implicit discounting of their credibility. One way of increasing credibility has been for "publications of the consumer movement to stress the number of people directly affected by the issues that the consumer groups take up, rather than the membership of the consumer group". Another way has been for consumer groups to collaborate on issues, as all four organisations discussed have done, and to actively seek out the views of consumers who are not represented in the consumer group's constituency, for example in the research projects undertaken by HIC.

The ability of consumer groups to access or attract media coverage has been largely dependent upon the amount of time and resources that the groups have devoted to this endeavour. HIC lists, in the annual reports, 50 media appearances (daily newspaper and radio) for the period 1987-88, increasing to 87 for 1989-90 (the latter figure included reports in other organisations newsletters). On the other hand, CHF has had periods where it did not attracted significant media attention, and knowledge of the role and work of the CHF, by service providers and consumers alike, has been limited. The topical, and sometimes controversial, nature of articles in ACA's publication Choice receive media attention from time to time but generally media coverage of the activities of consumer groups has not been extensive. To assist with the dissemination of information about

142. Tiemstra, p22.
143. Baldry, pp185-188.
144. A search of Presscom, the online database of the South Australian daily and local newspapers, for the period April 1988 to September 1994, revealed only 144 items mentioning ACA, 43 mentioning CHF and 26 mentioning AFCO; relatively few considering the thousands of newspaper articles printed each year and the considerable activity reported by the organisations themselves. It must be noted though that this search could provide only a very crude and possibly a somewhat inaccurate measure because of the structure of the database and 'string of words' text searching.
both issues and activities, the four consumer organisations publish their own journals and newsletters and, to assist access, CHF and HIC set subscriber rates according to income.

The success of consumer groups in pursuing consumer issues and precipitating change is open to interpretation. Tiemstra claims

"no consumer organisation, in the Progressive Era or at any other time, has been large enough, rich enough, or persuasive enough to be very influential. Their influence is always due to their ability to identify issues with mass political appeal". 145

However, perusal of various consumer groups’ annual reports indicate that the groups perceive themselves as having achieved some success in, for example, the extent of consumer protection issues that have remained on the political agenda, attributed to their persistent lobbying. The consumer groups are not unrealistic about their impact and have recognised the need to work together with other organisations and co-opt support for issues from whatever source may be available. Although mindful of this discussion about the limitations of consumer organisations, the four consumer organisations discussed have undertaken extensive activities in the area of health consumer issues, giving them some authority to be recognised as legitimate representatives of the consumer interest.

3.6 CONCLUSION: CONSUMERS, CONSUMER ORGANISATIONS AND COMPLAINTS SYSTEMS

All the organisations discussed have advocated the need for more effective mechanisms for consumers to utilise their rights of complaint and redress. The four consumer organisations discussed have all participated in the push for reforms to complaints mechanisms in the health care system. In particular, the different approaches taken by two of the organisations, the HIC and the CHF, are examined in more detail, in chapter five, for evidence of the specific components of the ‘consumer agenda’ in regard to health complaints systems. As well, the combined campaign by ACA, CHF, AFCO, HIC

and ACC, for the development and adoption of a national health consumers' charter, also discussed in chapter five, provides further indications of the commitment of these organisations to furthering the rights of consumers in the health sector against the rights and interests of more powerful service provider interests.

During the early part of the 1980s, government support for consumer organisations was more forthcoming than previously in two ways: financially and acceptance of the basic concepts underpinning the establishment of consumer groups. At least partial acceptance of the notion of greater accountability of, and community participation in, government processes had become a focus for some government departments at that time. The direction of the 1990s began differently, with governments seeking to reduce their spending by cutting or finding alternative ways of financing services provided, or supported, by government monies. These changes have had service implications for consumers, and have been met with mixed reactions from consumer groups. Some of the changes have been welcomed (at least initially) where it seemed that costs would decrease, choices increase and the quality of service for consumers improve. But funding for many consumer groups is even more insecure; for example, by 1994, the CHF's core grant was not increased and the HIC has lost its government funding. However, there are already indications that consumer activity will continue (albeit in a different form, if Herrmann's theory is correct) because of the changing interpretations of the nature of the consumer interest.

The arguments the various consumer organisations have put forward for changes to health complaints mechanisms, and for greater acceptance of consumers' rights in the health area, portrayed through their publications and accounts of their activities, constitute what is termed, in this thesis, the 'consumer agenda', discussed in detail in chapter five. Having established a better understanding of the context in which the 'consumer agenda' for complaints handling mechanisms has emerged and the legitimacy of the claims by these consumer groups to reflect consumers' voices, it is now necessary to explore the specific contribution of the dimensions of the consumer movement in health to the formulation and interpretation of health consumers' rights and health complaints systems.
CHAPTER FOUR
THE CONTRIBUTION OF THE CONSUMER MOVEMENT IN HEALTH

4.1 INTRODUCTION

The consumer movement in health constitutes a diverse range of ideas and activities stemming from a number of distinct social movements. An examination of the various activities and ideas generated by the different movements reveals a number of common elements, which, when combined, characterise the contribution of the consumer movement in health to health sector debates. The most prominent of the common elements have been: promoting the social view of health; valuing experiential knowledge; questioning information from professional sources; sharing information and knowledge about health and health care; developing statements of the rights of consumers when receiving health care; voicing consumers’ ideas about health and health services including complaints; and participating in decision making about all aspects of health service provision.

In a similar way to the broader consumer movement, the success of the consumer movement in health has been dependent upon several factors: presenting ideas that make good sense; establishing credibility; obtaining media exposure; and gaining access to sufficient resources. Baldry suggested that, in Australia, the ideas promoted by the consumer movement in health have percolated throughout much of the community and in ways that have influenced a value shift in public perception of at least some aspects of health care. The lack of an ‘exit’ option from the health system has increased the importance of, and the motivation for, consumers to organise themselves into groups and

---

1. As already noted the term ‘social movement’ has a specific meaning within some disciplines, but here it is used in a more generic sense to encompass associations of people, activities and ideas that form a recognisable and identifiable entity.
thus be better able to express their 'voice'. Underlying the diversity of activities of the consumer movement in health has been the commonality of elements discussed in more detail here.

The common elements identified provide valuable information and insights, necessary for gaining a more detailed understanding of health and health services from the perspectives of consumers. This provides a stronger empirical foundation from which the interpretation of health consumer rights and health complaints mechanisms can be derived and expressed as the consumer agenda, discussed in the next chapter.

4.2 THE CONSUMER MOVEMENT IN HEALTH

The multiple dimensions of the consumer movement in the health sector have been shaped by a number of the distinct, but interrelated, social movements that combined, and over time, have had a significant impact on many aspects of health service provision. The most notable social movements, excluding the broader consumer movement already discussed, that have contributed to this changing consumer perspective are: the self help group movement, based on the concept of self help or mutual aid and exemplified by the self help groups that have proliferated in the health arena; the women's health movement, redefining the ideas and attitudes about, and the experience of, health and health care; the Australian community health movement, incorporating the notions of primary health care and emphasising health promotion and community participation; the patients' rights movement (later to become the health consumers' rights movement), advocating legislative and health care provider behaviour change; and the self care movement emphasising taking responsibility for one's own health and promoting self care through the utilisation of the dramatic increase in popular information about medical conditions and their treatments.

As noted in the previous chapter, the identified consumer groups and wider consumer

---

3. Dissatisfaction with different aspects of health service provision applies to the private system as well as the public system in Australia. The central complaints bodies in both Victoria and New South Wales, for example, report receiving complaints about service provision in both public and private health sectors. (See also ch7.5.)
movement have frequently focussed on health issues, from the provision of uncontaminated food and sanitary systems to the availability and accessibility of health services. The diversity of the activities that now fall under the broad ambit of the consumer movement in health can be attributed to these different origins, although many of the early participants would not have identified with the consumer terminology used today.

**Self help groups movement**

Self help groups have contributed to the slowly increasing attention given by health service providers and governments to consumer issues in the provision of health services. In the health arena, the term ‘self help group’ has been applied to all kinds of groups although the purposes, composition and activities of the groups may be vastly different. An account of self-help activity in Europe, in the early 1980s, by the WHO Regional Office for Europe stated that

"self help and mutual support groups comprise those voluntary associations of individuals with a common problem, stigma or life situation which involves no professional control, although there may be professional involvement of a consultative kind, and in which there is no financial profit. Such groups usually engage in a combination of mutual help to members and to the public and political activity".4

A study in England, applicable to the Australian situation, identified five kinds of help that most self help groups at some time provided to their members: emotional support, information and advice, direct services, social activities and pressure group activities.5

Self help groups have emphasised the value of experiential knowledge and information sharing and helped to demystify expert knowledge. By offering their own services, forging new relationships with professionals, and building up comprehensive information resources about the illness or issue, self help groups have provided consumers with additional and, in some instances, alternative sources of knowledge, useful in better

---

understanding and commenting on their health, from their own perspective. However, the role accorded to self help groups in the provision of health services is still very much on the periphery of mainstream services and many health service providers are ignorant of the existence of the range of self help groups and what the groups have to offer. Even with appropriate knowledge, health professionals’ perceptions of the role of self help groups in the overall health system may be limited. Kickbusch and Hatch suggest that

“while self help activists are discussing a widening of options in health, professionals tend to see self help as a system supplementary to medical care provision - even as part of its referral system - with physicians defining the extent and content of this care and evaluating its success”. 7

Women’s health movement

The renewed activity of the women’s movement since the 1960s has contributed significantly to the consumer dialogue about health and health care provision. The activities of the women’s health movement in Australia grew out of and contributed to the broader women’s movement. While the emphasis of the movement has been on the health of women, the influence that the women’s movement has had in the conceptualisation of health and the provision of health care services affects all consumers. The detailed documentation and analysis of the women’s health movement, undertaken from a number of different perspectives, provide poignant insights into the struggles and developments of the last three decades in particular. This history highlights the significant principles and concepts introduced, and often practiced by women’s groups, that have challenged the existing notions of health and health care, and consequently significantly influenced the formation of the consumer agenda. Exactly what constitutes the women’s health

6. For example, a study conducted by the Health Issues Centre in Victoria in 1993 entitled *General Practitioners and Information on Locally Based Services* found that the general practitioners studied were relatively unaware of the range of self help groups available. M. Summers, “GPs and Information on Local Services”, *Health Issues*, no.35, June 1993, pp32-34.


movement has been open to interpretation. Broom, from her analysis of the history, maintains:

"the Australian women's health movement encompasses a range of views about how improvements in women's status, including health status, are best achieved. They are united by dissatisfaction with existing medical services, a critical view of modern medical professionals, a determination to bring about improvements in women's circumstances and a vision of a radically different society. It is a vision of a society in which women are not oppressed or systematically disadvantaged, and which is consequently not sickening to women, either directly or indirectly."

The women's health movement did not grow in isolated from other movements in health. The establishment of the women's health centres in the early 1970s, for example, coincided with, was spurred on by, and, in turn, added new dimensions to the Commonwealth community health program. This interconnectedness increased the strength of the influence of the movements on changing consumer expectations and attitudes about health care provision.

The women's health movement emphasised women's rights in relation to health care and, in particular, women's participation in all aspects of health care planning and service provision. To be able to do this effectively women had to gain sufficient information and knowledge about health and the health system and to develop new frameworks that better reflected their experiences of health and illness. The expression of women's wide dissatisfaction with the provision of health care required the combined effort and persistence of many, backed up by the systematic collection of data, before it was even acknowledged and still later followed by government and health service provider action to try to address some of the numerous issues raised. This, however, has not deterred the women's health movement from continuing to encourage women to comment on, complain about and participate in health decision making.

Australian community health movement

Running a parallel course to the consumer movement, the self help movement and the women’s movement in time, was a renewed interest and activity in community health care from the 1970s onwards. Although government and health worker driven, rather than consumer initiated, the community health movement in Australia did contribute to and advance the consumer health movement in a number of ways: through the promotion of the social view of health, encouragement of community participation in decision making about health care provision, emphasis on health promotion and disease prevention rather than illness treatment, and a focus on social justice and equity issues in relation to health and health care. The Community Health Program (CHP) was the first concerted attempt to bring about some changes in the provision of health services, in Australia, that could be said to be consistent with the ideas of the social view of health.12 The CHP had three main objectives: to refocus the health system on prevention of disease rather than treatment; to provide primary health care through means other than private general medical practice; and to increase community based care.13 In the first years of the CHP, 1973-76, over 700 projects received funding through the CHP, including a range of different services such as the women’s shelters that had not previously been linked to health services, let alone financed through the health budget.14

The formation of the Australian Community Health Association, in 1980, provided a formal mechanism for the community health movement to lobby government more effectively on health issues. Community health service workers often saw themselves as advocates for consumers and consumer groups within the health system. The notion of “healthy public policy” was promoted by the Australian Community Health Association

12. This program was initiated by the Commonwealth government, as part of the extensive platform of social reforms introduced by the short lived Whitlam Labor government in 1973 after 20 years in opposition.
and a few schemes which sought to implement the healthy public policy ideas at a local level, such as the healthy cities projects, received time limited government funding.\textsuperscript{15}

The CHP, however, has been subjected to a range of policy shifts and funding cuts over the years with changes in governments and has only ever commanded a very small proportion of the overall health budget.\textsuperscript{16} The original objectives of the CHP were probably rather ambitious in the light of the pervasive opposition from both health bureaucrats and health professionals. In many instances, individual treatment models were simply transferred from hospitals and institutional settings to community health settings.\textsuperscript{17} The opportunity given to consumers of some community health services to have a say in community health service provision provided a model for all health services. The inclusion of more diverse programs in the health sphere helped to highlight the place of social factors in maintaining health and the narrow focus taken by most mainstream health services.\textsuperscript{18} Many community health services remain some of the most ‘consumer friendly’ of health services by the way services are provided, and through their support and encouragement of consumer groups and consumer participation. While the latest guidelines for the accreditation of community health services and programs continue to reinforce this emphasis, restructuring of health systems, often incorporating community health services back into mainstream hospital based health structures, and limited budgets may evoke a more conservative response that is less inclusive of consumers in the future.


\textsuperscript{16} Palmer & Short, pp110-113.

\textsuperscript{17} Raftery, p30.

\textsuperscript{18} These funding arrangements have also been criticised for contributing to the 'medicalisation' of social problems where health experts had claimed a legitimate involvement in a range of social services and issues.
Patients' rights movement

The civil rights movement of the 1960s had drawn attention to the lack of rights afforded to certain groups in society. Within the area of health service provision there was growing discontent amongst some consumers about both the treatment they had received and the way they were treated by health service providers and the law. This was particularly so for those consumers of health services who were automatically deprived of their normal rights as citizens when confined to institutional care.\(^{19}\) Gaining recognition and acceptance of the need for explicit statements of patients' rights from health professionals and the public were perhaps most controversial in the mental health area. The abuses of people confined to mental institutions were well documented and a source of repeated government inquiry, even as recently as this decade.\(^{20}\) By the 1970s, with the advent of the 'deinstitutionalisation', people who had spent time in psychiatric institutions became more vocal about their experiences and, with the greater movement between community and institution, the institutions can under closer outside scrutiny.\(^{21}\) The New York Mental Patients' Liberation Project explained

"we have drawn up a Bill of Rights for Mental Patients - rights that we unquestioningly should have but rights that have been refused to us. Because these rights are not legally ours we are now going to fight to make them reality".\(^{22}\)

Their Bill outlined fifteen rights such as the right to be treated with decency and respect, the right to give informed consent, the right to decent living conditions and to retain one's own personal property, the right not to be abused, and the right to refuse to participate in research. In another example of a Bill of Rights, developed around the same time by a

\(^{19}\) For example, in South Australia, prior to the mid-1970s, people admitted to psychiatric hospitals were no longer eligible to vote or apply for social security benefits. They became totally dependent on the institution for their basic needs.

\(^{20}\) For instance, in Victoria there had been numerous boards of inquiry or parliamentary committees into psychiatric services this century (20th) to the early 1980s. For an indepth discussion of these issues see G. Lipton, "Politics of Mental Health: Circles or Spirals", Australian and New Zealand Journal of Psychiatry, vol.17, 1983, pp50-56.


woman living in California, it was stated “the goal of this bill of rights is to assist patients
in finding their way toward the status of full citizenship”.23

Much mental health legislation in Australia was reviewed and revised in the late
1.970s and early 1980s, incorporating greater attention to the rights of consumers using
mental health services, particularly their legal rights in relation to detention and custody in
psychiatric institutions.24 But these reforms did not go as far as consumers were
advocating in their bills of rights, and as recently as 1993 the Australian Human Rights
Commissioner stated that “both the form and substance of the [current] legislation work
against the assertion of rights by people with mental illness”.25 The setting in place of
equal opportunity and anti-discrimination legislation across the various Australian
jurisdictions during the 1980s advanced the recognition of the rights of citizens’ generally
and in this environment the focus on the need to better identify and explicitly state the
rights of consumers using health services gathered momentum. Various statements of
rights of health consumers and, more recently, health consumers’ charters have since been
developed by consumers, governments and service providers. (Discussed further in ch5.4.)

Self care movement

For many episodes of illness people do not seek out or receive formal medical care
but rely on self care and alternative therapies instead.26 The European Office of the World
Health Organisation, in making a distinction with self help, defined self care as

148. The bill entitled "A Bill of Consumer, Tenant, and Human Rights for Citizens using Outpatient
Mental Health Services" included rights such as: to refuse treatment and/or services, to confidentiality
of personal records, to utilise fully all economic rights and benefits, to a humane psychological and
physical environment, to maximum freedom, mobility and independence, and to information.
"unorganised health activities and health related decision-making by individuals, families, neighbours, friends, colleagues at work, etc; it encompasses self-medication, self-treatment, social support in illness, first aid in a ‘natural setting’, ie the normal social context of peoples everyday lives... The mos: important feature distinguishing it from self-help is that it does not imply purposeful organisation and is often provided on an ad-hoc basis in intimate settings".27

While health professionals have often regarded self care as an adjunct to their own services, and only to be undertaken with their guidance and advice, the care that people provide to themselves, or to others in their families, has often been fundamental to the management of health problems. The difficulties experienced accessing health services and limited treatment options available, even in quite recent times, has encouraged many to rely on their own resources in health matters, although this is rarely acknowledged by the health system or taken into consideration in health service planning. However, the notion that individuals should be held responsible for their own health and must take active measures to prevent illness and disease is prominent in Australian society.28 Much government sponsored health promotion activity in the last decade has centred on health education encouraging individuals to make changes to their lifestyles that might reduce their risk of ill-health.

Health treatments based on constructions of health and illness, other than the western biologically orientated medicine dominant across the Australian health system, have always been available to those willing and able to pay and community interest in what have been called the alternative therapies has risen.29 Bakx suggests that people may be turning away from “biomedicine” to alternative therapies (he uses the term folk medicine) for three reasons:

“Firstly, it [biomedicine] has culturally distanced itself from the consumers of its services; secondly, it has failed to match its propaganda promises with real

29. For example Palmer & Short note “ ‘Alternative health care’ is an umbrella term that applies to those types of health practices that exist outside the orthodox health care system”, but qualify this statement by discussing how changes over time in government policy influence what are considered orthodox and alternative therapies. Palmer & Short, pp155-158. There is also informal evidence that many general practitioners now offer elements of these therapies in the course of their work.
breakthroughs in combating the diseases created by modernism itself; thirdly, patients have become further alienated by negative physical and psychological experiences at the hands of biomedical practitioners themselves.30

Some conventional health practitioners have incorporated alternative therapies into their practices, such as the use of vitamins and acupuncture, and research findings on alternative therapies have begun to appear in academic and professional journals.31. As well as presenting different ideas about the treatment and prevention of illness and disease, the increased knowledge about, and availability of, alternative health care has offered a greater choice of health practitioner to some consumers.

4.3 THE COMMON ELEMENTS CHARACTERISING THE CONTRIBUTION OF THE CONSUMER MOVEMENT IN HEALTH

4.3.1 Promoting the Social View of Health

For many consumers, the impact of illness on their daily lives is much greater than the biological processes that are the focus of most illness treatments given. The social view of health offers a way of conceptualising health that better reflects their experiences than the previously little challenged biomedical view of health care prevalent throughout the health system. The notion of the social view of health is derived from the definition of health used by the World Health Organisation from 1946 onwards: health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.32 While this definition of health has been criticised for being too broad and all encompassing, it does allow the conceptualisation of health as "a multidimensional (holistic) phenomenon, with multiple determinants,... primarily defined by its positive (well-being) rather than negative aspects".33 This conceptualisation, emphasising the

31. Bakx, p34.
enhancement and maintenance of health, rather than the treatment of illness and disease, legitimised ways of working and providing services that have not traditionally been seen as relevant or appropriate within a health system dominated by the bio-medical paradigm.

From the outset, the women's health movement adopted a holistic approach to health that emphasised the importance of viewing women as whole people in the context of their social environments, rather than "the fragmentation fostered by contemporary specialist technical medicine". Broom notes that "feminist theory affirms the social model of health and actively rejects the limitations of the traditional medical model". This matched the developing ideas about the social view of health that were being increasingly adopted by many of the community health services, established in the early 1970s, as the basis for their activities.

The social view of health gained greater credence worldwide with the Declaration of Alma Alta, arising from a WHO conference held in 1978, which contained ten statements, including the view that health is a fundamental human right; good health is dependent on basic human needs being met; inequality in health status is unacceptable; and "attainment of the highest level of health is an important world wide social goal". Primary health care was seen as the stepping stone for achieving the actions required by the Declaration. Five concepts were identified as underpinning primary health services: services were to be available to all and provided according to need; services were to be affordable for the local community and culturally appropriate; services focussed on health promotion and disease prevention were to be offered in conjunction with curative and rehabilitative services; services were to encourage community involvement in planning and implementation; and health service activity was not to be confined to the health sector but must work in collaboration with other sectors of development. The Alma Alta

34. Broom, p52.
Declaration was the foundation for the proposal that a global strategy, *Health For All by the Year 2000*, be developed and implemented worldwide.\(^3\) The Health for All by the Year 2000 strategy, taken up and promoted by the WHO, was said to challenge “member states to achieve a level of health where all citizens were capable of working productively and participating actively in the social life of the community”.\(^3\) It required a commitment from Australian governments to improve the health of the Australian population, particularly amongst groups where identified health inequalities existed.\(^4\)

Eight years later, another WHO conference added impetus to the focus on a broader social view of health with the development and ratification of the *Ottawa Charter*.\(^4\) The Charter reiterated the need for commitment to the principles of social justice and equity for the achievement of health and that action to improve the health of the community should focus on five areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orienting health services.\(^4\) Community participation was identified as an strategy integral to all the areas for action. The implementation of strategies in accordance with the Charter, proved challenging, particularly those of community participation and intersectoral collaboration.\(^4\)

Both the Alma Alta Declaration and the Ottawa Charter shifted the emphasis, away from treatment of illness and disease, to action directed more specifically at the promotion of health and the prevention of illness and disease. Health promotion became so much of a buzz word in the 1980s that a 1993 National Health Strategy document declared that “Australia has an enviable record of effective health promotion to improve and maintain

---

39. Davis & George, p376.
41. This was the first International Conference on Health Promotion, held in 1986 in Ottawa, Canada.
42. Palmer & Short, p192; Davis & George, p377.
the health of its population". However, responding to broader social justice issues evoked by the social view of health has proved to be less attractive to many of health services than providing health education and individual services and the temptation to restrict activities to local concerns and individual change has been great. The political awareness and activity necessary to achieve social and health policy change required different knowledge, skills and methods of working which were often lacking amongst health workers, even community health workers, particularly in the early years. Some services did manage to take on agendas that encompassed broader issues.

The social view of health, by offering a construction of health and illness that went further than that provided by the bio-medical paradigm, has encouraged a focus on the multiple, tangible outcomes to consumers of their ill-health and treatment experiences inclusive of the perspectives of consumers rather than simply based on the perspectives of health service providers.

4.3.2 Valuing Experiential Knowledge

The experiential knowledge held by consumers about health, health care and the health system was seen as particularly important by the movements. The sharing of experiential knowledge provided different, often new, information about the experiences of illness and accounts of the actual practices of health professionals. Consumers were able to compare experiences and develop a good sense about what to expect from and what to ask for in relation to their health care. The value placed on experiential knowledge by peers increased some consumers’ confidence in expressing their opinions about the health system and what would most meet their needs. The combined knowledge held by the groups

45. Palmer & Short, p192.
46. See, for instance, Alexander for analysis of one community health centre's struggle to implement the goals of community participation and intersectoral collaboration.
within the movements strengthened the credibility of the consumer position in questioning health professional practice and structures and in making complaints.

While many of the early consumer groups and women's groups had a focus on health issues, the increasing importance placed on 'expert' knowledge about health matters, since about 1900, had devalued the reliance on sharing knowledge accumulated from the health experiences of family, friends and neighbours. The experiential knowledge of consumers has often presented quite a different picture to that of health service providers and the mismatch between the two has often resulted in considerable dissatisfaction on the part of consumers. Because health and illness touches all aspects of a person's life, everyone has some knowledge about health and illness. People pass on information and knowledge about their experiences of illness to others and adapt to their own needs the information they, in turn, receive. However, the status afforded this knowledge by health 'experts' has been minimal, and elaborate effort has gone into devising numerous diagnostic tools to be used in making medical diagnoses so that reliance on descriptions of symptoms provided by the person concerned is diminished. Regardless of the little value that health professionals place on the individual's beliefs about health, illness and cure, these personal beliefs, influenced by age, gender, cultural and social environments and previous experience of the health system, ultimately determine the steps taken by the individual in resolving their health problems.47

The self help groups, in particular, have acknowledged the individual's experience as valid and argued that this experience, combined with other individuals' experiences, provides an important source of information about the illness, treatment received and the health care system: "self help groups offer consumers and providers a unique form of knowledge based on collective experience".48 As groups of people organised around a specific health problem, issue or idea, their collective knowledge and views of the

47. Davis & George, pp240-247. Davis & George summarise a diverse range of literature to this effect.
intricacies of that health problem/issue/idea grew substantially. This was especially evident in areas where there was some controversy about the usual medical treatment used and considerable consumer dissatisfaction with the process of medical care, such as with mental illness and cancer. Through self help groups, consumers have been able to compare their experiences and begin to define what might constitute an acceptable level of care from a consumer perspective, which could then act as a gauge for others to assess their own experiences. The women’s health movement also placed a high value on the experiential knowledge of women on health matters. In the 1960s and 1970s, for example, women’s confidence in understanding their own bodies was re-established through the consciousness raising activities of women’s groups, the formation of self help groups and the publication of books, such as the Boston Women’s Collective’s Our Bodies, Our Selves.

This “experiential knowledge” has been described as “concrete, specific, pragmatic, holistic and orientated to here-and-now action”. It has proved to be particularly useful to consumers in deciding whether they have legitimate grounds to make a complaint about aspects of the care they have received. Through the sharing of experiential knowledge consumers have gained confidence in the validity of their own interpretation of their experiences. This combined knowledge of members has enabled groups to identify gaps in services and to take an advocacy role on behalf of their membership in a variety of ways, including representation on boards of management or advisory groups.

4.3.3 Questioning Information from Professional Sources and Health Care Practices

Obtaining information about all aspects of the health care system was regarded as crucial by the groups and movements to be able to advocate for change and to assist individual members. There was questioning of the information put forward by health professionals; how it was obtained, by whom and whose interests did it serve. The

women’s health movement, in particular, challenged the authority of health professional generated information and the professional monopoly of health information.

The need for research to focus on and reflect women’s experience of health, illness and disability was emphasised and actively pursued by the women’s health movement. Aggregated data can too easily hide health issues of importance to particular consumer groups. Re-examining health statistics disaggregated by gender revealed a divergent picture of the morbidity and mortality of women in comparison to men. It was also noted that much of the health research was based on data collected from predominantly male participants. The drive for the improved collection of specific data about women’s health has been influential in reinforcing the necessity for attention to be given to factors pertaining to the social environment, such as gender, age, ethnicity and social class, when examining and planning services for the health of a community.

Highlighting the different experiences of health, illness and disease by women and men, through sound research, the women’s movement has been able to challenge many professionally held beliefs, and to gain greater acknowledgment of the importance in recognising the diversity of health experiences amongst different groups within the community. How health and illness are perceived will, in turn, influence not only health

50. For example, the National Women’s Health Policy makes specific recommendations on this point. Commonwealth Department of Community Services and Health, National Women’s Health Policy: Advancing Women’s Health In Australia, Report presented to Australian Health Ministers in Burnie, 21 March 1989, AGPS, Canberra, 1989, pp72-73, & p82, & p100.
52. The appropriateness and usefulness of current health research methodology to women have been questioned, see for instance A. Oakley, Essays on Women, Medicine and Health, Edinburgh University Press, Edinburgh, 1993, Part IV, ch16-18. In particular, there has been considerable debate about the participation of women in randomised control studies: the Australian Public Health Association Women’s Health Sub Committee held a major workshop on this issue at the 1994 Annual Conference of the Association. Similar issues have been raised from within American epidemiology by N. Krieger, “The Making of Public Health Data: Paradigms, Politics and Policy, Journal of Public Health Policy, vol.13, no.4, 1992, pp412-427.
care service utilisation but also perceptions about whether the health care provided has been appropriate and satisfactory. The treatment by drugs and hospitalisation of women diagnosed with depression, for example, have been strongly criticised for concealing and failing to address the underlying societal structures that have been seen to contribute to and reinforce depressive illness in women.\textsuperscript{54} It was also found that women use health care services more often and differently from men, and, in turn, have been treated differently by health service providers, particularly the medical profession. The stereotypical images of women as wives, mothers and 'homemakers' and of women's bodies as "inherently defective", for example, has been prevalent amongst even quite recent student medical texts.\textsuperscript{55}

The movements brought into sharp focus the importance of health care providers understanding and respecting different consumers' interpretations of health and illness. The focus on factors pertaining to women and their interaction with the health system, for example, clearly demonstrated that health consumers' experiences of, and treatment by, health service providers were not the same. This raised questions about access and equity for all consumers and drew attention to the relevance of services and the way services were provided to particular groups in the community. Increased questioning of professionally generated information by consumers and the exposure of some of the assumptions underlying this professional knowledge have opened the way for greater review of current professional practices and knowledge, using more diverse criteria to determine the appropriateness and acceptability of professional advice and actions.

\textsuperscript{54} R. Jaggard, "What have You Got to be Depressed About? You've Got Him, the Kids, the Dog, the Goldfish, the Car, a Sunbeam Steam Iron, a Whirlpool Washing Machine, a Hoover, a Part-time Job ... So Take a Pill or Something!" in A. Smith ed., \textit{Women's Health in Australia}, 2nd Edition, University of New England, Armidale NSW, 1992.

4.3.4 Sharing Information about Health and Health Care

The importance of sharing information about health and health care from the perspective of consumers has been well recognised by the various movements. In a number of instances, to aid consumer accessibility to health information, the groups and movements have produced their own information in an easily understandable format and often given away free. These publications discussed different treatments, provided information about services and systems, sometimes challenged conventional health interventions and outlined consumers’ rights in accepting health care. Consumers are encouraged to seek out health information and become better informed and involved in their own health care decision making.

The women’s health movement, in particular, has had a strong “commitment to questioning medical monopolies on knowledge and practice”.56 It was thought that the empowerment of women through information and education would reduced the reliance on the medical profession as the sole source of advice about women’s health problems.57 Women have been encouraged to demand sufficient information to make informed choices about their medical treatment and medical care. The importance of sharing information amongst all women and acknowledging the individual’s expertise in the management of her own health have been stressed. Many women’s health centres have set a precedent by giving women using their service full access to their clinical records.58

To be able to effectively take greater control over one’s health and health care the need for up-to-date and reliable information is critical. The government sponsored health promotion campaigns, often undertaken with private charitable organisations such as the Anti-Cancer Foundation and the National Heart Foundation, have reinforced the idea of individual responsibility for health. These campaigns have made some health information

56. Broom, p117.
58. Broom, Damned if We Do: Contradictions in Women’s Health Care, p115.
that was previously the province of health professionals more readily available and accessible to the public and encouraged individuals to take greater control over their own health but, generally, this is still to be done within the oversight of health professions, leaving health promotion and disease prevention firmly in professional control. The ability of individuals to influence or change deleterious social conditions and environmental factors harmful to their health is often overlooked in the suggestions that individuals’ take primary responsibility for their own good health.

The volume and diversity of the health information increasingly available to the public through the mass media has become overwhelming and, sometimes, conflicting.\textsuperscript{59} Health related messages appealing to individuals’ concerns about their own health and offering advice about what can be done abound in the media. While media definitions of what constitutes a health problem and the information presented on what might be done about it have been based predominantly on conventional health professional knowledge, the controversies surrounding some of the issues have also highlighted the current limitations of that knowledge.\textsuperscript{60}

The sharing of information about health and health care has contributed to the demystification of some aspects of health professional knowledge and health service provision, allowing consumers to make more informed choices about their own health care and to take a greater role in advocating for health services that are more responsive to consumers’ needs as identified by consumers themselves.

\textsuperscript{59} See N. Milio, \textit{Making Policy : A Mosaic of Australian Community Health Policy Development}, Dept of Community Services and Health, Canberra, 1988, ch7 & ch10 for an informative discussion of the role and influence of the media, particularly the Australian press, in the health policy agenda setting process.

4.3.5 Developing Statements of the Rights of Health Consumers

The notion that consumers have rights when seeking health care has been fundamental to much of the activity of the movements. The safeguards that had been set in place to supposedly protect consumers in their dealings with the health system and health care providers, such as health professional registration boards and the state/territory health acts, had been found wanting. The paternalistic way in which much health care was delivered had fostered a health system that did not place emphasis on consumers’ rights.

Health system routines and procedures were often for the convenience of those providing the services rather than those receiving it. Health care professionals were accountable to their peers or management structures rather than consumers. Many consumers felt denigrated and traumatised by the health care treatment and professional attitude they had been subjected too.\(^6\) The vulnerability of consumers when seeking health care made it even more necessary that consumers’ rights should be stated explicitly. The need for consumers to be informed about their rights was strongly advocated by consumers’ rights groups and consumer developed statement of rights were circulated.

The move towards gaining acknowledgment and recognition that those using health services did have rights had two aspects: the title of ‘patient’ should not deprive people of their civil rights; and the sensitive nature of health care required that certain specific rights apply and be made explicit to consumers using health services. Despite professional codes of practice and legal requirements, the actions of many health service providers left consumers feeling powerless to question them or complain, and basic respect due to consumers as human beings was not always forthcoming. As consumers became more aware of the ambiguous results of some medical treatments and the nature of some medical research, the appropriateness of professionals making choices for others without their knowledge and consent was challenged.

61. This perception is heard often at consumers’ meetings in Australia. For a concise, grounded account of what they experience (albeit from an English source) see D. Bateman’s story of his treatment for haemophilia throughout his life highlighting the personal trauma he experienced. D. Bateman, “The Good Bleed Guide: A Patient’s Story”, Social History of Medicine, vol.7, no.1, April 1994, pp115-133.
For years self help groups, consumer groups and the women’s health groups have all advocated vigorously for greater recognition of the individual’s rights in their interactions with health care systems. Advocates for the adoption of statements of patients’ rights believe that the statements encourage health professionals and health systems to increase their responsiveness to individual consumers and become more accountable for their everyday actions, although how to effectively enforce the rights remains unanswered. The right to complain and have that complaint resolved is seen to be integral to upholding consumer rights but health complaints mechanisms rarely have been ‘consumer friendly’. Even where a legislative base supports some consumer rights, such as in mental health or professional registration board legislation, it has been difficult for consumers to establish and argue their cases and obtain satisfactory resolutions. (See ch7.3.)

The women’s movement, in particular, has vigorously advocated for the recognition of the rights of women to give informed consent, participate in decisions about their own health, to be treated with respect and dignity, and to confidentiality when receiving health care. Having control over one’s own body was seen to be crucial to gaining control over one’s life. Women’s ability to control their own fertility spearheaded campaigns to change abortion laws and increase the availability of contraception heavily controlled by the medical profession: “the women’s health movement has sought to enable women to ‘reclaim control’ of their bodies and lives”.62 Restrictive medical practices in areas of concern to women, such as pregnancy and childbirth, have been challenged.63 Tragedies such as the situation in New Zealand, where a number of women were included in a research trial without their knowledge or consent, were seen as further evidence of the medical profession’s general disregard for women’s rights.64

62. Broom, Damned if We Do: Contradictions in Women’s Health Care, p147.
Statements of patients' rights have not been generated solely by consumers. In the USA, where the patients' rights movement was most prominent, the American Hospital Association had developed and adopted a statement of patients' rights by 1972. In Australia, some health organisations have developed their own statements of patients' rights and responsibilities, particularly after this became a requirement of health service accreditation, but the statements were not well publicised or widely used. More recently the notion of a consumer's charter proposed by governments, has added a new dimension to the development of statements of patients' rights. This has provided the latest impetus for consumer groups to coordinate their efforts to develop statements of rights that more truly represent the concerns of consumers. (See ch 5.4, ch 6.4.3 & ch 7.4.2 for further discussion of these points.)

4.3.6 Voicing consumers ideas about health and health services

Dissatisfaction with mainstream health services and unmet need have been key motivations in the establishment of and ongoing work of many health consumer groups. Such groups have supported individual members in expressing their complaints about the health services they have received and have advocated for a health care system that is more responsive to their group members needs and possibly the needs of many other consumers. However, the lack of cohesion amongst the health consumer groups has reduced the opportunities for the groups to challenge existing systems with a united voice on issues of common concern. Their diverse purposes, often compounded by small size and limited resources, and more recently enforced competition between groups for diminishing

government financial support, have often acted as a barrier to the groups forming a ‘peak body’, as discussed in the previous chapter, to present a united voice.67

Advocating for the interests of their members, and the interests of others in similar situations, to be better understood, and their health needs better met, has been an important function of the self help groups. The actual nature of the self help group has determined the extent of the advocacy undertaken in challenging current systems. In the same way as seen in the broader consumer movement, self help groups may reflect radical or conservative agendas in relation to social change.68 In particular, self help groups have focussed attention on the relationship between the professional health service provider and the user of the service, including the appropriateness of some professional skills and attitudes. Stewart suggests that professionals are often ill equipped to take on the role most preferred by group constituents for professionals to take: that of consultants to a group. She concluded that “clearly, educational preparation is needed to enable health professionals to embark on the essential transition from provider to partner with self help groups in practice”.69 Reliance on professional involvement has been seen to be necessary by some groups because of the difficulties in obtaining funding and support from sources outside the health system. But this, in turn, has made it harder for the groups to take a critical stance in regard to existing health service provision and has contributed to the vulnerability of self help groups in conforming to service provider demands.70

The consistent exclusion of women from positions of power in the hierarchy of health service provision, until very recently and then still in very limited numbers, has meant that the control of the provision of health care services has predominantly been in

67. In South Australia, for example, this point is particularly pertinent to the self help groups in the mental health area who have not formed good networks with each other. The lack of a credible peak body representing the groups’ interests as a unified front has left the groups vulnerable to professional and bureaucratic interference, competition between the groups for public support and funding, and consumers without a prominent advocate.


69. M. Stewart, “Professional Interface with Mutual-Aid Self Help Groups: a Review”, p1156. This is also suggested in Kearney’s article.

70. Kearney, p31.
male hands that have not necessarily been sympathetic to women’s health concerns and needs, or, indeed, to the special needs of minority groups generally. The solution, in part, was seen to be health services set up and controlled by women. The women’s health centres, first established in the early 1970s, some with funding through the, then, new Community Health Program and all with many hours of voluntary labour from the women committed to founding them, experimented with new and innovative ways to provide health services that were more accommodating to women. Although many of the original centres have closed, or now operate in a different form, women’s health centres continue to provide a range of health services to women throughout Australia. The value of separate services for women has highlighted a similar need for separate health services for other groups in the community not served well by mainstream services such as migrants, Aboriginal people and industrial workers.

With a commitment to skill sharing and collective or participatory management, the women’s health centres provided alternative models to the hierarchical management of mainstream health services, which have been adopted, to some degree, by other services such as the community health centres. The focus on teamwork further lent itself to the greater sharing of professional skills and working with community groups. The close interaction that occurred between some health workers and consumers in the community group environment, where the emphasis on ‘therapy’ was minimal, gave health workers unique insights into the concerns of consumers and their experiences of health services, encouraging greater cooperation and partnership between consumers and providers, which also challenged the well established dependent relationship of the health consumer on the health service provider.

71. See Broom, Damned if We Do: Contradictions in Women’s Health Care for frequent references to this point.
73. This blurring of roles has also been a source of considerable professional conflict.
As the majority of health consumers continued to receive a large percentage of their medical care from mainstream health services, simply increasing the number of specialists health centres was not seen by the various movements as the only way to overcome the problems experienced by health consumers when using mainstream health services. For example, “improving the mainstream for women, both as patients and as staff, is one of the important goals for the women’s health movement”. From the women’s health movement perspective one measure of improvement to mainstream services would be the degree to which women are listened to and participate in decision making about all aspects of health care. The women’s health movement has been quick to point out, though, that women were not an amorphous mass all to be treated in the same way. As well, unless the self reported health concerns of women are taken seriously, women will not perceive that health systems are truly responsive to their health needs.

The groups that grew out of the movements argued that the organisation of the health system had to better meet the needs of consumers and set out to demonstrate how this might be done. Many of the direct service provision activities undertaken by the groups demonstrated alternative ways of providing services and the viability of new services. Some filled gaps in mainstream health service provision or provided specialist health services. Consumers were encouraged to comment on and complain about the health services they had received or that they wanted but were not available. Mechanisms were sought whereby health systems had to listen to the voices of consumers, often expressed collectively through the groups. While the health services did not necessarily

75. For example the need to develop specific health strategies for women from identified groups such as C. Alcorso & T. Schofield, *The National Non-English Speaking Background Women’s Health Strategy*, prepared for the Commonwealth-State Council on Non-English Speaking Background Women’s Issues, AGPS, Canberra, 1991.
76. Redman and colleagues, for example, found in a community survey that overweight and mild psychological problems were of most concern to women but that neither were specifically included in national health policy or health service provision initiatives. They also reported that a quarter of women surveyed expressed some dissatisfaction with the medical care they had received. S. Redman, D. Henrikus, J. Bowman & R. Sanson-Fisher, “Assessing Women’s Health Needs”, *The Medical Journal of Australia*, vol.148. 1 Feb, 1988, pp123-127.
want or act on the consumer feedback they received, the era of uncritical acceptance by consumers of health professionally determined advice and services has receded into the past.

4.3.7 Participating In Decision Making About All Aspects Of Health Service Provision

The movements stressed that the consumers' role went further than commenting and complaining to include active involvement in all aspects of health decision making. The various consumer groups had a firm commitment to the idea that making health care decision at any level should not be the exclusive domain of health service providers and government departments. The highly unequal relationship that existed between consumer and provider at an individual level in health care exemplified the situation. Consumers had little information about or control over resources. For this to change consumers had to be able to participate in health care decision making at all levels of the health system. Consumer participation in all aspects of health care was advocated. The proposition that health decision making should be undertaken as a partnership between consumers and health care providers was put forward, although some of the more radical groups maintained that consumers should have complete control.

For consumers and health service providers alike, the ideas of consumer and community participation in the health area have been influential. These terms are now commonly heard across the health arena, describing a diversity of activities undertaken by consumers in relation to health, from attending a public lecture on a health issue to involvement on boards of management, and in policy development. For two reasons it is useful to explore further how consumer participation has evolved and how it has been translated into the day-to-day activity. First, the right for consumers to actively participate in all aspects of health care has been a major focus of the consumer movement in health, and the different ways and means of achieving participation highlighted. Pursuing a
complaint has not generally been recognised as part of this participatory activity, although it is well recognised as an important consumer right. A closer, albeit brief, examination of the goals, scope and methods of consumer participation, as it is currently defined, will assist in assessing whether complaints mechanisms, not only provide for the right to complain, but also provide another participatory mechanism for consumers in the health area. The second reason for examining the development and implementation of the notion of consumer participation is for the lessons that may be revealed that, in turn, offer insights into the barriers to reform of complaints mechanisms.

It is important to note at the outset that, as was noted for consumer groups, much of the analysis of consumer participation activity has been undertaken by professionals based on their own criteria and sense of what is valuable. Consumer perspectives originating from consumer generated research are not well recorded, at least not in the academic and professional literature. Thus a particular emphasis is placed on considering whose interests are being served by the different interpretations of consumer participation. The term ‘consumer participation’ is used in this discussion, based on the broader and rather fluid interpretation of ‘consumer’ outlined in chapter three, in preference to other terms. However, the literature about public, citizen, consumer and community participation offer insights that enhances the understanding of consumer participation, regardless of the specific term used, and these sources have provided the basis for developing the following discussion.77

77. The terms community participation and community development have, at times, been used interchangeably in the professional and academic journals. Both include components of the process of engaging individuals and communities in activities to increase self-reliance and, in the health setting, promote better health outcomes. Community participation activities in the health area often rely on community development activities to enhance community interest in the potential benefits of participating and, in turn, community development strategies are based on community members participating. However, the term community development is more usually associated with a particular approach to practice used by professionals working with communities. The principles of the community development approach certainly incorporate the notion of community participation, but community participation activity does not only occur within the community development framework.
Descriptions of consumer participation

While a specific definition of participation may be elusive, there is agreement on some of the elements of consumer participation. Rifkin suggests that the definitions of community participation include several common elements: action; the right to make choices; and the prospect that the choice made could be effective. She goes on to say that “community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs”. This description would seem applicable to consumer participation in health care where the concept of geographic area is substituted by other commonalities, such as a particular disability or use of a specific health service. The idea that participation requires action that is more than being a passive recipient of services is noted by other authors. Brownlea describes participation in terms of getting involved or being allowed to become involved. Bracht and Tsouros go further in detailing that the involvement needs to be voluntary and it may include both formal or informal activities.

While Rifkin’s description envisages participation as taking place within the group context, other authors are less insistent on the group element. McEwen’s use of the term, for example, is based on individual action directed towards enhancing the health of the individual. McEwen sees participation as encompassing three primary concepts: individuals taking an active role in their own health care; individuals becoming better informed about health matters and performing tasks seen as the province of the health professional; and individuals wanting to be part of and have some responsibility for the decision making processes of health service provision and policy development. The two

79. Rifkin et al., p933.
82. McEwen et al, p2.
notions of individual action and group action are combined in the World Health Organisation’s description, as outlined in the *Alma Alta Declaration*,

“community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community’s development.”

Importantly these descriptions emphasise that, in the health area, community participation is a process, whereby individuals and communities gain at least some control over the other processes of needs identification and decision making.

**Consumer participation and government policy**

Although public participation through the election of representatives to parliament is a fundamental ideal of democratic society, the internal mechanisms of most government authorities have often been unknown and unfathomable to the general public. The advice of ‘experts’, either bureaucrat or professional, has been regarded as at least sufficient, and usually superior, in setting government procedures, protocols and determining policies. The climate of social change of the 1960s fostered an increased call for greater public participation in the decision making processes of governments. A number of explanations can be identified to explain this “rise of the ideology of public participation”, according to Bates, including: the idea that participation was a way for citizens to protect and promote their own interests in an era where it was held that governments could no longer be trusted to act in the interest of the public; the promise that increased participation would bring greater opportunity to monitor the provision of services and to act as conduit for public concerns about what services were needed and desirable, as government services

---

extended into a multitude of areas of social activity; the idea that public participation was a critical part of the workings of a modern democratic society with the increased diversity and complexity of contemporary communities; and increased credibility amongst professional groups across a range of disciplines, of the notion of public participation as a legitimate activity.\textsuperscript{85} Greater consumer participation had the potential to increase external scrutiny of government actions and ultimately to increased the accountability of public sector decision making and service provision to the broader community. However, Bates suggests that in Australia “demands for public participation have been less vocal than in Britain, and far less active than in the United States” and “the participatory mechanisms available to Australians are correspondingly meagre”.\textsuperscript{86}

Ideas about the value of participation in community life and ideas about the attainment of better health outcomes for those participating in such activities became intertwined in the health context. The policies and strategies of the World Health Organisation (WHO) called for supporting community participation within the health arena; justifying this position by noting that improvements to health did not rest purely on increasing health service provision by expert health professionals but could also be attained through equitable distribution of resources and “by the involvement of beneficiaries in decisions about care based on the principle of participation”.\textsuperscript{87} The idea that community participation was an integral component of health care provision gained further currency with the Declaration of Alma Alta, in 1978.\textsuperscript{88} Thus participation was seem not only to contributed to good health, but good health, in turn, enabled participation in community life.

Although both WHO documents encouraged working with, and the participation of communities, how this was interpreted and achieved (if at all) varied enormously, leading

\textsuperscript{85} Bates, pp12-17.
\textsuperscript{86} Bates, p21.
\textsuperscript{87} Rifkin et al., p931.
\textsuperscript{88} This declaration was issued by an International Conference on Primary Health Care, sponsored by WHO and UNICEF, and held in Alma Alta. (See also ch1.2.)
to questions about the goals, scope and nature of participation activity and how this might be assessed and evaluated. Although largely driven by service providers, the emphasis placed on community participation by the new public health movement, discussed in chapter one, led to some groups of service providers forming alliances with consumer groups and advocating for greater consumer involvement in all levels of health care decision making. Government policies in the health area began to include mention of consumer/community participation.\textsuperscript{89} The \textit{Better Health Commission} set up in 1985, for example, stressed community involvement, along with a focus on illness prevention and health promotion, as the cornerstone of the new directions envisaged for federal health policies at the time.\textsuperscript{90} Participation, it was stated, involved “information dissemination and sometimes a degree of influence over professional and governmental agencies” and it was also tentative linked to consumer rights.\textsuperscript{91} The ideal of community participation in health decision making was at least kept alive by the \textit{Health For All} Committee report produced several years later in 1988, although the major focus of the report was on identifying specific goals and targets for decreasing the incidence and prevalence of illnesses said to be of greatest concern to the Australian population (the illnesses identified reflected a health service provider orientation).\textsuperscript{92} A number of other documents, produced around this time, at the state government level, included the notion of community participation.\textsuperscript{93}

\textsuperscript{89} For example Commonwealth Department of Health, \textit{Health Care and the Consumer}, a paper prepared by the Policy and Planning Division, AGPS, Canberra, January 1985.


\textsuperscript{91} Better Health Commission, p74.

\textsuperscript{92} The Australian Health Ministers’ Advisory Council, in early 1987, established the Health Targets and Implementation (Health For All) Committee to develop a set of health goals and targets for Australia for the Year 2000, building on the work of the Better Health Commission.

\textsuperscript{93} A good example is the \textit{Primary Health Care Policy}, adopted by the South Australia Health Commission in 1989. The strategic direction document that followed the policy document, stated, as one of the principles necessary for the improvement of health, that “community members and consumers are involved in decision making about their own health care, conditions which affect their health and in the planning, development and control of health services and health policy... Community participation requires adequate resources, support, information and recognition”. South Australian Health Commission, \textit{Priorities for Primary Health Care in South Australia}, A Summary Statement of the SAHC’s Primary Health Care Policy & Strategic Directions Documents, prepared in conjunction with the Primary Health Care Policy Implementation Steering Committee, SAHC, 11 Hindmarsh Square, Adelaide, August 1993, p5.
Over the past few years, though, there has been a subtle change in the way that community participation has been portrayed, and subsequently linked with the new catch phrase in the health sector: strategic partnerships. Thus, the 1993 report reviewing and revising the national health goals and targets refers to “developing coalitions of interest involving communities, government and non-government organisations in the formulation and common pursuit of individual targets” and “in developing partnerships in decision making between professionals and their clients or patients”.94 Reference to consumer participation in government planning and decision making processes has not just been limited to committee and program reports but has also been included in various legislation and policy documents, for example the 1995 Health Services Bill proposed for SA and the 1992 National Mental Health Policy.95 However, in the economic and politically conservative climate of managed care, user pays and privatisation, it is questionable whether the intent behind the inclusion of these statements is really to encourage a decentralisation of health care decision making, giving greater control to local communities. The current direction of government policies suggests a move away from the all encompassing idea of consumer participation, to that of more limited partnerships and coalitions serving particular interest groups. (See also ch6.2.)

Goals of consumer participation

The perceived goals of consumer participation reflect the diversity of activities that are termed consumer or community participation. Lack of adequate goal definition is, however, one of the weaknesses of current participation activity and compounds the imprecision in clarifying outcomes that is often associated with consumer participation.

Increasingly, though, the literature on participation in the health field reveals a number of consistent themes suggestive of some consensus about the goals of participation. A frequently mentioned goal of participation is to provide community members with opportunities to express their “voices”, justified by the democratic right for all to express their opinions. As this can be a difficult thing to do, particularly for the more disadvantaged members of society, “it becomes important to create channels through which the public voice can be expressed easily”. However, being able to express one’s views does not necessarily result in change or action immediately. The idea that an outcome of consumer participation will be some action or change that better reflects the consumers’ expressed views, is widely held and reflects Rifkin’s notion of the elements of participation (discussed earlier) and in Bracht and Tsouros’s statement that the purpose of participation is to bring about “planned change or improved community life, services and/or resources.”

A further goal of participation has been to provide a mechanism for increasing government accountability. The National Health Strategy paper, Healthy Participation, suggests

“the process of public participation in health care decisions, coupled with accountability through providing information about the links between health interventions and outcomes, can assist in developing an efficient and effective health system”. The perspective here is that information about services provided by consumers through participatory activities, if acted upon, has the potential to improve the relevance and quality of the services. Participatory activity need not just be reactive; public involvement in government processes opens up these processes, and increases the likelihood of uncovering

97. Bates, p18, original emphasis.
98. Bracht & Tsouros, p201.
what is being planned, placing consumers in the stronger position of being able to be pro
active. Another goal of participation, and perhaps the hardest to achieve, has been the
transfer of decision making power to consumers from the ‘experts’. Significant consumer
involvement in decision making processes has been identified by some authors as a
fundamental component of participation. Brownlea suggests

"there is a strong ideological view that those who are affected by the decisions
should at least have an input into the making of those decisions, not simply in a
tokenistic fashion but in a real sharing of power".

Goals of participation can apply at the individual level. The notion that
participation is “good for the participants” and “enriching the individual” and will
ultimately enhance health is a consistent theme through the literature, particularly in service
provider reports of participation. To this end, the goal of participation may be for
individuals to be involved in decisions about themselves, such as the selection of the
treatment to be used for a chronic illness. An additional goal may be for individuals to
acquire new skills through the participation process. Rifkin suggests that participation
helps individuals and communities to help themselves. Thus participation becomes an
end in itself rather than only the means to an end.

Government and service provider ideas about the goals of participation disclose
quite a different orientation. For example, the goals may not be about the sharing of
decision making power but rather about gaining support for decisions already made,
assessing the acceptability of possible future decisions and seeking legitimisation of
decisions made elsewhere. Similarly, the expression of consumer voice may be seen as a

101. S. Arinstein, “A Ladder of Citizen Participation in the USA”, American Institute of Planners Journal,
102. Brownlea, p606.
103. Brownlea, p605 & p607. Consumers who have participated sometimes present a different picture; for
example, H. Bastian’s remarks about her work with the Maternity Alliance in a seminar to the
Department of Community Medicine, University of Adelaide, 6/6/95.
104. Verity & Tesoriero, p100.
105. S. Rifkin, Health Planning and Community Participation. Case Studies in South-East Asia, Croom
way to reduce negative feedback and complaints by channelling the dissenting voices into a controlled direction.\textsuperscript{107} Greater compliance by consumers with a desired stated outcome may also be a goal; for instance health promotion programs seeking predetermined individual lifestyle changes often stress that individuals participating in the decision making process of how lifestyle changes could be achieved are more likely to comply with the final program devised. Another goal may simply be to provide information and educative programs.\textsuperscript{108}

\textit{Consumer participation activity and health service planning and decision making}

A wide range of models and frameworks have been developed for considering consumer participation activity and to try to encapsulate the scope and methods used. Again these reflect the ideological assumptions underlying ideas about participation. Verity and Tesoriero maintain that, from a structuralist perspective, community action and gaining community control of the decision making processes become paramount; from a pluralist perspective consultative processes and advocacy through interest groups are the priority; and from a consensus perspective education and consultation are preferred.\textsuperscript{109} These different perspectives can be found across the spectrum of consumer participation activity in the health area and ultimately determine the methods employed by various groups, whether consumer, government or service provider.

Activities aimed at increasing control by consumers of the decision making processes is perhaps the most controversial of the goals of participation. Consumer control ranks at the top of Arnstein’s, now well known, ladder of participation, developed in the late 1960s.\textsuperscript{110} Alternatively, information and consultation processes are categorised as tokenistic participation and therapy as non participatory. Using Arnstein’s model ‘real’ participation is only achieved by a redistribution of the power held by the ‘experts’ (service

\begin{flushleft}
\textsuperscript{107} Verity & Tesoriero, pp100-101.
\textsuperscript{108} Bracht & Tsouros, p207.
\textsuperscript{109} Verity & Tesoriero, p94.
\textsuperscript{110} Arnstein, pp216-224.
\end{flushleft}
providers and governments) to consumers. The resulting conflict between the groups then becomes an inherent part of the process.\textsuperscript{111} Participation becomes "a bargaining activity between decision makers and other people who were previously excluded from that process."\textsuperscript{112} For this "devolution of power" to occur there must be decentralisation of decision making authority, the consumers must be seen as credible and there must be sufficient ongoing consumer interest in the process.\textsuperscript{113}

The multiplicity of decision making processes that occur throughout the health care area add to the potential scope of participation activity. In an attempt to more easily identify the varying degrees of participation in different health care decision making processes, Charles and DeMaio developed a three dimensional framework.\textsuperscript{114} The first axis marks the level of participation, in a similar way to Arnstein's ladder, from consultation through partnership (shared decision making) to "dominant" (consumer control).\textsuperscript{115} The second axis, denotes the decision making "domains" or the context in which the decision making occurs: at the individual treatment level, the service delivery organisation level or the broader state/national "macro" level. The domains also provide some indication of the established decision makers in that area, such as the doctor, and organisation manager or board. Along the third axis the "role perspective" of the consumer participants is represented; here Charles and DeMaio have divided participants into those taking a more restricted "user" view and those taking a broader "policy" view. The authors acknowledge that the categories are not mutually exclusive and suggest that this only contributes to the confusion about the scope of participation in decision making processes. This framework further highlights the complexity of participation activity in relation to one of the goals, that of increasing participation in decision making, but similarly useful frameworks could be developed for the other goals of participation activity identified.

\textsuperscript{113} Bates & Linder Pelz, pp178-190; McEwen et al, p20.
\textsuperscript{114} Charles & DeMaio, pp881-904.
\textsuperscript{115} The authors acknowledge that their categories are collapsed from Arnstein’s ladder.
A further distinction has been made between participation in formal decision making mechanisms, such as health service boards, and participation in community based activities such as self help groups and community development projects.\textsuperscript{116} It is through the formal decision making mechanisms that most major decisions about policy direction, service implementation and resource allocation are made in the health area.\textsuperscript{117} Therefore, participation in formal decision making mechanisms becomes particularly important for often excluded consumers. Charles and DeMaio note that instances of participation in formal decision making mechanisms in the macro and service delivery domains are scarce in the Canadian health system. In the Australian situation, consumer participation in decision making processes has sometimes been used to further interests other than those of consumers. (See also ch6.4.3.)

The multifarious forms that consumer participation activities have taken can be grouped into several main spheres: consultation, public discussion and debate, feedback and evaluation, lobbying and advocacy, and representation.\textsuperscript{118} There is substantial overlap between the different spheres of participation activity and much commonality in methods employed. While there is potential for all these forms of participatory activity to have a significant influence on decision making processes, all are limited to varying degrees. Consultation, widely used by governments and service providers, differs widely in practical application, depending on the purpose identified for the consultation and commitment to the process by the commissioning organisation and the consultants. Recognition and acceptance of alternative views is in the hands of those conducting the consultation, rather than those being consulted. Because of this lack of control over the initial agenda setting, the consultation process itself and the final outcome, many consultation processes have been regarded sceptically as simply public relations exercises.\textsuperscript{119} To try to overcome some

\textsuperscript{116} Bracht & Tsouros, pp205-206; Piette, pp187-197.
\textsuperscript{117} Piette, p187.
\textsuperscript{118} Dwyer includes volunteerism as another sphere. Dwyer, pp60-61.
\textsuperscript{119} Healthy Participation, p30.
of these shortcomings, consultation guidelines that encourage more meaningful participation, particularly from a consumer perspective have been developed.\textsuperscript{120}

Consumer involvement is also often not seen as necessary when establishing the initial parameters, the processes and the final outcomes of participation through public discussion and debate about matters of concern. Royal commissions, parliamentary and public inquiries, while providing opportunities for participation through submission writings and public hearings, are still constrained by their initial briefs.\textsuperscript{121} Patient and consumer satisfaction surveys, increasingly adopted as a way to obtain information about user perceptions of the health services provided (as already discussed in chapter two), frequently reflect service provider interests rather than consumer interests by the questions asked and the format of the questionnaires. Feedback obtained through other mechanisms such as discussion groups and advisory committees may result in more consumer initiated issues coming to light.\textsuperscript{122} The employment of structured evaluation methods may result in the systematic gathering of feedback from groups who might otherwise be missed. The growing importance placed on quality assurance activities and the development of best practice protocols, while currently controlled predominantly by service providers, offer potential areas for greater consumer involvement. (See also ch7.4.1.)

The ability to lobby decision makers on behalf of particular interest groups, a commonly accepted practice by governments and service delivery organisations, is potentially one of the most effective forms of participation because of the often direct link to decision making processes. But some groups of consumers have been less able to access or use these mechanisms to influence the decision making process. In the health system


\textsuperscript{121} The two public inquiries conducted by the Australian Human Rights Commissioner, Brian Burdekin, on youth homelessness and human rights and mental illness are good examples where the initial briefs were very broad and consumers were actively encouraged to put in submissions and. See the final reports: Human Rights & Equal Opportunity Commission, \textit{Our Homeless Children}, Report of the National Inquiry into Homeless Children, B. Burdekin, Human Rights Commissioner, AGPS, Canberra 1989; and Human Rights & Equal Opportunity Commission, \textit{Human Rights and Mental Illness}.

self help groups, peak consumer bodies and advocacy groups have increasingly taken up lobbying and advocacy roles on behalf of their members and consumers generally.

Other direct links with decision making processes through representation on boards of management, committees, regulatory bodies and other forums have been fraught with difficulties for consumers. For instance, the ability of a sole consumer representative to be fully involved in planning, advisory and decision making processes has been of concern to consumer groups. While active steps have been taken to increase the effectiveness of consumer representation, debates about appropriate mechanisms for the selection of consumer representatives, reporting procedures to their constituencies, and accountability processes continue. The Health for All Committee report, for example, noted concerns about the possible "lack of credibility" and accountability of consumer representatives. This was perhaps an indication of the still tentative acceptance, at health service provider level, of the consumers' role in health decision making, as the credibility and accountability of non consumer members of these boards and committees was not similarly questioned. Increasingly the inclusion of consumer representatives on decision making bodies has been mandated by legal methods, for example by inclusion in the constitutions of organisations and in acts of parliament, but this will not necessarily overcome the barriers to effective consumer representation, and may, in fact, weaken the position of consumers where representation is ineffective but the only means of participation provided for by the organisation.

---

125. It was suggested that nomination of representatives by consumer/community organisations may overcome these problems. The Health Targets and Implementation (Health For All) Committee, Health for All Australians, Report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference, AGPS, Canberra, 1988, p119.
Evaluation of and barriers to consumer participation activity

The diversity of participation activity, coupled with differing goal identification and multiple underlying ideological assumptions, has complicated the search for appropriate methods to evaluate consumer participation. Descriptive statistical data have been used to give counts of the number of people participating in various activities, including their demographic details, and to indicate trends in this regard, but this form of evaluation does not capture the dimensions or the processes of participation activity. Rifkin, in her groundbreaking work in this area, proposed that it was more useful to draw a relative measure of participation than trying to measure against a preconceived standard. In this way, the actual processes of participation are more likely to be encapsulated, that is "whether participation has become narrower, broader or remained unchanged". To do this Rifkin identified a model using a set of five indicators developed from her extensive analysis of case studies of community participation: needs assessment, leadership, organisation, resource mobilisation, and management. By representing the five indicators as spokes in a wheel formation, with minimal or narrow participation marked closest to the axle, and maximum or wide participation furthest away, it is possible to plot the levels of participation along each indicator spoke, providing an overall image of the processes of participation at a particular point in time for a particular health program or service. Rifkin points out that this model does not judge the quality of the participation activity, or the impact on health status, but does enable change to be tracked over time and by different assessors. Other criteria that may be used in attempting to evaluate consumer participation have also been proposed. For example, Bracht and Tsouros specify

"opportunity for and level of decision making or advising; amount and duration of time devoted to goal activities; representativeness of citizen and leader groups formed; degree of local ownership perceived and/or achieved; satisfaction with the processes of participation and achievement and long term maintenance of effort."

126. Rifkin et al., p933.
128. Rifkin et al., p937.
129. Bracht & Tsouros, p201.
While methods for the evaluation of consumer participation activities remain underdeveloped, much more has been written about the conditions necessary for participation activity to succeed and the barriers to achieving this. Brownlea asserts that the resources needed for successful participation are "power, knowledge and skills". The formation of groups can be one way that consumers can gain power. But the groups must maintain credibility and be perceived by consumers as holding a significant degree of community ownership. The groups must also be strong organisationally, community controlled and representative to the extent that all interested minority groups are represented. To maintain public and members interest, the groups need to identify successes. As with other consumer activity, time and money are crucial factors in determining whether people have the capacity to participate; without access to sufficient time and money participatory activity will be limited. Another way consumers can acquire power is through the commitment of government leaders and organisation officials sanctioning participation, including agenda setting; "good faith on the part of sponsoring group or agency".

Consumers need knowledge in a number of areas to participate effectively. In particular, they must have good access to information relevant to the situation in which they are participating. If consumers are to be as well informed as other more powerful groups, then the current interpretations of the notions of confidentiality and privacy, which can limit consumer access to information, must be challenged. Consumers are placed in a stronger position if they are able to draw on their own sources of information and conduct their own research. Consumers also need to have knowledge about the system in which they are participating and the relationships and connections with other systems.

130. Brownlea, p607.
131. Bracht & Tsouros, p201.
132. Piette, p194.
134. Brownlea, p608.
“Knowledge about how to penetrate the system” is particularly important if participation is not asked for or welcome.\(^\text{137}\) The obstructions and likely areas of resistance to participation must be identified and plans to overcome these made.\(^\text{138}\) A different sort of knowledge is required about the community environment. In depth knowledge of the local community, networks and the workings of the consumer group is vital, as the characteristics of the local community may enhance or restrict participation activity, such as the success or otherwise of previous participation efforts.\(^\text{139}\)

Consumers also need to possess, or develop a range of skills to participate in formal decision making processes with health service providers. For example, the ability to understand and use professional jargon is often essential if the consumers’ comments are to be taken seriously.\(^\text{140}\) Piette notes that the basis of the approaches to decision making processes used by consumer participants and scientific experts are different, potentially leading to significant disagreements in even seemingly routine decisions.\(^\text{141}\) Consequently, consumer participants need skills in conflict resolution strategies.\(^\text{142}\) Numerous other skills are required at various stages of participation, such as skills in the organisation and maintenance of groups, skills in advocacy, skills in being a representative, skills in committee work and meeting procedures, and skills in the effective use of the media. The learning of new skills that can be useful in other areas of life has been used as an incentive for encouraging consumers to become active participants.

The context in which the participation activity is to take place is also important to its success. Some activity within the community at large may be necessary to increase people’s awareness of the possibility of participating. Those participating may need assistance in acquiring the resources already mentioned, such as special training to increase

\(^\text{137}\) Brownlea, p608.  
\(^\text{138}\) Bracht & Tsouros, p203.  
\(^\text{139}\) Bracht & Tsouros, pp203-4.  
\(^\text{140}\) Brownlea, p608.  
\(^\text{141}\) Piette, pp190-191.  
\(^\text{142}\) Bracht & Tsouros, p203.
skills and the development of appropriate support structures with secure funding bases. Participation processes that are formally structured into an organisation or sanction by legislation increase the legitimacy of participatory activity. However, for participation to flourish "officials must learn how to work with consumers, as well as consumers learning how to participate effectively".¹⁴³

Even when the above conditions for success are fulfilled there are still other barriers to participation. The complex nature of the administrative structures of bureaucratic organisations, including the existence of multitudes of rules and procedures, present a formidable barrier for consumers to overcome. The goals of participation held by the consumers participating and the officials of the organisation may be quite different and potentially incompatible. As well, the officials may hold "unresponsive views towards prospective participants", perceiving consumers as not having sufficient authority or expertise to participate alongside the officials in discussions about certain matters or decisions.¹⁴⁴ Participation is further hindered by professionalism which binds those of similar expert knowledge and training to certain ways of thinking and behaving that may exclude and devalue the role of the consumer.¹⁴⁵ Participation calls for the sharing of expert knowledge and decision making, and a lessening of the demarcation between the roles of professional experts and consumer. A final point to note is that cultures differ in the value they place on participatory approaches to health decision making.¹⁴⁶

**Participation, consumers and service providers**

Consumers and service providers have differing ideas about and interest in the value of participation for themselves. Even though the idea of participation may be valued, people do not necessarily participate in health services planning and development before they become ill or need to use the services; when people are using the services they are

---

¹⁴³ Bates & Linder-Pelz, p178.
¹⁴⁴ Verity & Tesoriero, pp109-110.
¹⁴⁵ Dwyer, p61.
¹⁴⁶ Verity & Tesoriero, pp111-112; Brownlea, p614.
often to vulnerable to become involved; and when well the urgency to become involved is no longer there. 147 There is greater incentive for chronically ill people and consumers with disabilities and their families, who use health services regularly over the long term, to be interested in on-going participation, but even then the time and energy required may be too great. Some consumers may feel content with the traditional health service provision arrangements and, for example, may not want to take on a decision making role.148 As well, people may be unaware of the inequalities and variance in health status and the delivery of health services between different groups in the community.149

Not all members of the community take part equally in participatory activities and some people never participate in more formally organised activities. It has often been said that those participating are unrepresentative of the broader community, tending towards the better educated and middle class.150 This is not surprising as most mechanisms devised for participatory activity are likely to be

"skewed towards middle class styles of communication which require participants to be reasonably articulate, largely rational and non-emotive, logical and prepared to enter into a reasonable, direct and frank discussion about the relevant issues practices and policies".151

Others may be reluctant to become involved because they do not believe their participation will be taken seriously or make a difference. This reluctance may be exacerbated by "the feelings of powerlessness or humiliation which people often experience as patients".152 For others, though, the trauma experienced by contact with the health system may act as a motivating force to participate, which, in turn, becomes a means for coming to terms with their experiences.153 The idea of increasing "participatory equity" highlights the point that

---

149. B. Checkoway, "Citizens and Health Care in Perspective: An Introduction" in B. Checkoway ed
150. Bates & Linder-Pelz, p167; Verity & Tesoriero, p111.
152. Dwyer, p62.
153. Dwyer, p63; Brownlea, p607.
new ways must be found to enable as many people as possible to at least have the choice to participate if they so wish.154

Service provider and bureaucratic attitudes towards consumer participation are also mixed. Checkoway suggests that "consumers are perceived to hold views that are difficult to quantify, cause delays in action, expand the number of conflicts, and increase the cost of operations".155 As well, "participation essentially is untidy, unpredictable and expensive, characteristics which are disliked by both bureaucracies and politicians".156 Therefore, mechanisms for consumer participation have often been shaped to cause the minimum disruption possible, for example by ensuring consumer representatives on the board or committee, are outnumbered by staff members.

Even when there is official organisational sanction, consumer participation has not necessarily been supported, and sometime even sabotaged, by staff members particularly if they perceive that the outcomes of consumer participation may undermine their ‘expert’ positions. Most professionals are used to advocating their own and the interests of their peers, and expect to be consulted about service directions and priorities. Sharing this role with consumers requires learning new ways of thinking and behaving that challenge old beliefs about the behaviours and capabilities of consumers. Rifkin notes “until those who have control of resources are convinced that participation is a viable and desirable concept, it is likely to remain relegated to rhetoric”.157 Service providers, administrators and policy makers may have to face increasing suggestions and complaints about how they perform their duties as consumer involvement increases. Bates suggests it is ‘questionable whether greater participation leads to greater satisfaction with the government that has developed it’ as expectations about changes to service provision may rise with greater participation, leading to greater criticism when these expectations are not met.158 Bracht and Tsouros

155. Checkoway, p7.
156. Bates & Linder-Pelz, p177.
157. Rifkin et al., p93.
comment that "complex urban environments often develop more formal avenues and infrastructures through which citizen involvement is mediated and realised". However, this in turn can limit which consumers are able to participate. Not many consumers have the time and interest to devote to participation activity on an extended basis, yet many of the structures in place currently require that. New structures that encourage even minimal or 'once off' participation need to be supported.

Consumer participation ultimately challenges existing power relationships and decision making processes in the provision of health services and the development of health policy. Draper comments

"democratic approaches require a genuine commitment to consumer participation which is prepared to resource consumers and their organisations to exercise an effective voice, and to be inventive and lateral about the means of seeking consumer voices". Barriers preventing the full breath of consumers from participating are great. The influence on health care policies and services that consumers are able to achieve through participation can easily be minimised. The various factors mentioned, such as setting clear goals for participation and the methods used, have a significant impact on the outcome of consumer participation activity, and even then, the results can be difficult to evaluate. Regardless of the ideological basis of consumer participation, there will be an ongoing need to provide mechanisms to allow and encourage the full scope of participatory activity in health care planning and decision making.

4.4 CONCLUSION: THE CONSUMER MOVEMENT IN HEALTH, CONSUMER PARTICIPATION AND COMPLAINTS SYSTEMS

The activities of the movements, noted in this chapter, have created a milieu where closer scrutiny of health care provision has been fostered. Seven common elements emerge from the combined philosophies and activities of the consumer movements in the health

159. Bracht & Tsouros, p201.
160. M. Draper, Casemix and Consumers, Health Issues Centre, 1st Floor, 257 Collins St, Melbourne, 1993, p70.
area: the promotion of the social view of health; the valuing of experiential knowledge; the questioning of information generated by health professionals; the sharing of information and knowledge about health and health care; the explicit identification of the rights of consumers when receiving health care; the voicing of consumers’ opinions about health services, including complaints; and consumer participation in decision making about all aspects of health care provision. These elements can be closely allied to the consumer rights advocated by the broader consumer movement: for safety, to be informed, to have choices, to be heard, to redress and for consumer education, noted in the previous chapter. As could be anticipated, these seven elements give a good indication of the broad areas in which consumers would like to see changes in current health systems and health service provision practices. They form the foundation of the more specific ‘consumer agenda’ for health complaints mechanisms and the statement of health consumer rights.

While the movements specifically relating to the health sector have often evolved out of more general social movements, a major part of the impetus for the development of the different movements has been the paternalistic manner and practices of professional service providers, dismissive of the value of consumers’ experience and knowledge about their own health. The ideas and activities of the movements have challenged the reliance on and unquestioning obedience to professional advice on health matters; insisted on greater sharing of information and decision making; recognised and acknowledged the validity of consumers’ interpretations of their experience of encounters with health service providers; and drawn attention to the loss of human and social rights that sometimes resulted when receiving health care. Acceptance by health service providers that consumers have legitimate knowledge, experience and opinions about health and health service provision is a prerequisite for the greater accountability of health service providers to consumers and the establishment of partnerships between the two groups. It is also necessary if consumer complaints are to be taken seriously. The combined impact of the movements has helped change the way many consumers of health services now view
themselves in the health care relationships and, in turn, engendered some professional health service provider reflection on the issues.

The merits of consumers forming groups in order to participate has often been stressed. Some have claimed that without the combined strength of a group, the individual consumer's influence on policy is likely to be minimal except in exceptional circumstances. An atmosphere conducive to participation must be created in order that "people feel able to participate". The setting up of self help groups, women's groups and other health consumer groups has provided environments where consumers wanting to become involved can gain recognition, support, and encouragement from others of a similar mind (or concern!). The following chapter highlights the crucial role that consumer groups have played in demanding that complaints be heard and that consumer friendly complaints handling systems be set in place. However, the limitations of such groups have also been noted in chapter three, particularly in terms of the functions performed by the groups and who becomes involved. The groups can, in turn, become another barrier to participation if access to the participatory mechanisms is only available through the group.

Discussions about consumer participation activity in the health area generally have not included the making of a complaint as part of participatory activity. Recently though, the increased attention on complaints mechanisms in the health area, has highlighted the similarities of the process of making a complaint to participatory activities more broadly. Reviewing the goals of consumer participation as discussed in this chapter, it can be seen that pursuing a complaint is compatible with many of these. To complain is an active, purposeful process undertaken by consumers, and some consumers are able to clearly state their desired outcomes from the process. By complaining, consumers are exerting some control over events that have happen in which, at the time, they often had little control. They are asking for health service providers to account for what happened, through

161. Verity & Tesoriero, p104.
162. Bates & Linder-Pelz, p177.
providing more comprehensive information and explanations. Implicit in this is a challenging of the health service providers' interpretation of the same events, and a re-negotiation of the perceptions of the outcome. Although the events that caused the complaint to be made may have passed, similar events may be prevented from occurring in the future if the complaints are taken seriously. In this way complaints may influence future health service provider decision making. The potential for complaint mechanisms to offer a channel for consumer participation at the local level is explored further in chapter eight.

The consumer movements have vigorously lobbied for reforms to complaints mechanisms, as it has long been recognised that the mechanisms in place are critical for consumers to be able to express their right to complain and seek redress. Examination of the barriers to consumer participation offers insight into the behaviour of consumers, governments and service providers that may also apply in reforming complaints mechanisms, as both consumer participation and making complaints challenge the existing relationships and the power distribution between the three groups. It is clear that consumers, governments and service providers perceive the purposes and benefits of consumer participation differently. Detailing the different understandings of the three groups helps identify their underlying motives, which, in turn, reveals the assumptions and ambitions of each of the groups in the actions they take. Attention to the underlying motives of consumers, governments and service providers in proposed complaints mechanism reforms, is likely to lead to better understanding of the activities of the three groups in this area.

For consumers to be able to participate to any great extent they need: knowledge about the system and the specific area of involvement; skills in working together with others as part of a group, in formal decision making settings and in articulating one's position; and resources, particularly time and money to at least cover extra expenses. They also need to believe that their participation will be taken seriously and valued in the forum
in which they choose to participate, and that their participation will, in some way, make a
difference that will ultimately change things for the better for other consumers. These
factors may also be important determinants of whether consumers make a complaint and
are examined further in the following chapters.

The common elements that have been identified from the multiple dimensions of
the consumer movement in health, including the more detailed understanding of the goals
and scope of participatory activities, provide a comprehensive foundation from which the
more specific 'consumer agenda' in regard to complaints mechanisms in the health area
can now be determined.
CHAPTER FIVE

THE CONSUMER AGENDA FOR HEALTH COMPLAINTS SYSTEMS

5.1 INTRODUCTION

Consumer groups have argued that, for consumers to be able to exercise their 'right' to complain and seek redress, complaints mechanisms that are effective from a consumer perspective must be in place. Two questions immediately arise: what do consumer groups identify as the primary purpose of complaints handling? and what constitutes an effective complaints handling mechanism from the perspective of consumers? The answers to these two questions form the consumer agenda for health complaints systems. While consumer groups have campaigned for some time about the need to reform inadequacies of complaints mechanisms in the health area, the consumer agenda for complaints mechanisms has been articulated in detail only recently in Australia and is still evolving.

Different consumer organisations have advocated better complaints mechanisms in the health care system and some have now reached the stage of identifying what might be considered models of best practice for complaints handling from consumers' perspectives. This chapter traces the contribution of the two most prominent consumer organisations specifically set up to give consumers' perspectives a public 'voice' in the health area: the Health Issues Centre (HIC) and the Consumers' Health Forum of Australia (CHF). In chapter three, the establishment and development of these two organisations was outlined and placed within the context of the broader consumer movement activity. Both the HIC and the CHF have been active in advocating reform of complaints mechanisms in the health area from soon after their establishment in 1984 and 1986 respectively.¹ The two

¹ The management committees of the two organisations were formed late in these years, and the detailed work of the organisations began the following years, 1985 and 1987 respectively, but sometimes these second dates are given as the establishment years.
organisations approached the issue of complaints system reform in different ways: the HIC worked through providing a telephone advice service and conducting original research, helping to fill the significant gaps in knowledge, at the time, about consumers' experiences in using the complaints mechanisms in place and enabling the HIC to propose alternative mechanisms; the CHF worked at defining and developing the notion of consumers' rights in the health area, including the possibility of legal recognition of such rights, that could help to underpin the making of a complaint, as well as to gain acceptance of the idea that to be able to complain is a 'right' that service providers must take seriously. The two approaches dovetailed, late in 1992, in the publication, *A Consumer Perspective on Health Complaints Mechanisms in Australia*, which premised reforms to complaints systems on statements of consumers' rights.

The development of a charter for Australian health consumers, reflecting the 'rights' consumers saw as fundamental in their interactions with health service providers, became paramount as service provider and bureaucratic interpretations of consumers' rights began to be promoted. The lead in this process has most recently been provided by the Australian Consumers' Council, with the support of the other major consumer organisations discussed in chapter three, and a draft Health Consumers' Charter was circulated in 1994. The connection between statements of consumers' rights and complaints systems, seen as critical by consumer groups, has not always been recognised or acknowledged by health service providers.

Analysis of the documented 'consumer models' for complaints mechanisms provides further evidence of the essential components of a comprehensive complaints system from a consumer perspective. By linking the different approaches of the consumer groups, a 'combined' model can be clearly identified that provides a framework for a health complaints system that fulfils the consumer agenda. The specific application of these 'consumer' components to complaints handling mechanisms at the local level is discussed in chapter eight.
The persistent activity of the Health Issues Centre (HIC) in drawing attention to complaints mechanisms in health care services over the past decade have been well documented in HIC Annual Reports and through its journal *Health Issues*, featuring many and varied articles on the subject. Four strategies adopted by the HIC emerge from this documentation: providing a complaints advice service to the public; researching aspects of complaints handling, emphasising the consumer perspective; lobbying governments by submission writing and active participation on governmental committees; and producing publications giving alternative analyses of the current complaints handling situation including the development of principles to underpin complaints mechanisms. The attempt that HIC made to fill the void created by lack of information about complaints handling from the perspectives of consumers is particularly significant. The essential elements of the consumer movement in health, noted in the previous chapter, have underpinned the activities of the HIC in regard to health complaints mechanisms: the sharing of information and knowledge; questioning of professional practices; valuing experiential knowledge; outlining rights; encouraging participation; broadening ideas about health and making the consumers perspective known.

The need for reform of health complaints mechanisms in the state of Victoria, where HIC is based, presented as a major issue for the new HIC to take action. When HIC was established, the Social Development Committee of the Victorian Parliament had concluded an inquiry into complaints procedures in the health area, tabling the final report containing numerous recommendations in parliament in 1984. HIC immediately became actively involved in pursuing action on the recommendations by consulting with other consumer groups, holding a phone in, and writing submissions to the Minister for Health. By the third edition of *Health Action* (the forerunner to *Health Issues*) it was reported that

---

2. See ch7.5.2 for details of this report and the actions of the Victorian government on complaints mechanisms around this time.
“the Minister for Health accepted the HIC recommendations” for the establishment of an independent health services complaints office supported by appropriate legislation based on the principles identified by HIC. These principles were summed up as independence, universality, accessibility, clear definition of scope for health service complaints, adequate resources, adequate publicity, accountability and the power to act. The principles represented the antithesis of what was seen to be wrong with the complaints mechanisms available at the time and formed the basis of the framework for a model ‘consumer friendly’ health complaints mechanism that HIC was to promote over the next decade. HIC was represented on the Task Force set up by the Victorian Minister for Health to oversee the legislation development and implementation process.

In 1985, at the same time as it was achieving a political presence, HIC obtained funding for its proposal to establish Health Call (Complaints Advisory Link Line, originally named Health CATS - Complaints Advisory Telephone Service) to “provide a non-intimidating source of telephone advice and referral for those who wish to complain”. This service, under the auspices of HIC but with its own management committee, commenced early the following year and continued until the establishment of the Office of the Health Service Commissioner in 1988. Even in its short life Health Call identified that people from non-English speaking backgrounds were under represented amongst callers. To try to help remedy the situation a series of workshops about consumers’ rights and complaints pathways were conducted for community workers working primarily with people from non-English speaking backgrounds.

*Health Call* was important in several ways to HIC’s work on complaints mechanisms: it legitimated HIC’s role in discussions about complaints systems; it provided first hand information and experience of the limitations of health complaints mechanisms.

---

available at the time; it provided data on the nature of complaints that consumers wanted to make; and it increased HIC’s credibility in the eyes of consumers by providing a service that was not available elsewhere. The cessation of Health Call did not prevent HIC, through its in-house Task Force on Consumer Rights, continuing to speak out on health complaints mechanisms and to monitor the implementation of the Victorian legislation (the first in Australia) establishing an independent complaints body, the Health Services Commissioner. The original draft legislation had met with considerable opposition from health service providers, particularly the Victorian Branch of the Australian Medical Association and, despite a vigorous campaign by HIC in conjunction with other community groups, the final Act reflected a more conservative and constrained approach to complaints handling. For example, the Act contained no mention of the word complaint in the title, included a three year ‘sunset’ clause and delineation between the role of registration boards and the Health Services Commissioner was unclear, all matters of consumer concern.

Using the broader context of consumer protection for discussion and justification of complaints systems, HIC proceeded to generate a series of publications outlining their template for an effective consumer protection system and highlighting the limitations of the current system in Victoria. The first report, which was submitted to the Victorian Minister for Health, stated that the two major components of such a system were consumer complaints and provider regulation. The consumer complaints component was described as

“providing an independent means of resolving individual complaints and preventing similar occurrences at an individual level, and monitoring and taking action on patterns identified in aggregated data to improve the quality of health services”.

6. See ch7.5.2.
8. Health Issues Centre, Consumer Protection in Health - How Far Have We Come?, Submission to the Minister for Health, Caroline Hogg, prepared by Gillian Ednie in consultation with the Consumer Rights Standing Committee, Health Issues Centre, 1st Floor, 257 Collins St, Melbourne, April 1989, p2.
The report detailed problems already encountered by consumers with the implementation of the new Victorian legislation in regard to complaints handling and made recommendations to rectify the situation. HIC's second report, produced a year later, gave a much more sophisticated and comprehensive account of a consumer protection system stating that

"the overall aim of a consumer protection system is to safeguard consumer rights and thereby protect people from any form of inferior health care which may result in physical or mental harm and/or financial hardship".10

Information and education for both consumers and service providers, consumer compensation, quality assurance programs with consumer input and coordination of all aspects of the consumer protection system were added to the two components outlined in the first report as necessary key features of an effective consumer protection system.11 The report went on to discuss the initiatives of the previous few years in Victoria, such as consumer advocacy services, adding a number of recommendations for change likely to increase the effectiveness of these initiatives from a consumer perspective. The importance HIC placed on complaints mechanisms is again revealed by the statement at the beginning of the second report:

"The lynch pin of any system to protect health care consumers lies in that system’s ability to identify and resolve individual complaints and co-ordinate action on the implication of deficiencies identified for the future protection of all consumers".12

Building on the principles outlined in the second report, the major part of the final report in this series was devoted to tracing “the pathways for complaints”, under the current Victorian system, and highlighting some of the frustrations consumers might experience in using this complex and multifaceted system.13

---

Although much of HIC’s work was based on the developments within the state of Victoria, the national picture was also reviewed in 1989. Using a “checklist for consumers” developed by HIC, the health complaints handling systems in all Australian states/territories were compared. The questions covered by this checklist give a good indication of some of the aspects of a complaints mechanism considered necessary if consumers are to feel assured their complaints will be dealt with competently and fairly: that complaints can be made direct to the unit, and by telephone as well as letter; that the functions of the unit are written and available; that the unit can investigate and conciliate complaints; that the unit has sufficient staff and is independent from the health department; that government commitment include providing a statutory base; that the unit can take a broader coordinating role amongst the different health complaints mechanisms, such as the registration boards; and that consumers have access to independent advocates and complaints liaison officers.\(^\text{14}\) Considerable differences were found to exist between states/territories and it was concluded that “the degree of vulnerability of the consumer’s rights can be seen to be directly related to features inherent in the structures in place”.\(^\text{15}\)

In a follow-up article a year later in 1990, Caples asks “what role does the community want the complaints units to play?” concluding that “there is little in the way of coordinated community debate on what should happen” and

“the community needs to debate and decide upon what features must be considered essential [for a complaints system], and strong legislation and a strong consumer movement need to ensure this is enacted and maintained”.\(^\text{16}\)

However, vigorous debate about the essential features of central health complaints mechanisms has largely been confined to health service providers, government officials and specific consumer groups rather than the broader community, as the various

\[^{15}\text{Caples, p25.}\]
state/territory governments and Commonwealth government have taken action on complaints legislation. (See ch7.5.4.)

HIC conducted their own research into specific aspects of complaints handling. In 1990, a study was undertaken in which staff in 48 community based agencies were surveyed “in order to determine their understanding of complaints handling procedures for aggrieved health care consumers”.17 This study found evidence of limited knowledge and understanding of the function of the Office of the Health Services Commissioner, established two years earlier, amongst the personnel of these agencies, who were potentially in positions to advise consumers of a course of action to take to make a complaint. The report acknowledged that the Commissioner had made considerable effort to achieve visibility, but the results suggested that strategies for information dissemination needed review and that, as well, agencies had a responsibility for keeping staff informed of new developments.18

Another HIC study examined the experience of complaints handling in eight major Victorian general hospitals through indepth interviews with staff in key positions to comment, including Complaints Liaison Officers (CLO).19 Also, several consumers were interviewed about their experiences of lodging a complaint. The hospitals were found to use different processes, unique to each organisation and indicative of the view held by each organisation and the CLO about complaints, ranging from a public relations perception to a more serious consideration of accountability issues.20 Of particular significance in this report was the development of a set of basic principles that were seen to underlie an “ideal hospital complaints system” if it is to be “consumer focussed: one which recognises the

19. With the introduction of the Victorian legislation, all hospitals were required to appoint a Complaints Liaison Officer, although as the HIC study discovered, the interpretation of function and duties of this role varied greatly.
protection of consumer rights and is responsive to consumer interests”.\textsuperscript{21} The model proposed by HIC included:

- “opportunities for independent advocacy for people making their complaints to the hospital;
- accessible and open complaints systems, with a CLO who is identifiable and readily accessible;
- information on consumer rights and responsibilities, and on ‘how to make a complaint’, which is readily available to people using the hospitals;
- information and education to staff on complaints processes in the hospital, consumer rights, and on responding to complaints;
- the opportunity for consumers to be involved in the complaints processes, and to be kept informed of the progress of their complaints;
- the collection of data on hospital complaints which is comprehensive, including both ‘formal’ and ‘informal’ complaints and the experiences and views of consumers;
- extensive review and evaluation of the outcome of complaints and on the complaints process, with a focus on the consumer’s perception;
- the use of data on hospital complaints in service evaluation and planning and in quality assurance processes;
- a centralised complaints process which minimises staff discretion in handling complaints and offers the consumer channels for complaining which are independent of providers;
- the commitment of hospitals boards, chief executive officers and hospital staff to the constructive value of complaints to the hospital and to the complaints process”.\textsuperscript{22}

The dual purpose of complaints handling from HIC’s perspective unfolds on examination of this model. The first is the actual process of handling complaints; the mechanisms in place must enable individuals to make their complaint with the reasonable expectation that a satisfactory resolution will result. The second purpose of complaints handling is for health system changes to come about as a direct result of the information provided by the complaint/s. Both are based on the assumption that consumers’ experiences and perceptions of health care are as legitimate as any other views and must be taken seriously in the health service planning and evaluation process.

\textsuperscript{21} Health Issues Centre, Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus, p29.
\textsuperscript{22} Health Issues Centre, Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus, p29.
In 1993, HIC conducted a further study to investigate the feasibility of “linking consumer complaints information with quality assurance activities in hospitals to assist in improving health services from a consumer point of view”, with funding obtained from a charitable foundation and support from the Office of the Health Services Commissioner. HIC was concerned that the predominant focus of the Office of the Health Services Commissioner in Victoria had been on individual complaints resolution, although the legislation allowed the Office to take a much broader role in relation to the evaluation of and quality assurance programs in health service provision. The methods for the collection of data about complaints, and particularly the substance of the complaints, and the use made of the information by the hospitals and the Office of the Health Services Commissioner were reviewed in the study. Again a series of recommendations were made aimed at overcoming some of the difficulties and barriers identified with current data collection procedures. In particular, the need for improving the quality of the data collected about complaints, establishing a centralising system for reporting complaints and developing complaints handling protocols within and across organisations, devising a universal computer complaints data collection system for use by all organisations were stressed if data about complaints were to be of much value to quality assurance processes. HIC considered it was necessary for the Office of the Health Services Commissioner to take a lead role in coordinating and driving these proposals if the changes were to be achieved. HIC’s stance on the critical value of complaints data to any review of the health system is unquestionably reiterated throughout this report.

HIC was commissioned by the National Health Strategy to develop a background paper “address[ing] issues associated with achieving greater public participation and

accountability in the Australian health system". The final report identified as one of the five key objectives for the health care system that "the rights of people should be recognised, respected and assured". Recommended strategies to achieve this objective included the development of a charter of rights, the employment of complaints liaison officers or patient advocates, and the development of complaints procedures, all of which needed to be linked with quality assurance activities. Redress through complaints systems was seen to offer a way for increasing accountability of health services and the report claimed that "one of the important moves towards improving quality of care in Australia has been the establishment of complaints bodies". The report, through combining discussion about participation and accountability, made the connection between making complaints (part of the accountability process) and consumer participation activity, as both were seen as ways for involving people in determining health service provision.

HIC's position on complaints handling is perhaps best summed up in its brief description of the ideal scenario for hospital complaints processes as one which:

"would provide a mechanism sensitive to the disadvantaged position of the consumer compared to that of the provider. It would also include elements which are both preventive and proactive - rather than purely being reactive - enabling change in the hospital services. Most importantly, it would be based on the recognition that an adequate mechanism for allowing and responding to consumer complaints is an essential service in itself. As such, it ought to be a valued ingredient of the overall hospital service, subject to the same evaluation and accountability".

This 'consumer complaints model', developed and promoted by HIC, defined the essential components of such a model in terms of advocacy, access and availability, education,

support, consumer participation, complaints data, monitoring and evaluation, quality assurance, and a centralised process.\textsuperscript{31}

The dual focus on the individual and the health system permeates all HIC’s publications on the topic of complaints mechanisms but, more recently, the emphasis on the value of complaints data specifically to health system management has increased. It is difficult to identify from the documentation precisely why this emphasis has occurred, at this time, but the discussion in the next chapters suggests that it is consistent with the new demands (and language) of a changed political situation in Victoria (and elsewhere in Australia), where massive reductions in government funding of health and community services, including HIC’s government grant, has meant that all activity, including complaints handling, has come under scrutiny and had to demonstrate its essentiality or risk being cut. Aligning complaints handling to service provider dominated quality assurance and management activities may assist the likelihood of acceptability to the administrators controlling the budgets, but it may also jeopardise the consumer focus so keenly pursued by HIC.

HIC, from its inception, tackled the lack of appropriate complaints mechanisms in the health area from a consumer perspective. Perceiving complaints mechanisms as a fundamental part of a consumer protection system in health, HIC constructed the arguments for change in this context and expended time and resources to political lobbying and forming alliances with other organisations, including the Office of the Victorian Health Services Commissioner, that were most likely to have some influence. Without its own research efforts and involvement in direct service delivery, HIC would have had difficulty in providing informed comment on a number of issues in regard to complaints handling because of the limited knowledge and lack of relevant research, particularly Australian based research, in this area. The targeting of HIC efforts in direct service provision and

\textsuperscript{31} Health Issues Centre, \textit{Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus}, pp30-33 and \textit{The Role of Complaints in the Improvement of Health Services}, p35.
research helped achieve the credibility necessary for HIC to be identified as a significant group speaking for consumers' interests on matters relating to complaints handling.

5.3 **CONSUMERS' HEALTH FORUM OF AUSTRALIA: THE CONSUMERS' RIGHTS ROUTE**

The Consumers' Health Forum of Australia (CHF) identified complaints handling as an important component of the consumer protection system in the health arena, in a similar way to HIC. CHF chose to approach the issue of more effective complaints mechanisms by first advocating for clearly defined health consumers' rights, using strategies such as commissioning research on and the development of a statement of consumer rights and minimum standards for complaints mechanisms; and consulting with the CHF constituency, consumers and consumer groups about the issues relating to consumer rights and complaints handling. Noting that CHF is a 'meeting place of diverse interests', the Chairperson told the 1989 Biennial meeting of CHF members that

"Underlying this diversity is a basic belief in the validity of the consumer perspective. In giving expression to that perspective, the Forum brings together two organising principles of the consumer movement. One principle is to articulate the needs of health consumers disadvantaged through income, race, gender or age. The second principle espouses fundamental consumer rights clearly articulated in the wider consumer movement, and vital in the health arena: the rights to safety, information, choice, and education, and the rights to be heard, to redress for grievances, to satisfaction of basic needs and to a healthy environment".32

The CHF's actions in seeking out the differing views of consumers has been important in enhancing the reputation of the CHF for presenting a range of consumers' perspectives to health sector debates. The CHF focus on rights has not been purely on the individual at the expense of consumers as part of the broader community and CHF documentation clearly and frequently states that "consumers must also be seen 'collectively'".33 How consumers

---

become better informed about their rights and the possible need for a legal basis for such rights have been ongoing challenges for CHF.

The first general council of CHF registered the need to “produce consumer rights information” amongst a list of ten objectives on which the CHF intended to take action.34 A survey was conducted by CHF, in its first year (1987), with the dual purposes of identifying and making contact with health consumer groups around Australia, and seeking the groups’ ideas on the issues considered important for a national body, such as CHF, to pursue.35 Responses from 150 groups were received and consumers’ rights was amongst the top five priority issues identified.36 In 1988, CHF established the Consumer Rights Task Force to coordinate the Forum’s activities in this area. A year later, a report by the Chairperson of the Task Force listed their activities as having included drafting a statement of consumers’ rights in health; developing guidelines for consumer representatives; producing a guide to health insurance; setting up the legal recognition and protection of consumer health rights project; and developing a model system for the implementation of health rights.37

CHF’s first statement of health consumer rights was ready for publication in early 1989 and was distributed in pamphlet form, in seventeen languages, under the title Consumer Principles, Rights and Responsibilities in Health. The statement, which became known as the CHF’s Statement on Consumer Health Rights and Responsibilities, began with five principles which outlined the fundamental entitlements considered necessary to promote good health for all consumers: a healthy and safe environment to live and work in including having basic needs met; access to information and education for informed decision making; participation in the processes of policy and service planning and

35. Baldry, p165.
36. Baldry, p171. The other priorities were preventive health care programs, community education and participation in health care issues, women’s health care issues and lobbying government on behalf of members concerning health care policies and practice.
implementation; and equal access to health services; these principles mirrored the elements of the consumer movement in health outlined in the previous chapter. The principles also reinforced the notion that consumers' rights did not just rest at the individual level but also extended to the community level, and often required structural change if the rights were to be upheld.

The rights outlined in the Statement reflected the broader consumer rights mooted by the consumer movement (safety, information, choice, voice, redress, and education) but were specifically tailored to address the continuing concerns consumers had in using health services.

The twelve rights identified were:
1. The right to appropriate and quality of care;
2. The right to self determination;
3. The right to informed consent;
4. The right to privacy, respect and dignity;
5. The right to deciding who will be present;
6. The right to consulting others;
7. The right to seeking treatment from others;
8. The right to confidentiality;
9. The right to access to and amending records;
10. The right to comment and complain;
11. The right to compensation;
12. The right to refuse admission and to leave.

(See Appendix One for the CHF Statement in full)\(^{38}\)

The statement also encouraged consumers to take greater responsibility for their own health, by including recommendations, termed "consumer responsibilities", for certain actions that consumers could take that would "promote partnership between the consumer and health workers", for example providing the necessary information to health workers for them to be able to give good advice. The Statement provided the basis for CHF's activities in the area of consumer rights.

The need for the statement of rights to have a legislative base was glaringly apparent but the lack of information and the complexity of the situation, partly due to Commonwealth/State powers in the health area, made it difficult to know how to tackle the issues. Consequently, the CHF Consumer Rights Task Force called for tenders to undertake a consultancy to “report on the extent to which consumers’ rights in dealing with the health care system are and should be based in law”. The Sydney based Public Interest Advocacy Centre, already actively involved in consumer health advocacy and well suited to recognise and understand the issues of consumer concern, was contracted to undertake the task.

The final report of the consultancy, *Legal Recognition and Protection of the Rights of Health Consumers*, launched in November 1990, proved to be a key document in laying the ground work for CHF’s efforts in lobbying for the introduction of a national statement of health consumers’ rights. The report had four aims: to provide information on the current situation in regards to the law; to let the community know what was being done or planned in relation to health rights; to be the impetus necessary for consumer health rights to be given greater legal recognition; and, through the recommendations, “seek comprehensive reforms that will improve the health rights of all Australians, and to set an example for governments and consumers in other parts of the world”. Because of the consultative process used in its preparation, the report was claimed to reflect “the strength and commonality of consumer demands in the health area across the country”. The one hundred and six recommendations made in the report revolved around the central themes of

---

40. Public Interest Advocacy Centre, Sydney, describes itself as “an independent, non-profit community legal centre, which provides integrated legal, policy and information services” with a mandate to “pursue matters that are in the public interest through advocacy and representation of citizens, consumers and communities, and in particular, those people most disadvantaged in asserting their rights”. PIAC and Access to Justice and Human Rights, Update, leaflet, PIAC, Sydney, April 1993. In this way PIAC resembled the centres set up by Nader in the USA in the 1970s.
“a charter of consumer health rights, ensuring those rights which are generally common practice are recognised legally as principles, ensuring formal avenues for putting the consumer viewpoint in health administration and promoting ways to improve society’s health and wellbeing”.43

A key recommendation was that

“all legislation in Australia establishing health authorities should contain explicit statements of principle, objects, and functions referring to consumers or users of health services. These statements should be in terms of the recognition and promotion of consumer needs, rights, participation, representation, information and advocacy”.44

The report recommended linking regulation and licensing of health resources (whether they be facilities or personnel) with compliance with the charter of rights of health consumers and possibly also whether consumers have access to advocacy, designated standards and complaints mechanisms.45 A complementary publication, Making Health Rights a Reality, was also produced which gave a practical and easily understood ‘how to’ guide to action that could be taken, either individually or as part of a group, to promote consumer health rights, using the three steps: “deciding what rights are important to you..., putting your rights into practice... [and] lobbying for your legal rights”.46

In 1991, CHF moved to pursue the issue of health complaints mechanisms more directly by initiating a project to develop a comprehensive framework for a health complaints system that would meet consumer requirements and, in this light, examine current complaints mechanisms in the health area across Australia. This project concluded with the publication of the report, A Consumer Perspective on Health Complaints Mechanisms in Australia, a year later.47 The outcome was stated concisely in the beginning of the report:

---

43. Consumers’ Health Forum of Australia Inc, Making Health Rights a Reality, Consumers’ Health Forum, PO Box 278, Curtin ACT, 1989, pi.ii.
44. Consumers’ Health Forum, Legal Recognition and Protection of the Rights, p88.
46. Consumers’ Health Forum, Making Health Rights a Reality, pi.
47. Consumers’ Health Forum of Australia, A Consumer Perspective on Health Complaints Mechanisms in Australia, prepared by G. Ednie, Consumers’ Health Forum, PO Box 52 Lyons, ACT, 1992. Gillian Ednie, who prepared the report, had worked for the Health Issues Centre previously. Funding assistance for the project was received from the Federal Bureau of Consumer Affairs.
"First, it [the report] gives a summary and analysis of the complaints processes in each state and territory in Australia from a consumer perspective. Second it provides a set of minimum standards that consumers view as the requirement for an effective health complaints mechanism".48

Recognition and acceptance of health consumers’ rights underpinned the framework for the development of complaints mechanisms. The publication of the report coincided with the moves by the Commonwealth government requiring all states and territories to establish a central independent, statutory based health complaints mechanisms through the Medicare agreements. (See ch7.5.4) The report provided consumers and consumer groups around Australia with a common framework against which to assess any proposed reforms to complaints mechanisms.

The report concluded that the essential minimum standards for a complaints systems from a consumer perspective were:

1. Recognition of the health rights of consumers, including the right to participate in all possible aspects of complaints procedures;
2. Universal coverage of all health services, private and publicly provided services;
3. Independence based in legislation;
4. Public recognition, credibility and accessibility;
5. Consumer advocacy and support through the complaints system;
6. Adequate authority and powers to resolve complaints through conciliation, investigation and appropriate redress;
7. Role in improving the quality of health services including comment on appropriate practices;
8. Co-ordination of the health complaints system that is also open to review and evaluation;
9. Accountability of the complaints mechanism to consumers and the right to appeal decisions made;
10. Adequate resources to maintain effectiveness.49

These standards reflected the principles that the Health Issues Centre also regarded as essential. The work of the two organisations, the knowledge gained through the research and experience of the Health Issues Centre and the identification of consumer rights by the

---

CHF, together provided the groundwork necessary for the development of the minimum standards. Although the standards were described in rather general and global terms, they did outline some key features, important from the consumers’ point of view, but potentially contentious from the perspectives of health service providers and governments. In the environment of the Australian health industry, where intertwined arrangements of public and private provision abound and where government regulation has traditionally been resisted, universal coverage of all part of the health system and independence based in legislation, for example, have been opposed by some professional groups and state governments. (See ch7.5.)

The report examined the health complaints systems in each state/territory, in a similar way to that undertaken by the Health Issues Centre several years earlier, but using a more advanced and sophisticated criteria, based on the minimum standards. The disparity in systems around Australia aroused considerable concern amongst consumer groups and highlighted both the complexity and the lack of complaints mechanisms available in many states/territories. Not one of the minimum standards proposed by CHF was met by all states/territories and no state or territory system met all the criteria. The recently introduced Queensland system fared better that the longer established Victorian and NSW systems. At the time, Western Australia and Tasmania were considering the introduction of alternative systems that still only partially met CHF’s minimum standards. The report identified four different approaches that had been used by the states/territories in addressing health complaints handling: the “public interest investigation/ prosecution” approach, used in New South Wales; the “the conciliation and review approach”, first used by Victoria, then Queensland, and, at the time, under consideration by Western Australia and Tasmania; the “consumer focussed gradual reform” approach used in South Australia;

and the "undeveloped" (little or no action) approach in the two territories.  

Having identified the minimum standards and reviewed the situation with regards to complaints handling across Australia at the time, the report, *A Consumer Perspective on Health Complaints Mechanisms in Australia*, went on to discuss in some detail how the standards might be met through considering the "essential features of an effective consumer focussed complaints system".  

It carefully specified the desirable aims, the preferred local and central level structures, the necessary advocacy services, the form of legislation, the integration and shape of complaints pathways, the ways to improve the quality of health care services, the ability to improve the complaints system, and mechanisms to ensure accountability of and appeals against complaints systems. It also identified significant obstacles to reform including costs in establishing and maintaining the complaints systems, the complexity of issues and changes often required and the need for the commitment of government and health authorities to complaints handling.  

A final short section entitled "strategies for reform" encouraged individual consumers and consumer groups to take action to have the minimum standards for complaints mechanisms implemented through a series of suggestions about how this might be done. A 'how to' booklet, *Exercising the right to be heard: a consumer guide to improving complaints procedures in our health services*, provided a summary of the report and suggestions about action that consumers and consumer groups could take to focus attention on the shortcomings of current complaint systems, particularly questions to ask state and local health service authorities.

---

In 1993, the CHF developed a new strategic plan based on three broad principles which included the protection and enhancement of the rights of health care consumers.\textsuperscript{54}

As part of the process of implementing the plan, the Task Forces were disbanded and, instead, steering committees were set up for each activity and project of CHF. The development of a "charter for health consumers", incorporating the knowledge for the original statement and legal recognition project, was identified as a priority issue and a Charter Campaign Committee formed.\textsuperscript{55} The requirement that the states/territories each draft such a charter, included in the Medicare agreements, made this a matter of urgency.

CHF, along with the Health Issues Centre and other consumer groups, had serious concerns about the initial drafts of a model that was to be used by the individual states and territories in developing their charters.\textsuperscript{56} The drafts, which were developed by officers of the Commonwealth Department of Health with little consultation with consumers or consumer groups, did not reflect the notion of 'rights' in the terminology used and was limited to consumers who were using public hospital facilities only. Despite a meeting of major consumer groups and peak community bodies with the Department to express these concerns, and consultations by the Department with local consumer groups held late in 1993, the final one page document, launched by the Federal Minister for Health in February 1994, was not significantly different.\textsuperscript{57} Wide acceptance and support from consumer groups and health service providers sympathetic to consumers' rights generally were needed if a consumer conceived health consumers' charter was to be adopted nationally.

The restructured Australian Consumers' Council was prepared to take the lead in developing a national charter and the Executive Director of CHF, in her capacity as a


\textsuperscript{55} K. Moore, p19.

\textsuperscript{56} Health Forum Diary, "Public Patients' Hospital Charter", \textit{Health Forum}, no.28, December, 1993, p33.

member of the Australian Consumers’ Council, took on the chair of the Council’s Health Consumers’ Charter Sub Committee.58

Consumer rights has been a major focus for CHF from its beginning and that focus naturally led to a focus on complaints systems, since complaints systems offer an important option for sanctioning activities and behaviour out of line with consumer rights. CHF encouraged health consumer groups of all sizes to become involved in promoting consumer rights and seeking change to complaints handling by providing assistance and advice about how this maybe done. The well researched publications on consumer rights and health complaints systems, including detailed proposals such as the minimum standards, has not only provided consumers with information, but also enabled CHF to provided informed comment and debate on the issues at a time when significant reforms were being proposed.

By 1995, HIC and CHF had both made important contributions to increasing understanding and knowledge about consumers’ rights and complaints mechanisms in the health area. Through this work both organisations have raised the consumers’ “voice” when reforms have been proposed, providing clear and well argued consumer perspectives on the issues.

5.4 AUSTRALIAN STATEMENTS OF RIGHTS OF HEALTH CONSUMERS

Before discussing the consumers’ models for health complaints systems in more detail, it is useful to look more closely at recent developments in constructing charters for consumers of health services because of the critical link between consumers’ rights and complaints mechanisms. Patients charters, statements or codes of rights for consumers of health service are an emerging phenomenon of the 1990s. A number of ‘charters’ have appeared in Australia and around the world - Malaysia, Europe, England, Scotland and Wales, Korea, and India. As well, some countries have developed a more general citizens’

charter applicable to all government services. The idea of documenting consumers’ rights is not new; as already noted the activities of the consumer movement in health, in the 1960s and 1970s included proposing bills of rights for patients, particularly in the USA. What is new, though, is that the charters are increasingly appearing as government documents. As with complaints systems, an examination of the various charters reveals significant differences which highlight the conflicting agendas of consumers, governments and health service providers in promoting the charters and subsequently whether the rights expressed in the charters will ever be more than rhetoric for consumers. (See also ch4.3.5, ch6.4.3 and ch7.4.2.)

The charters are generally statements of rights and standards that users of health services can expect, such as access to health services, comprehensive information provision and the opportunity to make a complaint. Some documents have been generated by consumer groups, others by government bodies, and still others by local health services. Some are supported by legislation, such as the Queensland Health Rights Commission Act 1991; others are memorandums of understanding between key bodies, such as the Malaysian charter59; and some have no official status at all, such as the CHF’s Statement on Consumer Health Rights and Responsibilities. Sometimes there seems to be a preoccupation with the legal enforceability of rights in developing charters, but many citizens’ rights claims go much further than that stated in current legislation. For example, the United Nations covenants and declarations to which Australia is a signatory, such as the International Covenant on Civil and Political Rights, the International Covenant on the Economic, Social and Cultural Rights and the Declaration on the Rights of Disabled Persons, all endorse rights of which only some aspects have been incorporated in the

59. The key bodies were the Malaysian Medical Association, the Malaysian Dental Association, the Malaysian Pharmaceutical Society, and the Federation of Malaysian Consumer Associations reported in Shila Rani Kaur, “Historic Day for Patients’ Rights”, HAi News, Health Action International Clearinghouse, IOCU Penang, no.70, April 1993, p1. A more recent unconfirmed report suggested that the Medical Association has since withdrawn its support.
Commonwealth *Human Rights and Equal Opportunity Commission Act, 1986* and other state/territory acts.60

The charters have been seen by consumer groups as a way of increasing accountability of health services and service providers to consumers, promoting partnerships between consumers and providers, and raising consumer awareness about what can be expected from health service provision.61 The Executive Officer of the CHF wrote

"one simple and inexpensive but effective method of making the system more open and responsive is to develop a charter which sets out for consumers and providers the entitlements and standards which the health care system must deliver".62

Another consumer advocate, in arguing for consumers to support the development of charters, stated that "charters can fulfil a number of purposes - they can represent our [consumers] aspirations, they can educate and inform, they can assist us to articulate and act on our concerns and they can provide a means of having those concerns dealt with".63

Charters developed by consumer groups tend to use terms such as 'have the right to' rather than 'should be treated with' and include explicit and comprehensive statements about what the right may encompass. Consumer groups have stressed that charters must address individual rights but also collective rights of all consumers. Thus documents drafted by consumer groups tend not simply to deal with health service provision but start with a context statement of principles which can indicate a much broader orientation towards conceptualising health, for example, the Consumers’ Health Forum *Statement of Rights and Responsibilities of Health Consumers.*

---


Consumer groups recognise that the development of the charter is only the first part of the process if the rights are to be translated into the every day reality of the experience of the health service user.\textsuperscript{64} Consumer groups are not without some cynicism about the implementation of charters and have lobbied for the legal recognition of the rights expressed, and the establishment of complaints mechanisms to address grievances.\textsuperscript{65} While consumer statements have been criticised for seeming to be an idealist list of rights, they would not seem particularly unrealistic nor necessarily impossible to achieve. While, in some ways, the charters reflect what might be considered ‘good practice’ by many health care professionals, their focus on consumer rights is also a challenge to the traditional ways in which service providers, governments and consumers have thought about health service provision.

5.4.1 A Health Consumers’ Charter for Australia?

At the same time as the Commonwealth Department of Health was attempting to draft a charter for consumers of public health services, the Australian Consumers’ Association, the Australian Federation of Consumer Organisations, the Health Issues Centre, and the Consumers’ Health Forum had come together to form a “campaign committee” to tackle the issue of a national charter for health consumers that incorporated consumers’ perspectives. The 1992 Medicare agreement required each Australian state/territory to draft its own charter, raising concern that this fragmentation would result in an inequitable situation for consumers in different parts of Australia.\textsuperscript{66} The Australian Consumers’ Council (ACC), the advisory committee to the Commonwealth Minister for Consumer Affairs outlined in chapter three, had already established as one of its priorities the empowerment of consumers in the health area, and with links through its members to

\begin{itemize}
\item \textsuperscript{64} Moore, “A Health Consumers’ Charter”, pp11-12.
\item \textsuperscript{65} Evans, pp7-8.
\item \textsuperscript{66} Under Australia’s federal system of government, health service provision rests with the states/territories, although financial power lies with the Commonwealth. The Commonwealth reimburses about 80% of both medical and hospital fees through the Medicare program established by formal agreements between the Commonwealth and the States/Territories governments. (See ch7.2 and 7.5.4.)
\end{itemize}
the other consumers' organisations, the ACC seemed the appropriate (and willing) organisation to auspice the development of a national charter.

In mid-1994 the Council, along with the Centre for Health Law, Policy and Ethics at Newcastle University, sponsored a two day workshop on the issue. A mix of participants from consumer groups, professional associations and government officials (local, state and federal), focused on the drafting and the implications for implementation of a national charter. Guest speakers from England, Canada and New Zealand told of the introduction of health charters in their respective countries, highlighting the consumer experience. The Public Interest Advocacy Centre (PIAC) had been commissioned to prepare a draft document, building on the CHF documents on consumers rights. The introduction to the draft stated that

“A Charter ought to provide a broad framework of rights covering all aspects of health service delivery. Within that framework there need to be charters for specific situations or user groups, due to the special needs and issues that arise in particular contexts... Any charter is a dynamic document which will need to be monitored regularly and updated as required”.68

The detailed draft, following the same framework as CHF’s Statement, began with five fundamental principles, highlighting the broader ‘community’ context in which consumers rights needed to be placed and considered, and noting that these principles were consistent with the Covenants of the United Nations. Each of the twelve rights listed (slightly different to the CHF’s Statement) included sub points, making the document long, but the intent of each right unequivocal.69 The workshop culminated in the Newcastle Declaration for an Australian Health Charter of 29 July 1994, a one page statement outlining the aims

67. In particular the CHF documents, Statement of Rights and Responsibilities of Health Consumers and Legal Recognition and Protection of the Rights of Health Consumers, already discussed. The Legal Recognition and Protection of the Rights document had been produced by PIAC for the CHF several years earlier.

Page 193
of the Charter and calling for the implementation of the Charter by the beginning of 1995. The finalised draft of the Charter was to be presented to the joint meeting of Federal and State/Territory Ministers' of Consumer Affairs for endorsement as soon as possible, and through this group to the more politically powerful Australian Health Ministerial Council for consideration.

Unfortunately, the energy generated by the Newcastle workshop was not followed by rapid action. A redrafted document had not been circulated almost a year later (June 1995), although it was said to be imminent, and further consultations were proposed before the draft was to be finalised; the Commonwealth Minister for Health announced, in June 1995, the provision of a $50,000 grant to ACC to complete the work on the charter. It seemed that one of the primary purposes for developing a national charter, that of informing the development of the states/territories statements, would not be fulfilled, although some of the states/territories had been exceedingly tardy in developing their statements. The factors contributing to the diminution in momentum for reforming complaints mechanisms, discussed in the next chapters, seem to have also slowed the enthusiasm for pursuing the development of charters for health consumers.

5.4.2 Consumers' Charters and Complaints Systems: the Critical Connection

The interconnection between health consumers' charters and complaints systems is critical in two ways. The right for consumers to voice their grievances, that is to complain, has been recognised as a right in itself (as a component of the broader consumer right of redress) and has been included as such in the charters. However, it is easier for people to identify whether they have a legitimate complaint if they know what they have a right to expect from the health service provider. Therefore, complaints bodies have been seen to


71. C. Lawrence, Promoting Patients' Rights. $50,000 for ACC to Develop Charter, Minister for Human Services and Health, media release, CL262/95, 25 June 1995.
have an interest in ensuring that the rights of consumers are clearly defined and stated. The Queensland *Health Rights Commission Act 1991* is a good example of this, where the Commission was given the responsibility, not only to handle complaints, but also to “prepare a Code of Health Rights and Responsibilities setting out legal, social, and ethical rights of health consumers in Queensland”. For consumers to be able to, or even want to try to, complain, expending considerable resources and energy of their own in the process, consumers must have confidence in the complaints processes in place. Hence the need for well defined minimum standards and models of good practice for complaint systems from the perspectives of consumers.

The second point is that a well functioning complaints body, with a firm legislative base, can provide one conduit for the enforcement of the charters. The draft paper, prepared for the Newcastle workshop, included an assessment of how each component of the twelve rights outlined in the proposed Australian Health Consumers’ Charter could be enforced. One option for the enforcement of twenty of the total forty three components of the rights was the use of “complaints/ disciplinary action”. Civil action was considered to be the other major means of enforcement, but this is not renown as a ‘consumer friendly’ process. For nine components it was assessed that enforcement was doubtful or not possible, and for another two no enforcement was required.

While the adoption of a charter of rights of health consumers is recognised as only part of the solution to increasing participation by consumers in the health care system, the current interest in charters has helped focus attention on the need for, and operation of, current complaints systems. The real influence of the charters on health service delivery in Australia is still to be tested. However, the limited nature of some of the proposed charters suggest that their impact on health service delivery will be minimal and in terms that are

more compatible with bureaucratic and service provider agendas than the consumer agenda.

5.5 CONSUMER MODELS OF HEALTH COMPLAINTS SYSTEMS

As already discussed, both HIC and CHF have developed consumer models for complaints systems: HIC in the context of hospital complaints mechanisms; and CHF in the context of a state/territory wide system. The Consumers' Association (CA) of the United Kingdom, where consumer experience with the various complaints mechanisms of the national health system over the past decade in Britain has been more extensive than the Australian consumer experience, has also defined the necessary components of a complaints systems from a consumer perspective offering another useful model for health consumers in Australia. A summary of the points outlined by these three models is shown in Table One: Models of Complaints Systems Proposed by Consumer Organisations.

The stated primary and secondary functions of the complaints system and aims provide the mandate of the complaints system and, consequently, both the CA model and CHF model begin with these. The CA model identifies the primary function of the system as resolving individual complaints with the secondary function as providing feedback to improve services. This is in line with one of the criticisms of the NSW Complaints Unit, that the public interest concerns had sometimes overshadowed the resolution of individual complaints. The CHF model identifies six aims beginning with the rights of consumers, in line with the CHF approach to complaints systems already discussed. The resolution of individual complaints, co-ordination of complaints systems, education about rights and complaints pathways and improvement in the quality of health services through the use of complaints data follow.

74. Consumers' Health Forum, A Consumer Perspective on Health Complaints Mechanisms, and Health Issues Centre, Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus as the primary documents.
TABLE ONE. Models of Complaints Systems Proposed by Consumer Organisations

<table>
<thead>
<tr>
<th>PRIMARY &amp; SECONDARY FUNCTION/AIMS OF COMPLAINTS SYSTEMS</th>
<th>CONSUMERS' ASSOCIATION (UK)</th>
<th>CONSUMERS' HEALTH FORUM (Aust)</th>
<th>HEALTH ISSUES CENTRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY FUNCTION: address the concerns of the complainant, mission statement stressing that the concerns of the complainant are paramount.</td>
<td>AIMS: 1. To recognise, promote and protect the rights of health care consumers. 2. To provide an independent accessible mechanism for resolving consumer complaints and the necessary support. 3. To co-ordinate, resource and monitor other components of the complaints network. 4. To provide information and education to consumers and service providers on consumer rights and complaints pathways. 5. To improve the quality of health services.</td>
<td>UNIVERSAL COVERAGE: all consumers of all health services have access to an independent process, uniform procedures across services.</td>
<td>EDUCATION: of staff of the complaints processes, complaints handling &amp; consumer rights and responsibilities.</td>
</tr>
<tr>
<td>SECONDARY FUNCTION: act as feedback to service providers, to help improve services in general.</td>
<td></td>
<td></td>
<td>ACCESS &amp; AVAILABILITY: availability of clear information on complaints process, rights and responsibilities, high public presence of CLO.</td>
</tr>
<tr>
<td>APPLICABLE TO WHOLE HEALTH SYSTEM</td>
<td>RECOGNITION OF CONSUMER RIGHTS: including the right to complain &amp; to participate in all possible aspects of complaints procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LINKED WITH CONSUMER RIGHTS</td>
<td>PUBLIC RECOGNITION &amp; ACCESSIBILITY: easily accessible, widely known &amp; hold credibility in the community, adequately resourced.</td>
<td>ACCESS &amp; AVAILABILITY: availability of clear information on complaints process, rights and responsibilities, high public presence of CLO.</td>
<td></td>
</tr>
<tr>
<td>VISIBILITY &amp; ACCESSIBILITY OF COMPLAINTS MECHANISM</td>
<td>VISIBILITY: procedure &amp; circumstances publicised, encourage complaints. ACCESSIBILITY: straightforward &amp; involve no cost to consumer.</td>
<td>ADVOCACY &amp; SUPPORT: for the consumer throughout process, advocates recognised as formal representatives in complaints procedures.</td>
<td>ADVOCACY: able to access advocate, particularly if the complaints system is internal. SUPPORT: for consumer in making the complaint &amp; throughout the process (also for CLO and staff handling complaints).</td>
</tr>
<tr>
<td>ADVOCACY &amp; SUPPORT FOR CONSUMER (COMPLAINANT)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Issues Centre, *Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus*, HIC, 1st Floor 257 Collins St, Melbourne, Melbourne, Nov. 1991.
<table>
<thead>
<tr>
<th>Models of Complaints Systems Proposed by Consumer Organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONSUMERS' ASSOCIATION (UK)</strong></td>
</tr>
<tr>
<td><strong>POWERS AND AUTHORITY OF COMPLAINTS MECHANISM</strong></td>
</tr>
<tr>
<td>FLEXIBILITY: procedure should be able to address itself to a variety of complainant aims.</td>
</tr>
<tr>
<td><strong>CO-ORDINATION &amp; ACCOUNTABILITY &amp; EVALUATION OF COMPLAINTS SYSTEM</strong></td>
</tr>
<tr>
<td>TRANSPARENCY: workings of the procedure clear, complainant able to find out what stage complaint has reached, full details of the investigation made available. SPEED: pre-defined time limits for the stages &amp; final resolution in an investigation. IMPARTIALITY: independent of the service providers it investigates, have an appeals procedure, conduct of the investigation not to be altered by those responding to the complaint. EFFECTIVENESS: those carrying out the investigation have access to the information &amp; expertise needed to assess the complaint properly, should be able to initiate action to address the complainants' concerns.</td>
</tr>
<tr>
<td><strong>CONSUMERS' HEALTH FORUM (Aust)</strong></td>
</tr>
<tr>
<td>INDEPENDENT BASED IN LEGISLATION: independence of unit from health care service provider system, commitment of government, direct access by consumer. ADEQUATE AUTHORITY &amp; POWERS: conciliate, investigate, recommend &amp; enforce, ensure confidentiality, protect consumers from being penalised or discriminated against, consumer choice in resolution process. RESOURCES: sufficient resources allocated to all components of the complaints system, increased allocation when demand increases or setting up initially.</td>
</tr>
<tr>
<td><strong>HEALTH ISSUES CENTRE</strong></td>
</tr>
<tr>
<td>COMMITMENT: of Boards of Management, CEOs, hospital staff, to the constructive value of complaints and to the complaints process.</td>
</tr>
<tr>
<td><strong>PARTICIPATION</strong> by the consumer throughout the process, &amp; to be kept informed of progress. CENTRALISED PROCESS: need to be other channels independent of the service provider which the consumer can use (minimise staff discretion in handling complaints). MONITORING &amp; EVALUATION: of the outcomes of complaints &amp; the complaints process with focus on consumers' perceptions.</td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
</tr>
<tr>
<td>Sufficient resources allocated to all components of the complaints system, increased allocation when demand increases or setting up initially.</td>
</tr>
<tr>
<td><strong>COMMITMENT</strong> of Boards of Management, CEOs, hospital staff, to the constructive value of complaints and to the complaints process.</td>
</tr>
<tr>
<td><strong>PARTICIPATION</strong> by the consumer throughout the process, &amp; to be kept informed of progress. CENTRALISED PROCESS: need to be other channels independent of the service provider which the consumer can use (minimise staff discretion in handling complaints). MONITORING &amp; EVALUATION: of the outcomes of complaints &amp; the complaints process with focus on consumers' perceptions.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>APPEALS TO OTHER BODIES</td>
</tr>
<tr>
<td>FEEDBACK TO HEALTH SYSTEM (EVALUATION AND QUALITY ASSURANCE)</td>
</tr>
</tbody>
</table>
| PROCEDURE TO BE USED IN COMPLAINTS HANDLING | PROCEDURE: same for all NHS health services with the Health Services Com. Remaining as appeals mechanism for all categories of complaints:  
1. establish what the problem is & what outcome the complainant wants (possible legal action should not be reason for refusing to investigate);  
2. investigate the case (complainants should have full access to all information uncovered by the investigation, can be referred onto a complaints committee if not resolved at first stage);  
3. produce actual outcome which resolves the matter to the complainant's satisfaction, inform the complainant fully of the actual outcome and the reasons for it (would not deal with disciplinary action or compensation). | PROCEDURE FOR CENTRAL BODY:  
1. encourage direct resolution if possible;  
2. acceptance of complaint;  
3. preliminary assessment;  
4. conciliation;  
5. investigation;  
6. prosecution;  
7. reporting requirements. |                                                                                   |
Because of the complex mixture of the public/private divide in the provision of health services in Australia, the CHF model highlights the need for a complaints system that applies to the whole health system, that is, there is universal coverage of all health consumers.\footnote{Doctors in Australia may be either State-salaried or paid on fee-for-service (partly reimbursed in most cases by Medicare or private health insurance); hospitals may be either State, ‘public’, (funded by the Commonwealth and the States/Territories) or private (usually, also, attracting some government funding). See also ch7.2.} Already there has been legitimate concern that there could be fragmentation of complaints handling, because the clause in the Commonwealth State/Territory Medicare Agreements requiring the establishment of independent complaints units only includes reference to “public patients”.\footnote{Commonwealth Department of Human Services and Health, \textit{Public Patients’ Hospital Charter: What You Can Expect under Medicare in Australian Public Hospitals}. In South Australia the Minister for Health expressly rejected a wider brief for the charter; see ch7.5.3.} In an era of privatisation and contracting out of government services the need for universal coverage is even more important as the distinction between public and private provision becomes increasingly unclear. As well, services may be received from a variety of providers in different health settings creating a maze for consumers to traverse to find the appropriate body to whom to make a complaint.

All three models highlighted the need for complaints mechanisms to be visible and accessible so that they can be confidently used by consumers. In addition, public recognition of the existence of such mechanisms needs to be fostered. The visibility and accessibility of the complaints systems complements the need for information and education about consumer rights and complaints pathways so that consumers can take action. Education of health service providers about consumer rights and complaints handling is another aspect. Both the HIC and CHF models make a specific point of the need for advocacy and support for the consumer when making a complaint. The difficulties consumers experience in negotiating complaints pathways in the health system, the emotional distress often engendered by the circumstances of the complaint and the imbalance between the consumer as ‘patient’ and the ‘expert’ service provider increases the vulnerability of the consumer not to proceed with a complaint.\footnote{This is supported by findings from my field research, discussed in chapter eight.} The availability of
advocacy and support services, such as the role performed by some Complaints Liaison Officers, can be of great assistance to the complainant. In instances where the service provider may be supported by legal counsel, such as might occur before a registration board or with conciliation, consumers also need to have access to an independent advocate who is allowed to accompany them to any meeting.

The powers and authority considered necessary for a health complaints mechanism are expressed in different ways by the three consumer models. The CHF model emphasises independence based in legislation and sufficient powers to ensure the central unit can investigate, conciliate, prosecute and enforce outcomes. Adequate resources are to be made available. In the CA model the need for the system to have the flexibility to accommodate the majority of complaints is stressed while commitment to complaints handling by the most highly placed officials in the health system is stressed in the HIC model. The inclusion in all three models of the elements of co-ordination, accountability, and evaluation of the complaints systems recognise that scrutiny of the complaints system itself is necessary if the effectiveness of the systems in meeting consumer need is to be assessed. The CA model stresses transparency, speed and impartiality in complaints handling; the HIC model emphasised participation of the consumer throughout the process. Co-ordination of the various components of the complaints system and the development of standardised procedures to reduce service provider discretion, that might disadvantage the consumer, are also highlighted. Consumers need to retain the right to pursue complaints through mechanisms other than the central health complaint body, such as the Ombudsman or litigation, and to have access to an appeal process against the decisions or actions of the health complaints body.

The systematic collection and reporting of data are identified as critical to the usefulness of the information that complaints, and the resolution of complaints, can provide to the health system. Consistent with the aim of improving the quality of health systems, the consumer models link complaints information with quality assurance activities
and the evaluation of services. Both the CA and CHF models outline the procedures to be used in complaints handling by central complaints units. A number of stages are identified: encouragement of direct resolution with the service provider if this seems possible and the consumer does not feel intimidated by using this process; acceptance and preliminary assessment of the complaint including advancing options for the satisfactory resolution of the complaint; independent investigation of the circumstances of the complaint and keeping the complainant fully informed throughout; resolution of the complaint with an outcome that is satisfactory to the complainant and that may include conciliation or prosecution.

A more complete framework for a consumer model of complaints systems emerges by combining the three models constructed by the consumer groups. Using the headings listed on the left hand column of Table One and the components from each of the models, the Combined Consumer Model for Health Complaints Systems, Table Two, provides a clear and detailed outline of the components of complaints mechanisms in the health area, all of which are essential if the system is to be regarded as 'complaints enhancing' and effective from the perspectives of consumers.

The opportunity for the multiple involvement of consumers in complaints handling processes is evident from the components included in the models. At an individual level, it is envisaged that consumers will be able to take an active part in the actual complaints handling process by providing information and clarification about their complaints not only initially but throughout the process; and by providing ideas and suggestions during the resolution stage. To be able to do this effectively, consumers may need assistance in clearly articulating their position and desired outcomes; support and advocacy for the complainant must be built into the mechanisms, not merely seen as adjunct to be provided if resources allow.

80. The project undertaken by HIC in 1993 provides a practical demonstration of how this might be achieved. Health Issues Centre, The Role of Complaints in the Improvement of Health Services.
### TABLE TWO Combined Consumer Model for Health Complaints Mechanisms

#### AIMS OF COMPLAINTS MECHANISMS:

1. To provide an independent accessible mechanism for resolving consumer complaints.
2. To recognise, promote and protect the rights of health care consumers.

#### FUNCTIONS OF COMPLAINTS MECHANISMS:

1. Address the concerns of the complainant; mission statement to stress that the concerns of the complainant are paramount.
2. To improve the quality of health services; and provide direct feedback to health service providers and recommendations for improving health services from complaints data.
3. To provide information and education to consumers and service providers on consumer rights and complaints pathways.
4. To co-ordinate, resource and monitor other components of the complaints network.

#### PRINCIPLES:

1. **APPLICABLE TO WHOLE HEALTH SYSTEM**
   
   Provide universal coverage; all consumers of all health services have access to an independent process; uniform procedures for complaints handling across services.

2. **LINKED WITH CONSUMER RIGHTS**
   
   Role in the development of detailed statements of consumers’ rights; increase recognition of and education of consumers and service providers about consumer rights and responsibilities including the right to complain and to participate in all possible aspects of complaints procedures.

3. **VISIBILITY & ACCESSIBILITY OF COMPLAINTS MECHANISM**
   
   Complaints mechanisms to be visible; procedure and circumstances well publicised, encouraging complaints; to be accessible and available; procedures to be straightforward; clear information provided about complaints pathways; and involve no cost to consumer. Also to be publicly recognised and hold credibility in the community and adequately resourced.

4. **ADVOCACY & SUPPORT FOR CONSUMER (COMPLAINANT)**
   
   Advocacy and support for the consumer throughout process; able to access independent advocate (at no cost), particularly if the complaints resolution is taking place internally; advocates to be recognised as formal representatives in all stages of the complaints procedures. Also designated person in each health service organisation to have responsibility for complaints handling in that organisation.

5. **POWERS AND AUTHORITY OF COMPLAINTS MECHANISM**
   
   Complaints mechanism must have independence based in legislation; specific to health complaints; sufficient powers to ensure the central body can investigate, conciliate and prosecute; and powers to be able to enforce the implementation of recommendations. Flexibility of procedures to be able to address a variety of complainant aims; direct access by consumers and adequately resourced to meet demand. Commitment of government and highly placed officials in the health system to the constructive value of complaints and to the complaints process. Able to ensure confidentiality, protect consumers from being penalised or discriminated against and consumer choice in resolution process.
### TABLE TWO  Combined Consumer Model for Health Complaints Mechanisms

**6. CO-ORDINATION, ACCOUNTABILITY & EVALUATION OF COMPLAINTS SYSTEM**

Workings of the complaints mechanisms and procedures to be transparent and clear; complainants able to find out easily what stage the complaint has reached; complainants able to participate in the resolution and to receive full details of the process of the investigation; pre-defined time limits for the stages and final resolution in an investigation to be set, complainant to be informed of any changes in timeline.

Independent of and impartial to the service providers being investigated and conduct of the investigation not to be altered by those responding to the complaint; centralised process to be independent of the health services completely.

Central body has responsibility for the coordination of health complaints system and for the development of standard procedures and policies; empowered to recommend and monitor changes concerning all aspects of the complaints system; devise codes of practice minimising staff discretion in handling complaints; those carrying out the investigation have access to the information and expertise needed to assess the complaint properly; able to initiate action to address the complainants' concerns.

Accountable to individual consumer and service provider involved, also accountable to executive authority and to the public through regular reports, external review of complaints handling processes every few years. Monitoring and evaluation of the effectiveness of the complaints mechanisms, particularly the outcomes of complaints and the complaints process with the focus on consumers' perceptions. Consumers to be involved in the formation, on going development, and evaluation of mandatory complaints mechanisms and monitoring complaints outcomes.

**7. APPEALS TO OTHER BODIES**

Complainants should have the right to appeal about a decision, first to an independent body or other complaints mechanisms such as the Ombudsman. Complainants also to retain the right to pursue other avenues, for example through the courts.

**8. FEEDBACK TO HEALTH SYSTEM AND IMPROVING HEALTH SERVICES**

Data about complaints to be collected systematically; data to include qualitative data and consumer orientation; data to be comprehensive, covering both formal and informal complaints.

Monitoring and analysis of complaints' causes and substance, trends and patterns, refer on issues to relevant bodies, regular public reporting of complaints and resolution/action taken.

Complaints data to be fed into and used in service evaluation and quality assurance activities; complaints data to be actively promoted to inform improvements to health service provision. Implementation of the recommendations arising from complaints to be monitored.

**PROCEDURE TO BE USED IN COMPLAINTS HANDLING FOR CENTRAL BODY:**

1. Encourage direct resolution only if complainant has sufficient confidence in mechanism and support to proceed;
2. Acceptance of complaint, establish what the problem is and what outcome the complainant wants (prospect of possible legal action should not be reason for refusing to investigate);
3. Preliminary assessment, including voluntary choice of using process of conciliation or further investigation;
4. Investigation: complainants should have full access to all information uncovered;
5. Prosecution of the service provider, if necessary, by the complaints body before an appropriate authority; or recommendations made direct to the health service providers.
6. Reporting requirements, produce an actual outcome which resolves the matter to the complainant's satisfaction, inform the complainant fully of the actual outcome and the reasons for it.
7. Monitoring of outcomes to ensure that changes have been sustained over time where recommendations for individual or systemic changes have been part of the resolution of the complaint.
At the broader level, there is a role for consumers in the development and monitoring of the everyday operations of complaints mechanisms to ensure that the ‘consumer’ understanding of the various desirable components is reflected in the actual implementation. This may be formalised through advisory committees and boards and specific evaluation projects. Also at the broader level, there is a role for consumers in the interpretation of complaints data and the implications for changes to system and procedures in health service provision through, for example participation in quality assurance committees and activities.

The focus on complaints data being used to inform change to health service provision is fundamental to the consumer interest in complaints handling. Without this link between what has happened at an individual level, that is the substance of complaints, and what changes are implemented at a systemic level, the full value of the investment in the better handling of complaints is ignored. For many consumers it is the knowledge that their complaint may improve the situation for others in the future that is the critical determinant of their satisfaction with the complaints handling process. It is their contribution to health service improvement. The matters captured in complaints data may not represent all areas proposed by consumers for changes to health service provision and health systems (and consumers do not necessarily have homogenous views on these issues), but the substance of complaints does present a significant part of the picture that must not be overlooked.

5.6 CONCLUSION: THE CONSUMER AGENDA FOR HEALTH COMPLAINTS SYSTEMS

The previous chapters have focussed on the consumer movement and organisations that have been instrumental in shaping the consumer agenda in the health area. The emphasis by the broader consumer movement on the recognition of the fundamental rights of consumers and, specifically, the right to complain and seek redress, has led to the active involvement by consumer organisations in campaigning for the establishment of, and
changes to, health complaints mechanisms. This has included conducting research from the consumer perspective and developing ideal models, as outlined in this chapter, shaping the consumer agenda for health complaints mechanisms. This agenda, and the primary purpose of complaints handling from a consumer perspective, has two parts which I have termed 'the individual' and 'the collective'.

The individual concerns the recognition and acceptance of each consumer's right to complain and to have the complaint dealt with to their satisfaction. It acknowledges that consumers can make a legitimate assessment about the health service they have received. It requires that consumers have sufficient knowledge of their rights and are given sufficient information to assist them in making their assessment. It realises that health care is a personal experience and that to make a complaint against an 'expert' health provider or complex health system requires energy and resources and that many consumers will need assistance in taking action. It emphasises that the consumer needs to be kept informed and involved in the process of resolving the complaint and that the outcome reached contains some satisfaction for the consumer.

The collective concerns the notions of commonality and community amongst health consumers, that is collaboration between consumers, and between consumers and providers as equal partners in the health enterprise. It recognises that what consumers have to say about their experience is just as valid and relevant as any other group. It acknowledges that the information from complaints can contribute to understanding of health service delivery and should be used to help plan and shape services. It realises that each complaint reflects a negative experience felt by a consumer and that other consumers may be similarly affected. It emphasises that the resolution of complaints should involve sustained change to the health system, procedures and service providers.

Within the context of the broader consumer movement, consumer organisations have work hard to gain credibility and authority to be able to put forward the consumers' 'voices' on health matters. Using the common elements that characterise the consumer
movement in health as the foundation, models of complaints handling reflecting the perspectives of consumers have been identified by these organisations. The critical link between statements of consumers’ rights and complaints mechanisms have also been highlighted. The models have been used to assess existing health complaints systems across Australia, all of which have been found wanting from a consumer perspective.

The combined consumer model for health complaints systems offers a framework for complaints handling reflecting the two parts of the consumer agenda: the individual and the collective. It clearly articulates the components of a complaints system necessary for complaints handling to be effective from the perspectives of consumers. However, reforms to health complaints systems around Australia in recent times, have not necessarily reflected or incorporated the ‘consumer’ components into the new systems. Exploration of the multifaceted agendas of governments, public sector managers and health service providers, which follow in the next chapters, suggest that the consumer agenda for complaints systems has primarily gained acceptance only where this has coincided with or could be used to further the agendas of these other groups, who control health policy, planning and service delivery implementation and decision making. The individual part of the consumer agenda has found more favour than the collective part as the continued individualisation of complaints and complaints handling allows the challenges to current systems presented through complaints to be contained or ignored. The individualisation of complaints and complaints handling presents a major barrier to ‘consumer’ reforms to complaints handling mechanisms at the local level. (See ch8.4.) Consumers ‘voices’ on complaints handling reforms have easily been relegated to second place in the face of the agendas of more influential groups.
CHAPTER SIX

GOVERNMENTS, PUBLIC SECTOR MANAGERS AND COMPLAINTS SYSTEMS

6.1 INTRODUCTION

To understand better the complaints mechanisms currently in place and proposed for the health sector it is necessary to examine the broader developments in addressing complaints introduced by governments across Australia. Over the past two decades three distinct tendencies have emerged: the establishment of mechanisms with a legislative base for the ‘independent’ scrutiny of the administrative decisions and actions of public sector agencies, such as the Ombudsman and Administrative Appeals Tribunals; the development of mechanisms for the internal management of complaints in line with the new corporate management style, with its attendant consumer focus; and the setting up of consumer affairs portfolios within governments with explicit consumer protection and complaints handling functions not restricted to public sector activities. As complaints mechanisms specifically devised for dealing with health care complaints encompass all three tendencies it is pertinent to look more closely, in this chapter, at these developments, the models they present and the government and bureaucratic agendas underlying their implementation. More detailed discussion of the complaints mechanisms operating within the health system follows in the next chapter.

The transformations of complaints mechanisms has occurred in, and partly because of, an altered environment of public sector services provision where talk about accountability has become increasingly important. Public sector administration has been significantly reformed in the context of economic concerns about public sector spending and changing ideas about the role of government in direct service provision. Moves toward corporatisation and privatisation of public sector services have dominated the reforms and
Private sector business practices have been increasingly put forward as the most appropriate model for government services to emulate. This chapter provides an analysis of the complex and much debated changes in administrative practices that have been adopted throughout the public services of the different Australian governments, highlighting some of the significant developments and trends which have contributed to creating an atmosphere within government services that is more conducive to hearing grievances, although not necessarily to act upon them.

The belief that the handling of the complaint should occur as near as possible to the source of the complaint, preferably by the individual organisation concerned rather than a central body, is imbedded in all the mechanisms discussed in this chapter. Always a survival technique for the various central mechanisms to cope with overwhelming workloads with limited resources, but now part of their complaints handling philosophies, the central agencies generally will not take up a complaint unless the complainant has already tried to resolve the complaint with the agency/person concerned. The more recent widespread adoption of alternative dispute resolution methods has added another dimension to the complaints handling process, not necessarily in the consumers' favour. Local resolution of complaints has been further reinforced by the development of an Australian standard for complaints handling, outlining the 'best practice' processes and procedures that organisations should adopt if their complaints mechanism is to meet the standard. However, this standard is still deficient in some areas, from a consumer perspective.

It is concluded in this chapter that the interest in greater accountability that has included the establishment or review of complaints mechanisms has been internally driven, for government and bureaucratic purposes; it has not necessarily led to direct benefit for or increased accountability to the consumers using the services, or the public at large. The milieu of legislative reform and review, restructuring and changing work practices within public sector services has created a more conducive environment for raising the consumer
agenda and hearing complaints. However, the complaints mechanisms created have consistently taken a predominantly individualised approach, seeking individual resolutions for individual consumers about their complaints; solutions that are unlikely to challenge the prevailing status quo.

6.2 CONTEXT: RESTRUCTURING THE PUBLIC SECTOR

The past two decades have been witness to considerable reform in the organisation and functioning of government bureaucracies at state/territory and federal levels. The social and political climate of change prevalent across western democracies in the late 1960s and early 1970s, that supported the revival of the consumer movement discussed previously, also brought with it a renewed scrutiny of government processes. In a similar way to that noted for the consumer movement, each cycle of change in government practices has resulted in the development and adoption of identifiable new forms of administration, influenced by the prevailing dominant ideas about the role of government and the structure and responsibilities of the organisations charged with carry out the functions of government. Each cycle has brought with it theories and practices that, in turn, influence the next cycle and administrative reforms embraced. In the Australian context, Halligan and Power have identified five phases in the development of administrative systems of government organisations.1 For the purposes of this thesis it is particularly relevant to examine the characteristics of the fifth and most recent phase, which extends from the 1970s to the present time and in which, Halligan and Power maintain, the

"traditional paradigm of ‘protected pluralism’, which sat well with the Technicist and Administrationist types of Australian regimes, has been supplanted by a new paradigm of Strategic Political Direction".2

---

Within this context of changing ideas and practices about the administration of public services and the related role of government there have been significant developments in complaints handling by at least some government services.3

The accountability of administrative decision making by public officials became a focus of concern in the early 1970s, stimulated by the upsurge in legislative reform, combined with expressions of liberal disquiet about the extent of government regulation and control over many aspects of daily life. The scope of activity by governments expressed in legislative and regulatory frameworks had grown substantially in the preceding decades. However, many legislative arrangements were found to be inadequate to deal with the complexities of modern society in a number of areas. This led to extensive reform, around this time, of much existing legislation as well as the introduction of legislation in areas where none had existed previously. The consumer affairs legislation and consumer affairs bureaux set up in the 1970s, which are discussed in more detail in a subsequent section in this chapter, provide a good example of an area where legislative and public sector activity was extensively reviewed and expanded.

At the federal level, the Commonwealth Administrative Review Committee, under the chairmanship of Sir John Kerr, outlined in 1971 a series of proposals for a comprehensive revised system of administrative review to be introduced. The traditional systems of judicial and parliamentary review associated with the doctrine of ministerial responsibility and pursuit of grievance through common law were considered cumbersome, slow, costly and inaccessible to many.4 Some government agencies had established mechanisms to cope with situations where those affected by decisions wanted the decision reviewed and, in some cases, had set up tribunals to hear appeals but these mechanisms were thought to be ad hoc, confusing and often difficult to use. Although modified by

3. Within the administrative context the term 'grievance' tends to be used in preference to 'complaint'. However, as there does not seem to be a distinguishable difference in interpretation, as discussed in chapter one, the two terms will be used interchangeably.
recommendations from subsequent Committees, the Kerr Committee’s report is recognised as having provided the groundwork for the series of Commonwealth administrative laws (often called the administrative law package) that were introduced over the next decade.\(^5\)

The administrative law package provided a sophisticated framework for administrative law practices in Australia, creating new mechanisms to specifically address individual grievances and to call to account administrative decision making (discussed in the next section).

Governments of both parties took up the agenda of administrative law reform. The Kerr Committee had been set up under a Liberal government. The short lived Whitlam (Labor) government introduced the legislation for the Administrative Appeals Tribunal and the Ombudsman. The following Liberal government actively pursued the remainder of the package and the then Prime Minister, Malcolm Fraser, considered administrative law reform as a major achievement of his government.\(^6\) As well, the reforms received support from judges and lawyers keen for the actions of government to be held more accountable along legal principles.\(^7\) Halligan and Powers contend that these reforms were in line with the “administrationalist” style, which emphasised impartiality, formal rules, and procedural correctness, dominant within the bureaucracy of the Commonwealth government at the time.\(^8\)

The administrative review reform agenda of the 1970s was, however, overtaken by the new agenda of management reform.\(^9\) The return of the Labor party as the majority in government, in 1983, began a new era of challenging established administrative practices

---

7. Bayne, p1040.
8. Halligan & Powers, p76.
in government bureaucracies at the Federal level. Similar challenges to the workings of public sector agencies were occurring at the state/territory government level during the same period. The principles underlying the 'new managerialism' and 'economic rationalism' ideologies that came to prevail have had significant ramifications for the way the public service is financed, structured and, ultimately, for the way services are delivered. Notions such as 'structural efficiency', and 'strategic planning' have become firmly entrenched in administrative practices, although interpretations of their meaning and implications for service delivery have differed. More recently revised industrial arrangements for the public sector, as reflected in award restructuring, have highlighted these changes, for example by redefining jobs in terms of expected outcomes from work performed. As well, greater acceptance of the 'generalist manager', demonstrated by the introduction of a senior executive service in the Commonwealth government, has given rise to a different view of the role of manager.

Terminology new to the public sector, such as 'corporate management', 'new managerialism' and 'management for results' became part of the vocabulary of public administrators in the mid 1980s, and are now commonly found in Australian publications pertaining to public administration. These terms encompassed

"the growth of a new set of concepts, already prevalent in the private sector, now adapted for public service management. It includes the development of departmental mission statements and objectives, the publication of corporate plans, the introduction of schemes for decentralisation, devolution of responsibility and risk management, and the development of performance indicators for systematic measurement and evaluation".10

Differing interpretations of the impact of the 'new managerialism' on public sector structures and service delivery has been debated by those avidly supporting the new managerialist stance and those highly critical of it. The series of articles from 1987 to 1990 in the *Australian Journal of Public Administration* provide examples of the arguments put

forward by critics and supporters of the reforms. The debates centre around three major issues: the nature of public sector activity compared to the profit making private sector and the appropriateness of the techniques of the ‘new managerialism’ to public sector administration; assessment of the achievement of the stated goals in the intended way by the adoption of the techniques; and the role of consultation with and participation by the public (and also more junior staff) in deciding the new directions.

The traditional role of the public service bureaucracy as impartially administering the policies of elected governments within the boundaries of extensive legal and procedural frameworks was seen both as an obstacle to reform and as insufficient to handle the complexities of modern government activity. Halligan and Power maintain that, for example, the Hawke Labor Commonwealth government of the mid 1980s was attracted to the concepts of the new managerialism because it "offered both a new framework for directing the public service and a rationalisation for exerting greater government control". Considine thinks that the introduction of ‘new managerialism’ techniques within the public service represents a move away from ‘bureaucratic methodologies’ of earlier public administrations to the structures and methods of operation of the private sector. To this end, outputs become emphasised, rather than inputs; program budgeting, rather than appropriation budgeting; financial reward as motivators of senior staff, rather than career commitment and administrative independence; economic rationality, rather than the legal and procedural framework; and the public become imagined stockholders or investors.


wishing to maximise the market value of their assets.\textsuperscript{14} In line with private sector management strategies, emphasis on marketing and customer relations have become fashionable activities in the public sector. While Halligan and Power see this change as a new approach to public administration, Yeatman argues that these ideas are “a technical approach to public administration and public service couched within a broader policy framework dominated by economic considerations”.\textsuperscript{15}

The reforms to management practices in the public sectors across Australia over the past decade are now well documented.\textsuperscript{16} It has been suggested that the reforms are really a combination of two reform agendas evolving from different sources, that of financial reform and that of management reform.\textsuperscript{17} The declining economy and the demand for public services to decrease spending, despite increased usage, along with budgetary initiatives by governments overseas, contributed to the climate supporting reforms in budgetary practices, including a move away from the traditional appropriation method budgeting to a program budgeting system.\textsuperscript{18} Program budgeting required information about the delivery of public services in a form that could be used to measure performance defined as the efficient achievement of the objectives of the organisation.\textsuperscript{19} As demand for government services increased, the performance and productivity of the public sector was identified as an area in need of reform, and it was asserted that a more “businesslike” approach would achieve the improvements wanted.\textsuperscript{20} Private sector strategic management practices offered to provide, amongst other things, the performance information required

---

\textsuperscript{15} Yeatman, \textit{Bureaucrats, Technocrats, Femocrats}, p14.
\textsuperscript{16} This included documentation by government departments and committees, for example, the Task Force on Management Improvement, \textit{The Australian Public Service Reformed: an Evaluation of a Decade of Management Reform}, AGPS, Canberra, 1993.
\textsuperscript{17} J. Wanna, C. O’Faircheallaigh, & P. Weller, \textit{Public Sector Management in Australia}, Centre for Australian Management, Griffith University, Macmillan Education Australia, South Melbourne, 1992, pp97-98.
\textsuperscript{20} Caiden, p45.
for program budgeting. Whether the outcome of one or several agendas, “Australia’s administrative culture” has undergone radical changes.21

The implementation of the reforms have proceeded with local variations at the state/territory and federal levels and at differing paces.22 However, there has been consistency in the articulation by governments of the broad objectives of the reforms, which are well summarised in the Commonwealth publication Building a Better Public Service:

“The key objectives of the management reform program pursued over the past decade were to develop a [Public] Service that:

. was more responsive and accountable to Ministers and the Parliament;

. was more efficient, effective and equitable, with rational means for the distribution of resources to priorities, and which gave managers greater flexibility in managing those resources; and

. had more streamlined staffing policies which more effectively pursued merit and equal employment opportunity”.23

An important component of the management reforms has been the concept of “continuous improvement” using the management cycle (planning, budgeting, implementing and evaluating). This has led some public sector agencies to devote greater attention to consumer satisfaction with services provided and to the handling of complaints.24

The recent reforms to the public sector have not been limited to management and internal procedures but also encompassed the commercialisation, corporatisation and privatisation of some services that were provided by government organisations. Transformation of a number of Commonwealth statutory authorities into government business enterprises, to replicate commercial business practices, for example, was intended to improve the profitability of these agencies and, at the same time, increase their responsiveness to public demands for better services in areas such as telecommunications.

22. For discussion of some of these differences see Halligan & Power.
24. See ch6.4.4.
and civil aviation. The idea that governments should withdraw from the provision of services in areas where private businesses were already operating, or could be involved, led to the contracting out and eventual sale of public sector services at all levels of government. Mutual recognition legislation was introduced across Australia to “remove regulatory impediments to interstate trade and the mobility of labour, creating more competitive national markets”. An integral part of the move towards mutual recognition has been the identification of standards or competencies and best practice benchmarks for various industry and professional practices. These moves have been reinforced by the renewed emphasis on Australian private and public sector businesses achieving international competitiveness. The role of governments in monitoring and regulating commercial activities through such agencies as consumer affairs has also been under review. This changing context of public sector administration over the past two decades has supported the emergence of new and different mechanisms to address consumer complaints.

6.3 ADMINISTRATIVE LAW REFORMS AND COMPLAINTS HANDLING

The 1970s has already been noted as a significant time for the advancement of the consumer agenda. It was also a time for significant administrative law reforms at both Commonwealth and State government levels, as one way of calling to account government instrumentalities. Griffiths identified several policy objectives underpinning these reforms:

“They are designed, both in the public interest and in the interests of individual justice, to make administrative officials accountable to independent and impartial agencies for their actions and decisions; in the interests of open government, to eliminate unnecessary secrecy in administration; and in the interests of good public administration, to improve the quality of primary decision making.”

27. See ch6.5.
At the Commonwealth level, the administrative law reform package consisted of the Administrative Appeals Tribunal Act 1975, the Ombudsman Act 1976, the Administrative Decisions (Judicial Review) Act 1977 and the Freedom of Information Act 1982. More recently the Privacy Act (1988) has added another dimension to this package. Of particular importance here is the establishment of specific mechanisms to address grievances and hear appeals about particular areas of government processes and decision making: the Ombudsman, able to investigate and review decisions made and actions taken in that process, providing a model of a central complaints mechanism; and the tribunals with the power to review and replace administrative decisions, such as the Commonwealth Administrative Appeals Tribunal. The Freedom of Information and Privacy legislation also warrant further examination as they have focussed attention on consumer and community rights in regard to information held by government agencies. Exploration of the current everyday workings of these mechanisms provides insight into the issues that have arisen in their operation and the implications for complaints handling mechanisms within the bureaucratic sphere and more generally.29

While other legislative changes, such as human rights and equal opportunity legislation, have also created mechanisms for dealing with individual grievances, the systems set in place by the administrative law reform 'package' exemplify the issues raised by the implementation of complaints handling mechanisms based in legislation. The administrative law reforms introduced in Australia, especially by the Commonwealth government, have been regarded as innovative and world leading in the interpretation of

administrative law. Broadly the purposes of the reforms were to bring about an increased accountability and equity in government administration with particular emphasis on the justice of government decision making and actions, characterised by "openness, fairness, participation, impartiality and rationality". The Access to Justice Advisory Committee maintains that a "fundamental aspect of access to justice is the ability of an individual who is adversely affected by a government decision to obtain an impartial and speedy review of that decision".

The reforms to administrative law have provided three pathways for addressing individual grievances about government decisions: merits review, enhanced judicial review and ombudsman review. The Access to Justice Advisory Committee contends that:

"An administrative justice system fails if it does not provide:

- a comprehensive, principled and accessible system of merits review;
- a requirement that government decision makers inform persons affected by government decisions of their rights of review;
- a simplified judicial review procedure by comparison to judicial review under the common law;
- a right for persons who are affected by decisions to obtain reasons for those decisions;
- broad rights of access to information held by government; and
- an adequately resourced ombudsman or commissioner of complaints with a general power to review government action."

Only the Commonwealth government currently comes close to meeting these criteria. The states/territories have been less inclined to set in place the range of mechanisms thought necessary for a comprehensive system and have proceeded at varying paces. The concept of the Ombudsman has been the most readily accepted; all states/territories had one by the end of the 1970s.

32. Access to Justice Advisory Committee, *Access to Justice. An Action Plan*, R. Sackville Chair, Report to the Minister for Justice and the Attorney General, Australian Government Publishing Service, 1994, p321. The Committee’s task was to examine how the legal system could be reformed "in order to enhance access to justice and make the legal system fairer, more efficient and more effective"(pi).
The subsequent sections draw on the Commonwealth legislation and agencies for examples to highlight the issues arising from the administrative law reforms. Together these mechanisms, along with the similar mechanisms introduced by state/territory governments, have contributed to greater acknowledgment within public sector circles that administrative decision making should be open to less formal review than that offered by the courts, and increased recognition of the need for appropriate grievance procedures/complaints mechanisms to be set in place. However, the mechanisms created through the administrative law reforms also have drawbacks and further discussion of the issues that have become evident with the implementation of these particular styles of complaints handling mechanism concludes this section. It should be noted that the mechanisms currently only pertain to administrative decision making and actions by officials of government agencies and that the decisions and actions of the private sector fall completely outside this sphere. The next chapter reveals the extent of the jurisdictions of the complaints handling mechanisms is particularly important in the health care area, where the public and private sectors may not be as clearly delineated.

6.3.1 The Ombudsman

The most prevalent model introduced to provide a central mechanism to handle complaints about public sector services has been the Office of the Ombudsman. The establishment of an Office of the Ombudsman was adopted rapidly by the states/territories and the Commonwealth in the first half of the 1970s. The very nature of the Ombudsman made the concept more acceptable to public sector administrators and politicians because, as Curtis notes, “it is the lack of power in the Ombudsman which enables it to fit more easily into the framework of responsible government”.34 Despite New Zealand’s example

of establishing an office of the Ombudsman in 1962, the idea was initially rejected in Australia in the early 1960s as too expensive to implement. However, by the late 1960s the groundswell of support for the establishment of offices of the Ombudsman had grown considerably. In 1971 legislation was first passed in Western Australia creating an ombudsman-like Parliamentary Commissioner of Grievances. South Australia followed with similar legislation, but using the title Ombudsman, in 1972; Victoria in 1973; and Queensland and New South Wales in 1974, all prior to the Commonwealth Ombudsman Act of 1976. By the late 1980s numerous Offices of the Ombudsman existed world wide and an international association of the Ombudsmen had been formed.

Issues of relevance to all the Australian Offices of the Ombudsman are highlighted by examining the work of the Commonwealth Ombudsman. The original proposal by the Kerr Committee Report was for a Commonwealth “General Counsel for Grievances”, to sit within the legal system, and with a broad role that included advising citizens of their rights to appeal and the possibility of proceeding on their behalf. However, the subsequent Bland Committee did not support these ideas and instead recommended a return to the more narrow role of Ombudsman, already adopted in several states. This located the Ombudsman within the parliamentary system under the executive arm of government, and did not include the power to make new decisions nor to be involved in policy or social reforms. Some of the current tensions and criticisms of the Ombudsman’s role relate to the differing views about the relationship of the Ombudsman to the Parliament and scope of action that can be taken.


Page 221
The role of the Commonwealth Ombudsman has primarily involved the handling of individual complaints about administrative decisions or actions. The Senate Standing Committee on Finance and Public Administration, in the 1991 report entitled *Review of the Office of the Commonwealth Ombudsman*, maintained that

"the traditional role assigned to the Commonwealth Ombudsman is more concerned with the resolution of particular grievances than with the systematic reform of the administration or with the coordination of the whole system of administrative review".41

However, the current Ombudsman notes several other aspects to her role: to advocate for change in areas assessed as problematic; and to encourage open debate about expectations of standards of service and decision making provided by government agencies. To this end the Ombudsman sees her Office as "joining the debate about best practice standards and client rights".42

The offices of the Commonwealth Ombudsman, located around Australia, deal with thousands of inquiries and complaints each year.43 In 1993/94 just over 40% of the 37,772 approaches made to the Commonwealth Ombudsman resulted in a complaint, slightly less than the previous year and partly attributable to the separation of telecommunications industry complaints that were now dealt with by the new industry-specific Ombudsman.44

Over three quarters of the complaints were made by telephone, although more complex complaints are requested in writing.45 In line with the notion that the Ombudsman should deal with complaints in an informal and speedy manner, many of the complaints are concluded in a matter of days through telephone contact with the agency concerned.

---


42. Commonwealth Ombudsman, p1. The current Commonwealth Ombudsman, Ms Phillipa Smith has a reputation for a strong consumer orientation and innovation in her work. She was the first Manager of the New South Wales Health Department Complaints Unit and she also worked for consumer groups such as the Australian Consumers' Association. (See ch7.5.1.)

43. It is noted that the Commonwealth Ombudsman is "busy by world standards" in *Review of the Office of the Commonwealth Ombudsman*, p57.

44. Commonwealth Ombudsman, p27.

Formal approaches to agencies are reserved for the complex matters requiring more extensive investigation.\textsuperscript{46} The majority of complaints involve a relatively small number of Commonwealth agencies having the greatest contact with the public; consistently complaints concerning the Department of Social Security amount to over 20% of the total complaints made to the Ombudsman each year.\textsuperscript{47} Overall, the number of complaints to the Ombudsman account for only a small portion of the total number of administrative decisions made; for example, it has been estimated that complaints against the Department of Social Security amounted to less than 1.5 complaints per 1000 decisions made.\textsuperscript{48}

Of the mechanisms within the sphere of administrative law, the Ombudsman offers the most informality in following up grievances. The Ombudsman can investigate the circumstances of the complaint but in formulating remedies is limited to making recommendations only and cannot substitute a new decision. The Commonwealth Ombudsman

\textquote{attempt[s] to bring complaints to a resolution in which both sides agree on the facts of the complaint and on the fairness of whatever final decision is made by the agency following the Ombudsman’s intercession}.\textsuperscript{49}

Of the complaints finalised in 1993/94, in just under half the cases the Ombudsman exercised the discretion not to investigate or to discontinue the investigation for reasons such as the need for the complainant to approach the agency first, the complaint being too old or withdrawn, or the matter was being dealt with by another court or tribunal. The other half of the complaints lodged were investigated to an outcome and in approximately one third of the cases the complainant received a substantial remedy, a further third of the complainants received a partial remedy, and with the final third either the complaint was

\textsuperscript{46} Commonwealth Ombudsman, p28.
\textsuperscript{47} Together with complaints against the Department of Social Security, complaints against the Child Support Agency, Telecom, the Department of Employment, Education and Training, the Australian Taxation Office and Department for Immigration and Ethnic Affairs amount to over 70% of all complaints received in 1993/4. Commonwealth Ombudsman, Appendix A, Table A2.
\textsuperscript{48} This estimate was made using data based on the statistical digest of the Department of Social Security for the year 1989/90 year and statistics from the Ombudsman’s Office in the Review of the Office of the Commonwealth Ombudsman, p55.
\textsuperscript{49} Commonwealth Ombudsman, p12.
found not to be substantiated or a remedy was not required. The remedies that were recommended included letters of apology, review of the original decision and compensation. Chief executive officers of some departments have been given the delegation to make compensatory ‘act of grace’ payments of small amounts, on the Ombudsman’s recommendation.

The remedies that were recommended included letters of apology, review of the original decision and compensation. Chief executive officers of some departments have been given the delegation to make compensatory ‘act of grace’ payments of small amounts, on the Ombudsman’s recommendation.

The role of “impartial reviewer of complaints” precludes the Ombudsman from taking on a role of advocating on behalf of the complainant. Several Ombudsmen have commented, though, that they do take an active role in ensuring that a complainant is able to adequately put forward their case. In pursuing an investigation the Ombudsman does have formal powers such as requiring a person to provide information, and examining witnesses under oath. The extent to which an investigation is continued is at the discretion of the Ombudsman, not the complainant. It was noted in the Review of the Office of the Commonwealth Ombudsman report that

“some justified complaints may not be satisfactorily resolved by the Ombudsman but the cost of increasing the Ombudsman’s investigative or follow up capacity in relation to the vast majority of relatively simple complaints would exceed any likely benefit”.

Both a recent survey commissioned by the Commonwealth Ombudsman and the survey undertaken as part of the Review, revealed a reasonable level of satisfaction expressed by complainants with the action taken by the Ombudsman. Criticisms of the Commonwealth Ombudsman’s processes, although in the minority, included inadequate

50. Commonwealth Ombudsman, p30. For the period from establishment till 1990 just over half of the complaints were concluded in the complainant’s favour, either substantially or partially, according to the Review of the Office of the Commonwealth Ombudsman, p13.
51. During the trial period of this delegation to section heads in four agencies, the average ‘act of grace’ payment was just over $2,000, with the highest at $8,000, and payments had been made in only 19 instances in the two year period. Review of the Office of the Commonwealth Ombudsman, p31.
53. Tomasic & Fleming, p270; it is also noted that staff will assist complainants in documenting their complaints in the Commonwealth Ombudsman, p28.
54. The formal powers available to the Ombudsman are in many ways similar to those of a Royal Commissioner. Tomasic & Fleming, p271.
follow-up, delays and lack of skills to deal with complaints in specialised areas.\textsuperscript{57} The accessibility of the Ombudsman, particularly to disadvantaged groups in the community, has been of concern and the Commonwealth Ombudsman makes particular note of this as an area for further attention.\textsuperscript{58}

Several processes are available to the Ombudsman if an agency ignores or does not act on the Ombudsman's recommendations. The Commonwealth Ombudsman has the power under section 15 of the Act to make a formal report to the head of the agency concerned and to send copies to the relevant Minister. If actions satisfactory to the Ombudsman are still not taken the Ombudsman can submit a report to the Prime Minister (under section 16) and as a last step to the Parliament (under section 17). From the establishment of the Office to 1991, the Commonwealth Ombudsman had only made 19 reports to the Prime Minister and two to Parliament.\textsuperscript{59} Even this does not guarantee action; although the positions taken by the Ombudsman in the two section 17 reports to Parliament were subsequently supported by the Senate Standing Committee of Constitutional and Legal Affairs on further examination of the issues, none of the various recommendations had been acted upon five years later.\textsuperscript{60} Alternatively, or as well, the Ombudsman may threaten to publicise the inaction of agencies through the Ombudsman's Annual Report and the media. Ombudsmen and agency heads have commented that the threat of adverse publicity has been influential in stimulating agencies to action.\textsuperscript{61}

The extent to which the Ombudsman should focus resources on issues arising from complaints that point to systemic reforms has been the subject of debate. The Senate

\textsuperscript{58} Commonwealth Ombudsman pp33-35; for comprehensive discussion of these points see Administrative Review Council, Access to Administrative Review by Members of Australia's Ethnic Communities, Report No.34, AGPS, Canberra, 1991.
\textsuperscript{59} Review of the Office of the Commonwealth Ombudsman, pp177-178.
\textsuperscript{60} Review of the Office of the Commonwealth Ombudsman, p24.
\textsuperscript{61} Review of the Office of the Commonwealth Ombudsman, p23.
Standing Committee that reviewed the Commonwealth Ombudsman’s performance concluded

“the bulk of the Ombudsman’s work involves facilitating the correction of administrative errors or correcting misunderstandings by complainants. Most such cases are resolved relatively quickly and, considered individually, have no lessons to offer for the overall system of public administration, although some lessons can be drawn from them in bulk”.62

and went on to state

“The Committee believes that the principle role of the Office should remain the investigation and resolution of complaints by individuals against the administration. Significant systematic benefits will continue to arise from such a role but these will occur as a spin-off from the Ombudsman’s primary task of resolving complaints”.63

The Access to Justice Advisory Committee took a different view, suggesting that “a focus on systemic problems could be a useful, if largely invisible, improvement in access to justice for many disadvantaged Australians”.64 Selby, having previously held a senior position in an office of the Ombudsman, is critical of the Ombudsman’s focus on the individual complainant suggesting that inquiries are

“almost invariable blinkered and the remedy is offered to the complainant rather than the community or the bureaucracy as a whole”.65

More recently the potential for the work of the Ombudsman to be linked with quality control activities within agencies has been emphasised.66 The Ombudman does have the power to initiate inquiries on her own initiative, for example where there are indications of maladministration, but this is not intended as a general review mechanism of public sector procedures.67

64. Access to Justice Advisory Committee, p319; the current Commonwealth Ombudsman agrees with this view, Commonwealth Ombudsman, p2.
66. The Commonwealth Ombudsman outlines six strategies in the corporate plan for her Office, one of which is to “maximise the impact of the office upon improving public administration and accountability”. Commonwealth Ombudsman, p167.
67. Biganovsky in Harris & Waye eds., p156-158; the Commonwealth Ombudsman also mentions the importance of “my capacity to undertake own motion inquiries” to “identify and prevent the systemic causes of complaints”. Commonwealth Ombudsman, p2.
Central to the credibility of the Ombudsman is the notion of independence. Although the appropriate legislation may set up the Ombudsman as an independent body, sometimes as an officer of Parliament, the nature of the administrative arrangements devised will have important implications for the independence of the Ombudsman. The current system of appointment of the Ombudsman in place in Australia, which does not require consultation with or the recommendation of the Parliament, “means, in effect, that the Ombudsman is appointed by the majority party making up the government of the day”. Similarly, the Ombudsman may be bound by public sector employment conditions in employing staff. The Offices of the Ombudsman sit within the executive arm of governments and hence are subject to the budgetary restraints and cost saving measures imposed on all government departments. Bakewell, commenting on his time as the Ombudsman in South Australia, stated

“whenever I require new or updated equipment I am forced to go cap in hand to the Premier or the Premier’s Department. This is obviously undesirable and subjects me to indirect (but real) control by the executive and bureaucracy”.

The annual reports of the various Offices of the Ombudsman have made consistent reference to insufficient allocation of resources, both in terms of staff numbers and physical resources, to be able to deal efficiently and effectively with the workload of complaints generated.

The Ombudsman’s lack of power to make new decisions or binding recommendations has meant that the Ombudsman has had to find different ways to bring about their preferred solutions. Tomasic and Fleming maintain that “the effectiveness of the Ombudsman as an institution ultimately rests upon its capacity to persuade or shame an agency to alter its practice or decision”. The Ombudsman, by necessity, must build

---

68. See for example the discussion by Biganovsky in Harris & Waye eds., pp154-155.
70. Bakewell, p53. It is worth noting that Bakewell was widely regarded as having previously been the most powerful public servant under a reformist government.
71. Review of the Office of the Commonwealth Ombudsman, p81; for further discussion of the impact of insufficient resources see also Caiden & Valdes, pp200-201.
72. Tomasic & Fleming, p269.
working relationships with the agencies concerned. This, along with the Ombudsman's inability to enforce sanctions, has been seen by some as possibly compromising the impartiality of investigation and the outcome obtained.\textsuperscript{73} The Review of the Office of the Commonwealth Ombudsman found that agencies, such as the Department of Social Security, that have the most dealings with the Ombudsman commented positively on the Ombudsman's influence on their agency's processes.\textsuperscript{74} The Review also concluded that the majority of complaints made to the Ombudsman were handled informally, with the need to take further steps, such as reporting to the agency head, occurring relatively infrequently. However, the Review was more critical of the Commonwealth Ombudsman's ability to handle complex complaints, such as complaints involving allegations of official corruption, which required extensive investigation by the Ombudsman and were likely to be less amenable to amicable agreement.\textsuperscript{75} The Ombudsman's effectiveness is further dependent upon "the effectiveness of the Parliament as a watchdog over the administration" and, as already noted, there have been instances where the recommendations of the Ombudsman have been ignored.\textsuperscript{76}

Until recently the notion of the Ombudsman has only been associated with the handling of complaints about the administrative decisions of and actions by the public sector. However, the pursuit of economic policies promoting self regulation across a variety of industries and services has generated a proliferation of industry specific "ombudsman" type mechanisms to handle grievances, such as the Australian Banking Industry Ombudsman Scheme.\textsuperscript{77} Concern that the credibility and integrity of the notion of the Ombudsman may be compromised by unscrupulous use of the title has led the Commonwealth Ombudsman to draw up criteria that must be met before the title can be used. This criteria relates to issues of independence, jurisdiction, powers, accountability

\textsuperscript{73} Review of the Office of the Commonwealth Ombudsman, p26.
\textsuperscript{74} Review of the Office of the Commonwealth Ombudsman, p60.
\textsuperscript{75} Review of the Office of the Commonwealth Ombudsman, pp65-69.
\textsuperscript{76} Curtis, p59; see also Selby, p174.
\textsuperscript{77} For more details of the Australian Banking Industry Ombudsman refer to Access to Justice Advisory Committee, pp306-308.
and accessibility. The obligations on the self regulating industry financing an industry Ombudsman include making the service free of charge to complainants; allowing the Ombudsman to publish annual reports and to make statements in the public interest; agreeing to be bound by the Ombudsman’s decisions; and making sufficient funds available for the Ombudsman to carry out the necessary duties.78 As the lines between public and private sectors become more blurred, the extent of the public sector Ombudsman’s jurisdiction has been queried. The Commonwealth Ombudsman noted that the increasing trend to contract out and fund private organisations to provide services has resulted in gaps, with areas which would have previously been covered no longer in her jurisdiction.79

The establishment of the offices of the Ombudsman have been one of the most visible political and bureaucratic solutions to the problem of dealing with complaints from individuals about the actions of the public sector. With the intent to control workloads, the offices of the Ombudsman have placed emphasis on internal review and resolution of complaints prior to the Ombudsman becoming involved. In some instances, the Office of the Ombudsman, drawing on their own experience of complaints handling, have taken a role in assisting agencies to develop more effective internal complaints handling mechanisms.80 However, accessibility to the Ombudsman’s services may be compromised if in all situations internal review is required as a preliminary step.

The workings of the Ombudsman provides a demonstration of a well established model of complaints handling of administrative issues. The Ombudsman has a wider scope to investigate administrative actions than the administrative review tribunals, including not

80. Informal presentation by the SA Ombudsman, E Biganovsky, to a meeting of the Independent Health Complaints Unit Working Party attended by the author, held at the Migrant Health Resource Centre, Adelaide on 7th August 1995. The Independent Health Complaints Unit Working Party is a coalition of consumer groups and individuals pressing for the establishment of an independent health complaints unit in South Australia. (See ch7.5.3.)
only the decisions made but also other areas of activity such as the way a person has been treated by staff of the agency.\textsuperscript{81} The lack of power available to the Ombudsman to implement recommendations and the limited resources, which can compromise the Ombudsman's independence and credibility, are an indication of the ambivalent support by public sector systems for such mechanisms. The administrative arrangements devised for the offices of the Ombudsman provide an effective means of bureaucratic control over the functioning of the Ombudsman and the extent to which the Ombudsman is able to tackle issues of a systemic nature. Complaints handling by the Ombudsman then remains individually focussed, causing little disruption or challenge to established administrative systems.

Offices of the Ombudsman have dealt with complaints about health care provision in public sector services over the years. However, the Offices of the Ombudsman have generally not been well set up to deal with complaints that arose from the complex nature of health care and issues of professional judgement in the provision of services. The limitations of the Offices of the Ombudsman generally and, more specifically, in handling health complaints, and the restriction to public sector services only, have been part of the impetus for establishing separate central health complaints units in some states. With the 1992 requirement of the Medicare agreement that all states and territories establish an independent unit to handle health complaints about publicly provided medical and hospital services, at least one state has opted to use the Office of the Ombudsman as this avenue, despite strong criticism from consumer groups. (Refer ch7.5)

\textsuperscript{81} The survey of complaints files conducted by the \textit{Review of the Office of the Commonwealth Ombudsman} found that of the 414 cases examined, the complaints could be categorised as involving oppression in 3.9\% of cases surveyed, rudeness 3.1\%, improper conduct 2.4\% and harassment 1.4\%. \textit{Review of the Office of the Commonwealth Ombudsman}, p129.
6.3.2 Tribunals: the Commonwealth Administrative Appeals Tribunal (AAT)

Tribunals to review and adjudicate on decisions made by public sector agencies have been set up as quasi judicial alternatives to the court system in a number of different jurisdictions by successive Commonwealth and State/Territory governments. Based on the premise that the tribunals can offer better access to a review process without compromising the principles of natural justice, the Tribunals have been accorded varying powers, usually supported by legislation, in determining the outcome of disputes. In further examining this more formal model of complaints handling, the Commonwealth Administrative Appeals Tribunal (AAT), is used as the primary example.\(^82\)

The first initiative in the series of administrative law reforms at the Commonwealth level was the passing of the *Administrative Appeals Tribunal Act 1975*. This created a new forum for the independent review of administrative decisions, the Administrative Appeals Tribunal (AAT). The 1993/94 Annual Report of the AAT describes the mission of the Tribunal as providing "aggrieved persons and agencies with independent review of a range of administrative decisions of the Commonwealth to ensure that in each case the right decision was made".\(^83\) While not covering all Commonwealth government administrative decisions, the jurisdiction of the AAT has increased considerably over the past two decades and now is contained in 264 separate enactments. In the 1993/94 period 4,576 applications were lodged with the AAT and 1,113 formal hearings held, about half of which were heard by a three member tribunal reserved for the most complex cases.\(^84\) Veterans entitlements, taxation, employment and retirement benefits and social security entitlements, as in previous years, remain the four areas that attract most of the appeals. Adverse administrative decisions in these areas, of course, have significant financial ramifications for the individuals involved, who may have no choice but to appeal an unfavourable decision.

---

82. Within the Australian context, the AAT is held to be one of the most exemplary and encompassing of Tribunals, although confined to Commonwealth public service actions.


84. Administrative Appeals Tribunal, p152-154.
A number of features distinguish the AAT from the courts exercising a judicial review process. Central to the AAT’s work is that, typically, the merits of an administrative decision are emphasised when reviewing decisions, and the review is not limited by issues of procedural formalism. This has had implications for the review of policy matters as “the very nature of merits review implies that a consideration of issues of policy is a natural extension of this approach to the review of administrative decisions”.85 Nor is the AAT bound by the rules of evidence and it can consider evidence that may not be allowable in other legal forums. While there is considerable emphasis on informality of process compared to other legal mechanisms, such as the courts, the AAT does have a number of formal powers such as being able to compel people to attend hearings, answer questions and produce documents.86 As well, the Act specifically outlines the right to obtain reasons for an administrative decision from the original decision maker, irrespective of whether an appeal follows.87 This had not previously been the case with other administrative review mechanisms and some commentators have suggested that this, in turn, has had the overall effect of more comprehensive and clearer reasons for particular decisions being given as a matter of course in the first instance.88

The AAT has the important power to set aside the original administrative decision and to substitute a new decision, although this can only be done within the parameters of the powers and discretions of the original decision maker. Griffiths explains

“the Tribunal’s function is not to review the decision or reasons of the primary decision maker with a view to detecting any error either in that decision or in the accompanying reasons. Rather, the Tribunal steps into the shoes of the primary decision maker to determine what is the correct or preferable decision”.89

85. Tomasic & Fleming, p3.
86. Griffiths, p453.
87. Tomasic & Fleming, p54.
89. Griffiths, p454.
However, the AAT is not restricted to considering only the information used by the original decision maker and may draw on new and different information. The Tribunal’s decision is also subject to appeal and any party to the proceedings may lodge an appeal to the Federal Court of Australia. According to the AAT 1993/94 Annual Report, 122 appeals against AAT decisions were filed in the Federal Court in the 1993/94 period, slightly less than in previous years.

While the AAT has been hailed as a successful mechanism for reviewing administrative decisions, the very components of the AAT that are identified as advantages over the court system, in turn, present problems. The informality and flexibility of proceedings belies the fact that decisions are still substantially made on principles of law and that, without legal representation, individuals making an appeal may be significantly disadvantaged. Genn, in her study of the workings of various administrative tribunals in Britain, concludes

"despite the appearance of informality in tribunal hearings, the inherently adversarial nature of proceedings, the necessarily ‘legalistic’ nature of tribunal decision making, the predictable inability of litigants convincingly to advocate their own cases, and the limited ability of tribunals to compensate for these disadvantages, results in hearings that may fail to do justice to the cases that come before them. In simple terms this means that cases with merit are lost by default".

In Australia, the particular difficulties facing Australians from a non-English speaking background, for example, in accessing and using appeals tribunals include not only a lack of knowledge about the availability of the administrative review system but also different understandings of legal procedures, lack of provision of interpreters and confusion about which mechanism to use. A recent amendment to the AAT Act, in 1992, now places an

90. Tomasic & Fleming, p127.
91. This appeal must be based on questions concerning the legal principles on which the decision was made by the AAT, although the final interpretation of this is left to the Federal Court. Tomasic & Fleming, pp133-134.
92. Administrative Appeals Tribunal, p165.
obligation on agencies to inform consumers of their rights in instances where decisions are reviewable.95

Certain procedures introduced by and forced upon the AAT, in an effort to maintain efficient functioning, have had the unintended consequence of restricting access to the AAT. The Tribunal is not necessarily the first step for those wishing to appeal as it is expected that, in most cases, there will have been an internal review of the decision by the appropriate department or agency before an application to the AAT is accepted.96 In 1987 a substantial fee ($300 by 1991; the same amount as an application to the Federal Court) was introduced for lodging an application with the AAT, although applications relating to income maintenance were exempt, and in many instances a fee, although much smaller, has been introduced for the internal review of administrative decisions.97 It has been noted that AAT proceedings have become more formalised in recent years, with the more informal procedures increasingly retained for the preliminary conference.98 The process of mediation has been introduced as another means of handling grievances brought before the AAT. While the numbers of cases dealt with through mediation has increased, concern has been expressed about the appropriateness of the mediation process to administrative review, particularly that it may “lead to an applicant trading off some rights in exchange for other concessions”.99

The states/territories have generally been slow in following the Commonwealth’s lead in establishing wide ranging administrative appeals tribunals to cover decisions made

95. Administrative Review Council, Review of Commonwealth Merits Review Tribunals, Discussion Paper, Administrative Review Council, GPO Box3222, Canberra, September 1994, p87. It is noted in the discussion paper that it is too early to assess the impact of this change in terms of the number or nature of reviews requested.
96. For further discussion of the internal review process see, pp41-44. In some areas of government activity, such as decisions made by the Department of Social Security, the specialist Tribunal for the area must review the decision first. The efficacy of this requirement is also discussed in Review of Commonwealth Merits Review Tribunals.
by the state public sectors services. Despite recommendations to most state governments to adopt similar measures, general administrative appeals tribunals had only been established in two states by 1993: Victoria, in 1984 with rather limited jurisdiction, and the Australian Capital Territory, on self government in 1989. Aronson, examining why in New South Wales “the political and bureaucratic will to establish an administrative appeals tribunal (AAT) seems to have disappeared”, even though it was an election promise as far back as 1988, suggested in 1993 that in the current climate of deregulation and privatisation he was “forced to the conclusion that an AAT is now perceived within government as itself constituting red tape”. He went on to identify at least thirty two state tribunals and boards whose jurisdictions could be taken over by a general administrative appeals tribunal, possibly resulting in significant gains in efficiency and effectiveness.

The Commonwealth merits review tribunals system, of which the AAT is a major part, is currently under review by the Administrative Review Council (ARC). A discussion paper, released for public comment in late 1994, outlined a number of criteria against which the ARC thought that the current system could be assessed: ability to ensure a correct or preferable decisions is made in each individual case; accessibility and responsiveness of the mechanisms to those entitled to use them; promotion of better quality primary decision making within government agencies; influence on the development and improvement of policy and legislation; coherence and consistency throughout the total system of merits review; and efficient use of resources. These criteria reflect both the original intent of the reforms to systems of administrative merits review and the areas

100. Access to Justice Advisory Committee, pp328-332; see also M. Harris, “There’s a New Tribunal Now’. Review of the Merits and the General Administrative Appeal Tribunal Model”, in Harris & Waye eds, p189.
101. Aronson, p208 & p211.
where there has been some concern about the way implementation has proceeded. The terms of reference of the review and the questions posed in the discussion paper suggest that the final recommendations may focus on the streamlining of administrative procedures and better linking of merits review with other public sector management strategies emphasising quality improvement. Whether the implementation of such changes will indirectly result in a winding down of administrative merits review as it currently exists remains to be assessed.

The AAT constitutes a formalised mechanism for the handling of individual grievances about administrative decisions. The prerogative of the AAT to substitute its own decision, which it considers to be preferable, fair and maybe to the advantage of the complainant, gives the AAT a power that is not accorded to other complaints handling mechanisms. However, the AAT is limited to reviewing specific administrative decisions only, which have been brought to the AAT's attention by individual complainants, and can not initiate its own inquiry. Moves to make the internal review of decisions mandatory, as it already is in some agencies, and the greater use of intermediate, but often cheaper, tribunals, which in effect filter out grievances, has meant that the AAT has become a complaints handling mechanism increasingly reserved for the most difficult and complex grievances about administrative decisions. As well, the potential influence of the AAT on future administrative decision making is reduced by the resolution of grievances using alternative processes, such as mediation, prior to a determination by the AAT through a formal hearing. The lessons to be learned from complaints are subsequently individualised and minimised, providing little challenge to existing bureaucratic systems.

6.3.3 Freedom of Information and Privacy Legislation

*Freedom of Information legislation*

The *Freedom of Information Act 1982* was another important part of the Commonwealth's administrative law reform package. While not a mechanism for handling
individual complaints as such, except about release and content of information held, the introduction of Freedom of Information (FOI) legislation has encouraged the development of three elements important in creating an milieu in which people feel able to complain. First, it promoted the notion of the right of citizens to obtain information about government actions and decision making that had previously only been available to the ‘expert’ and/or bureaucrat. Adequate information about such things as the services provided by an organisation or the basis on which decisions are made are crucial to the complaints process from a consumer perspective. Second, the FOI legislation gave people the right to view information about themselves held by government departments including hospitals and health services. Although access to medical records has been more restricted than some other areas of information, FOI legislation has enabled a number of people to see their medical records which might have been denied to them otherwise. Finally, FOI legislation allowed individuals to request correction of information held by government agencies about themselves which they felt to be out of date or incorrect.

Australian interest in the concept of FOI was stimulated by the introduction of FOI legislation in the United States of America in the 1960s. Consumer rights advocates such as Ralph Nader stressed the importance of access to information held by governments. (See ch3.4) Although a committee to consider the viability of Commonwealth FOI legislation was set up by the Whitlam government in 1972, it was not until almost a decade and several different committees’ reports and revised bills later that the legislation was finally passed. The Commonwealth FOI legislation came into operation in 1982, and was considered an innovation for Westminster style national governments. It was designed “to extend as far as possible the right of the Australian community to access to information

in the possession of the Government of the Commonwealth”. However, there were limits on access to information, particularly in areas of government activity concerning national security and law enforcement, and where individual privacy may be compromised: for instance cabinet documents were exempt, as were documents where disclosure was deemed to be contrary to the public interest. If access to requested documents is denied there is provision for review of the decision, first through internal review by the department concerned, then to the Ombudsman or the AAT or through judicial review by the courts. Bell notes that these three features (a right to access to government documents; exemptions provided to some agencies and documents; and provision to appeal a FOI decision to an independent body) are common to most FOI legislation.

A number of benefits were seen to potentially flow from the introduction of FOI legislation. The fact that government records could be accessed placed government processes under possible scrutiny at any time. Officials of several government departments noted that the introduction of FOI legislation focussed attention on their internal record management systems, leading to subsequent improvements in them. Government departments hold a great deal of information in a variety of areas that could be of considerable use in other settings and FOI legislation provided easier access to obtaining such information. For individuals, the FOI legislation has provided the right to obtain access, in most cases, to the growing amount of personal information held by government agencies.

110. R. Bell & H. Watchirs, “Freedom of Information: the Commonwealth Experience”, Australian Journal of Public Administration, vol.47, no.4, December 1988, p299 & p301. The authors note that this provision does not seem to have been well utilised in Australia, in contrast to other countries such as USA.
The Commonwealth FOI Act has been used to access information, although this still amounts to only a minute proportion of the information held by government agencies. In the 1993/94 period there were 36,547 requests for information across 91 agencies, an increase of 8.1% on the 1992/93 period. Of these requests only 5.3% were completely refused, with 74.9% of requests granted in full. The Departments of Veterans' Affairs, Social Security, Taxation, and Immigration and Ethnic Affairs received the most requests, together over 92% of all requests. Veterans' Affairs, with 29.4% of the total requests, was able to grant 99% of the requests in full. Given that the major work of these agencies concerns individual entitlements, it is fair to assume that the majority of requests relate to personal information rather than policy documents or other material, although no aggregated data is held on the nature of the requests nor the profile of those requesting information. Only a very small fraction of the total requests result in a further application for amendment of personal records, increasing from 49 in 1989/90 to 334 in 1992/93, and falling again to 224 in 1993/94; 16.4% of the applications for amendment of personal records in 1993/94 were refused.

A unique feature of a number of Australian FOI laws is the requirement that a decision refusing a FOI request must be reviewed by a senior official within the relevant department (internal review) before an appeal can be made to an independent body. In the 1993/94 period 348 applications were made for an internal review to be conducted, resulting in some concession by the agency to the applicant in about a third of the cases. The step of internal review has attracted some criticism for increasing the complexity of the

appeals process, possibly encouraging more conservative decision making in the first instance and increasing the cost both to the applicant (some departments impose a fee for internal review) and to the organisation. Further appeals can be made to the AAT and the Ombudsman but, with the introduction of a substantial fee for lodging an appeal with the AAT, the Ombudsman has been more commonly used as the appeals avenue in recent years.

The introduction of FOI legislation has had important implications for the health consumer. The Commonwealth Act, for example, specifically allows individuals to access documents containing their medical records held by Commonwealth services, although, under s41 (3), a qualification is added that if the agency considers the “information of a medical or psychiatric nature concerning the person making the request ... might be prejudicial to the physical or mental health or well being of that person” the documents will be released only to a medical practitioner nominated by the person. Gaining access to medical records and reports may provide consumers with information about themselves that they had not known previously, and in some instances this may be crucial to begin civil or criminal proceedings in situations where there has been an adverse outcome from medical treatments.

Knowledge of the procedures for making a request and knowledge about the type and range of documents held by the agency is necessary to be able to use the FOI legislation to access information effectively. For a FOI request to be valid the application must be made in writing, detailing the documents required, and a fee must be paid. The

117. In the 1993/94 period the Ombudsman received 200 complaints related to FOI requests, while 58 appeals were lodged with the AAT. The highest number of FOI request appeals made to the AAT (310) occurred in the 1984/85 period, prior to the introduction of the substantial lodgement fee. Attorney-General’s Department (Commonwealth), Freedom of Information Act 1982, Annual Report 1993-94, p22. Some of the complaints to the Ombudsman concern delays and the way the request was handled. Commonwealth Ombudsman, Part 3.
120. Tomasic & Fleming, pp369-411.
request may incur further costs: a fee for time taken in searching for the documents; and another fee for the photocopying or other costs incurred in providing copies of the documents.\textsuperscript{121} In some circumstances the prescribed fee may be waived, particularly where the requested documents are about personal information, such as held in Department of Social Security files. To assist with the detailed identification of the documents that may be requested

"Australian FOI laws require all departments and agencies subject to the legislation to publish a statement detailing their functions, decision-making processes, policy documents and arrangements available for the public to inspect its "internal Law".\textsuperscript{122}

One of the benefits of the introduction of FOI legislation noted by officials of several government departments has been to focus attention on internal record management systems leading to subsequent improvements.\textsuperscript{123} Government departments hold a great deal of information in a variety of areas that could be of considerable use in other settings and FOI legislation provides easier access to obtaining such information.\textsuperscript{124}

Concerns have been expressed about the actual implementation of FOI Acts, in particular the high cost associated with meeting the requirements of the legislation.\textsuperscript{125} Other areas of concern include: the extent of exemptions granted to agencies, some claiming that exemptions are too numerous and too broad while others suggest that the range of current exemptions are appropriate; the interpretation and use of the public interest test; the relevance of the applicant’s reasons for requesting the information and the purpose

\begin{flushright}
122. Villanti, p73. Recent annual reports of various government departments provide evidence of the agencies’ efforts to comply with these requirements.
124. R. Bell & H. Watchirs, “Freedom of Information: the Commonwealth Experience”, Australian Journal of Public Administration, vol.47, no.4, December 1988, p299 & p301. However, this provision does not seem to have been well utilised in Australia, in contrast to other countries, for example USA.
125. At the Commonwealth level it was estimated that the total cost of processing FOI requests was $13.8 million in 1993/94, at an average cost of $382 per request, of which only $241,075 was recovered through charges levied. Attorney-General’s Department (Commonwealth), Freedom of Information Act 1982, Annual Report 1993-94, p1 & p20.
\end{flushright}
for which the information will be used; and the accessibility and effectiveness of review procedures when requests are refused. More recently, new and different forms of government service provision have called into question the application of FOI, for example where corporatised government agencies are competing on a commercial basis. As it is noted in the Commonwealth FOI Annual Report 1993/94,

"the past few years have seen significant developments in the area of freedom of information in certain Australian States and overseas that have challenged the traditional boundaries of freedom of information. In some jurisdictions these initiatives have made FOI more responsive to community needs and more accessible to the public; in others there has been a slight drawing back to a less generous position". The extension of FOI principles to cover some aspects of private sector activity has been proposed, as has already happened in relation to personal information in New Zealand.

While the broad intentions behind the introduction of FOI legislation emphasises greater accountability of public services stemming from opening up government information, and therefore processes, to the public eye, perhaps the most notable result has been that individuals have been able to view information about themselves, previously available only to government officials, and to request amendment to those documents if necessary. However, the focus has moved from systemic accountability to individual concerns and individualised responses, leaving the vast majority of government processes and information closed to public view. The relatively small number and limited nature of FOI requests suggests that this legislation is not necessarily seen as accessible or useful to many Australians. As Zifcak comments

"First, freedom of information is a somewhat sophisticated and legalistic means of advancing one’s cause. To use it successfully requires confidence, assertiveness

126. For comprehensive discussion of these points see Australian Law Reform Commission & the Administrative Review Council, Freedom of Information, ch5: Exemptions - General Issues, ch6: Specific Exemptions, & ch8: Review Mechanisms.
129. For further discussion about extending the ambit of Commonwealth FOI legislation see Australian Law Reform Commission & the Administrative Review Council, Freedom of Information, ch14: Possible Extension of FOI to Private Sector Bodies.
and patience. Secondly, for many people, access to documents is still perceived as a privilege and not a right".\textsuperscript{130}

The applicability and implications of FOI legislation in the rapidly changing environment of public sector service provision remains in question.\textsuperscript{131}

\textit{Privacy legislation}

The need for greater control over the uses made of personal information held by various organisations became increasingly apparent with the widespread introduction of electronic technology to manage such data. The passing of the \textit{Privacy Act 1988} by the Commonwealth was in line with Australia's obligations, as signatory to the International Covenant on Civil and Political Rights, to protect the liberties and privacy of individual Australians.\textsuperscript{132} Consequently, the Privacy Commissioner has been located within the Human Rights and Equal Opportunity Commission. The Privacy Act encompasses several different elements: the legal obligation of Commonwealth government agencies to abide by the Information Privacy Principles set out in the Act; the regulation of some specific situations such as the use of tax file numbers, consumer credit reporting practices, and data matching practices; the encouragement of the voluntary adoption of the Information Privacy Principles by private sector organisations; and the establishment of a Privacy Commissioner. The eleven information privacy principles outlined in the Act, based in part on the 1980 Organisation for Economic Cooperation and Development guidelines for the handling of personal information, cover areas such as the manner and purpose of collection of personal information, storage and security of personal information, access and alteration of records containing personal information, and the limits to the use and disclosure of personal information.\textsuperscript{133}

\begin{thebibliography}{9}
\end{thebibliography}
The Privacy Commissioner has taken a prominent role in the implementation of the Act, in line with his responsibilities as specified under the Act. These responsibilities include the immediate functions of handling complaints about privacy issues and monitoring compliance with the Act to the broader function of promoting the uptake of privacy principles throughout the private sector and the community. By the time of his 1993/94 Annual Report, the Privacy Commissioner was able to state that “the Privacy Act 1988 is an established feature of the regulatory environment within which Commonwealth Government agencies and the finance and banking sector operate”.\(^{134}\)

However, the guidelines and practices developed have been sector specific and consistency across sectors has become an issue. The Privacy Commissioner suggests there is an urgent need for the development of a national policy on privacy protection and for further consideration of the current scope of privacy legislation, with the rapidly changing information technology.\(^{135}\)

Although rights of access to information and protection of privacy are usually contained in two separate pieces of legislation, there is some overlap between the two; for example individuals can obtain access to and amend their health records through both.\(^{136}\) The Privacy Commissioner received 751 written enquiries/complaints relating to specific issues about the privacy of personal information in 1993/94. Of these only 143 were assessed as “potentially involving interference with privacy” and formally accepted as complaints.\(^{137}\) The Privacy Commissioner notes that in this period his discretion not to continue an investigation had been used more extensively in situations where the complainant had not first directly approached the organisation concerned. In 97 of the 250

---

134. Privacy Commissioner, p3.
137. Privacy Commissioner, p55.
privacy complaints finalised in 1993/94, no evidence was found that the privacy of the complainant had been compromised, and a further 48 were withdrawn or lapsed.138 The Privacy Commissioner does have the power to make a determination in relation to a complaint, if the complaint has not been resolved through negotiation, including awarding compensation to the complainant.139 In a similar way to FOI legislation, privacy legislation has given added weight to the idea that individuals have a right to see personal information held about them by agencies, and that agencies, in turn, have an obligation to ensure that the information is correct, kept confidential and not used for other purposes.

6.3.4. Administrative Law Reforms and Complaints Handling

The ability of the system of administrative law to achieve the aims underlying the implementation of the reforms has been the subject of considerable debate.140 Australian commentators have gained first hand knowledge and experience of the issues surrounding the implementation and impact of a comprehensive system of administrative review through the examples provided at the Commonwealth level. The issues include the nature of the justice offered by administrative review, the impact on policy directions, the influence on primary decision making and the costs of maintaining the system. One commentator suggests "there seems to be a certain degree of disillusionment that a system intended to produce effective remedies for maladministration has proved to be apparently so cumbersome and costly".141

The claim that the new mechanisms are able to offer better access to justice in a form as fair as the traditional court system has been challenged. For instance, the administrative tribunals have been said to provide a less rigorous form of review and their

139. Two determinations were made by the Privacy Commissioner in 1993/4, one resulting in a payment of compensation to the complainant and the other that no further action be taken. Privacy Commissioner, pp58-59.
140. See for example the conference proceedings of "Administrative Law: Retrospect and Prospect" held in 1987 and reported in Canberra Bulletin of Public Administration no.38, April 1989.
141. Curtis, p55.
acceptance by governments to have been based not on the claimed pursuit of greater justice for all but on political and cost considerations. The most disadvantaged groups in the community, it is suggested, are further disadvantaged by being restricted to using inferior systems. The requirement that internal reviews and intermediate review/appeals bodies consider the matter prior to the statutory administrative appeals tribunal and the use of preliminary hearings as part of the tribunal process, may discourage people from pursuing an appeal beyond that stage. Carney, in an examination of the impact of administrative review process in relation to the Social Security Act and Department’s operations, goes so far as to say “regrettably, the contribution of administrative law in Australia has been to render welfare rights more vulnerable”. However, supporters of the reforms maintain that without the option of more informal mechanisms for administrative review the inaccessibility of the court system would leave many people with no mechanism for pursuing appeals against administrative decisions, particularly as access to legal aid has been increasingly restricted.

The direct link between policy objectives and administrative decision making has led to suggestions that administrative review, particularly merits review, may interfere with the implementation of government policy. A new decision by the AAT, for example, can have profound policy implications, as well as cost implications. Even supporters of the administrative reforms have noted that policy making should remain the prerogative of duly elected governments rather than arise from judicial decisions that are not accountable

142. For discussion of this point see Genn, pp396-397, & pp410-411.
143. For further discussion of this point see T. Brennan, “The Hidden Dimension of Administrative Law, First Tier and Internal Review - II”, Canberra Bulletin of Public Administration, no.58, April 1989, pp141-145.
144. T. Carney, “Cloaking the Bureaucratic Dagger? Administrative Law in the Welfare State”, Canberra Bulletin of Public Administration, no.58, April 1989, p131. The Department of Social Security ranked amongst the top agencies against which grievances were lodged through the Ombudsman and the Administrative Appeals Tribunal and also for requests for information through the Freedom of Information Act.
146. Walsh, p31.
to any constituency. The need for caution and restraint in judicial decision making in this area of "public policy and unreasonableness" has been emphasised.  

One of the original objectives of the reforms had been to improve the quality of primary decision making. While it has been difficult to isolate the impact of administrative review from the other influences on administrative practices, particularly in a time of intense and multiple change, a number of commentators have suggested that "the prospect of review has encouraged many administrators to pay more careful attention to the factual and legal bases of their decisions". They suggest that there has been a marked improvement in the documentation of reasons given for decisions; ambiguous policies and procedures have been clarified and, where none existed, new ones set in place; training of primary decision makers, particularly front line staff, has been taken more seriously and resources set aside specifically for this purpose; and the internal review mechanisms have been enhanced. However, others maintain little has changed and "it [administrative law in Australia] has cloaked with a veneer of respectability the reality of a system which has done little to promote accuracy, which has little entitlement to be accorded legitimacy, and which is less than impartial".

The costs involved in having an extensive system of administrative review in place has come under scrutiny, particularly in times of alleged economic stringency. The costs arise at a number of levels: the cost of maintaining the agencies such as the Ombudsman and the Administrative Appeals Tribunal; the costs of legal advice to applicants (which may be supplied through legal aid) and to departments, particularly if appeals progress to the federal court stage; the cost of internal and intermediary mechanisms; the cost of changes to administrative practices and flow on financial implications of some decisions.

---


148. Griffiths, p462; see also Curtis, pp65-66.


where new precedents are set. On the other hand there has been concern that the fiscal and management policies currently in place in the public sector, emphasising efficiency and cost savings, may threaten the administrative review processes. For example, the impact of significant staff reductions on primary decision making and the viability of adhering to justice principles such as due process. Aronson rather cynically suggests

"unless there is a massive and obvious failure of the system, my suspicion is that injustice is cheaper than justice, particularly if the instances of injustice are only sporadic and only moderately visible. Justice and good quality administration are probably expensive".

More recently it has been claimed that some administrative review process, for example obligations under FOI legislation, have imposed a financial disadvantage on government services seek to compete on commercial grounds with private sector companies.

All the mechanisms established with the administrative law reforms have been, and continue to be, the subject of major review. None of the reviews have suggested that the legislation and mechanisms be disbanded, but numerous recommendations for change have been made. In some instances, the implementation of the recommendations has led to greater community knowledge about rights to, and availability of, the review of administrative decisions and how to access the system. As the Hon. Mr Justice Brennan, one of the prominent supporters of the reforms from the beginning, commented

"The structures of administrative review now offer an opportunity for individuals to meet the anonymous and sometimes remote agencies of the state on more equal terms. The interests of individuals are more fully acknowledged, and the repositories of power are constrained to treat the individual both fairly and according to the law, even if the sustenance of the law is defective".

---

154. Aronson, p211.
Requesting reconsideration of a decision or making a complaint has resulted, in many cases, in a more favourable outcome for the individual affected by the original decision or action.\textsuperscript{157}

Together, the mechanisms do have significant powers with the necessary legislative backing to demand greater accountability of those undertaking administrative decisions or actions. The AAT has the power to vary a decision; the Ombudsman has the power to investigate a variety of administrative actions including decisions taken and to use adverse publicity if recommendations are not taken up; and the Privacy Commissioner has the power to make a determination in relation to a complaint if mediation cannot resolve the issue. The use of this ‘power’ has tended to be concentrated on individual concerns and outcomes rather that challenging established bureaucratic systems. In many ways the mechanisms of review, themselves, can be said to have become bureaucratised, with modes of operation similar to the government organisations whose decisions and actions they are there to review and staffed by officials well schooled in bureaucratic procedures. To the individual, the limits imposed on the mechanisms by jurisdiction and insufficient resources resulting in referral elsewhere and delays, can further compound this image.

Increasingly the relevance of the administrative review system to current, and considerably changed, forms of government service provision has been questioned. The reforms to administrative review were set in place at a time when the “Administrationalist” style, referred to by Halligan and Powers, was paramount within the public sector. The emphasis with this style on formal rules, procedural correctness and impartiality was highly compatible with the expansion of administrative law. Griffiths suggests the accountability demanded by the reforms, in turn, has “strengthened the legitimacy of public administration by obliging decision makers to explain and rationalize their decisions”.\textsuperscript{158}

Without a review system in place there is potential for escalation of discontent and greater

\textsuperscript{157} Griffiths 1985, pp461-462; See also Administrative Review Council, \textit{Review of Commonwealth Merits Review Tribunals}, Appendix Table A.2.3.

\textsuperscript{158} Griffiths, 1985, p446.
pressure for major change. Certainly the reforms provided much needed mechanisms for
dealing with dissatisfaction about some public sector practices, particularly in relation to
individual grievances, and provided a measure of accountability within the public sector.
The Access to Justice Advisory Committee maintained that a comprehensive system of
administrative review is a “crucial ingredient in an accountable system of government”
However, the moves towards corporatisation and privatisation within the public sector have
brought with them different management and administrative practices, discussed further in
the next section, which do not necessarily include ideas of accountability based on external
review of actions and decisions by outside bodies.

Already within the system of administrative review there has been a significant shift
towards a different style of operation that promotes a focus on the local informal resolution
of grievances, through mechanisms such as internal review systems, and the use of
mediation between the parties involved, facilitated by officers employed by agencies, such
as the AAT and the Ombudsman. The trend towards greater use of internal resolution
and mediation has implications for individuals wishing to use the systems created by the
administrative law reforms. Going through several ‘tiers’ of review requires energy and
resources on the part of those requesting the review or making a complaint. Individuals
may then be discouraged from legitimately pursuing the matter further. As already
noted, individuals may be disadvantaged by using mediation in order to come to some
resolution with a much more powerful organisation. (See ch2.2.3.) The ever present
power imbalance between consumers and the organisations they are seeking or receiving
services from is not easily overcome.

160. See Attorney-General’s Department (Commonwealth), Justice Statement, Office of Legal Information
and Publishing, Attorney-General’s Department, Robert Garran Offices, National Circuit, Barton ACT, 1995;
Access to Justice Committee Report, p278; see also H. Astor and C. Chinkin, Dispute Resolution
161. This is referred to as ‘complaints fatigue’ in chapter two or “appeal fatigue” in Administrative Review
The administrative review mechanisms established under the administrative law reforms of the 1970s and early 1980s have played a significant part in increasing the opportunities for individuals to take their concerns about decisions or actions of public bureaucracies to an independent body. The workings of these mechanisms set important precedents that have been taken up in the establishment of central health complaints mechanisms, discussed in the next chapter. However, the functioning of the mechanisms has been predominantly an individualised approach, addressing individualised concerns and offering individualised solutions. Bureaucratic control and influence over the processes of administrative review mechanisms have had a substantial impact. Challenges to the broader structure and procedures of the bureaucratic systems of government through these mechanisms have been incremental rather than dramatic. The anticipated greater accountability to the public resulting from the implementation of these mechanisms has only been forthcoming on an individual basis, and then limited to those with the knowledge and resources to make use of the mechanisms. Complaints or grievances are dealt with, but the messages they provide of relevance to the broader system have been largely unheard.

6.4 MANAGERIAL REFORMS AND COMPLAINTS SYSTEMS

Managerial reforms within the public sector have given complaints systems new meaning and status. To understand better the nexus between the two it is necessary to explore these reforms and the basis on which they have been founded. The adoption of ideas of 'corporate management' by governments in the 1980s has resulted in major reorganisations of the financing and structure of public sector services, including the public health system. The reforms were put forward as the key to increasing public sector efficiency and productivity and therefore accountability to Ministers and Parliament. Largely based on concepts and ideas taken from private business management, the reforms have become firmly imbedded in public sector organisation and have had a significant impact on both the structure of public service agencies and the provision of services, from
the way that services are described through to how the services are actually provided. It should be noted that what is often referred to now as “corporate management” was the piecing together and application of various theories about the modern management of organisations to public sector service provision: “corporate management has no single author, no unitary logic. It was never designed as a coherent, intellectually justifiable program”. However, similarities in the new management strategies set in place across public sector services have given rise to an identifiable “corporate management” style of public administration.

The idea of continuous quality improvement, adapted from total quality management concepts, has been particularly influential in some public sector management circles. The changes that the managerial reforms introduced were often couched in terms of offering better and more responsive service to users, now called customers, as highlighted by the development of various charters and exemplified by the English Citizen’s Charter. If public sector services were to be seen to achieve best practice and international competitiveness in their area, greater attention had to be paid to consumer satisfaction with services and to dealing adequately with complaints when they arose, preferably at the local level. Managers now had a direct interest in consumer responses to proposed services and service implementation, including information from complaints, as a source of data to be used in advancing the agencies’ and the managers’ own positions. As the following analysis indicates, however, the full impact of the managerial reforms on agency based complaints handling mechanisms, in particular, is still to be fully realised.

6.4.1 Reforms to Management Practices in the Public Sector

Proposals to reform public sector administration were not new or unusual; reviews and inquiries into the area have consistently taken place throughout Australia’s history.

162. G. Davis, “The Prospect for Public Bureaucracy” in Davis, G., Weller, P. & Lewis, C. eds., p176; See Halligan and Power for detailed discussion about the implementation of different ideas on management by the various Australian governments.
The administrative law reforms discussed in the previous section were an outcome of one such review. The 1970s had promoted a move away from the traditional administrative values of impartiality, integrity and probity to a "new public administration" which placed a higher value on the notions of access, equity, and participation.163 These changes paved the way for the gradual introduction of business practices which focussed attention first on outputs, then on outcomes, and shifted the concern away from administrative processes. Davis cautions that the most recent management reforms must be viewed within the context of the economic paradigm (often termed "economic rationalism") that has dominated political agendas over the past decade in Australia and which has been highly critical of public sector administrative practices; "criticisms of public bureaucracy reflect a broader orthodoxy that minimum government is economically desirable".164 The performance and productivity gains made in many areas of the public sector have been overshadowed by this relentless drive to 'downsize' the provision of services by government through commercialisation and privatisation.

The notion of the management cycle of planning, budgeting, implementing and evaluation was central to the management reforms. Described by the Commonwealth Management Advisory Board as a "system-based approach designed for continuous improvement of program activities", the use of the management cycle required public sector services to undertake a number of new activities, such as strategic planning and the development of performance indicators.165 Strategic planning involved the identification of the "mission" or "vision" of the organisation, and the goals and the objectives necessary to accomplish this. It was no longer assumed that the primary "business" of each agency was easily discernible: it was to be clearly described in the mission statement.166 However,

164. Davis, p175.
165. Management Advisory Board & its Management Improvement Advisory Committee, Performance Information and the Management Cycle, pv.
166. The mission of the Commonwealth Ombudsman, discussed in the previous section of this chapter, as documented in her 1993/94 Annual Report, provides a good example.
the statements of missions, goals and objectives needed to heed the policy directions set by the government of the time and, in particular, the Minister to whom the agency was accountable. Through this process "ministers are now in a better position to set strategic directions for their portfolios and to direct the efforts of their departments". The greater political control over the activities of public sector bureaucracies not only increased financial accountability but also increased the vulnerability of public services to other reform agendas. Davis suggests that although they are "intended to enhance the efficiency of the public sector, business methods ultimately provide opportunities for business to take over many government services". The attractiveness to the private sector of providing services, recently the domain of the public sector, has been enhanced by the transformation of some public sector services to corporate style government business enterprises.

Another aspect of the management reforms was the realignment of agency activities under identified "programs". Each program related to specific key objectives of the organisation and it was through the programs that the objectives were to be achieved. The links between programs ultimately determine the structure of the organisation and the programs became the main units for management and budgetary purposes. For public hospitals and health services, as in other areas of public sector services, this presented a challenge to the traditional hierarchy of organising budgets and services. (See ch7.2.) The managers of each program became responsible for outlining more specifically the priorities and activities to be undertaken by that program, and the measures to be used to evaluate performance. The managers were also accountable for determining the efficient and

167. Management Advisory Board & its Management Improvement Advisory Committee, Building a Better Public Service, p9; also see Wanna et al p6.
168. Davis, p177.
169. The Annual Reports of the Commonwealth Attorney-General show this move to a program base. The 1991/92 and 1992/93 reports refer to the Departmental structure of different sections, one of which was the "Social Policy Group" that included the Federal Bureau of Consumer Affairs. While these earlier reports included mission statements and aims for each area, it was in the 1993/94 that the program areas, with well defined objectives and performance measures, are identified: the Federal Bureau of Consumer Affairs became sub-program 2.3 of Program 2: "Business and Consumer Affairs", Attorney-General's Department, Annual Report 1991-92, AGS, Canberra, 1992; Attorney-General's Department, Annual Report 1992-93, AGPS, Canberra, 1993; Attorney-General's Department, Annual Report 1993-94, AGPS, Canberra, 1994.
effective use of the resources allocated to the program and "the pursuit of more efficient ways of utilising resources" occurred as expenditure became more closely tied to specific activities and outcomes.\textsuperscript{170}

The management reforms emphasised three strategies: 'making performance count', leadership and strengthening the culture of continuous improvement.\textsuperscript{171} An important element of making performance count was the need to identify performance measures or indicators. To be able, to do this new methods of collecting information about activities had to be developed and significant resources were redirected to this task. While some advised a balance between quantitative and qualitative data, the parameters defined for data collection tended to be focussed on the more easily quantifiable activities and outcomes rather than the qualitative outcomes that often seemed intangible.\textsuperscript{172} Thus length of waiting lists for surgery, waiting times for hospital admissions and number of operations performed became indicators of performance, rather than the, often more difficult to define, better health outcomes from the interventions provided. Attempts to standardise the different performance assessment methods used across the public sector, which would make comparison between different areas easier, have not been particularly successful because of political influence and the variety of methods advocated and already in use.\textsuperscript{173}

The introduction of casemix funding arrangements for hospitals is a good demonstration of how this standardisation has occurred within particular sectors. Although feedback from

\textsuperscript{170} Wanna et al, pp81.
\textsuperscript{171} Management Advisory Board & its Management Improvement Advisory Committee, \textit{Building a Better Public Service}, p13.
\textsuperscript{172} M. Considine, "The Corporate Management Framework as Administrative Science: a Critique", \textit{Australian Journal of Public Administration}, vol.47, no.1, 1988, p12; the Management Advisory Board, for example, did advise that "qualitative and quantitative indicators are both important. The use of only one kind of measure can lead to misdirected effort and a mis-allocation of resources". Management Advisory Board & its Management Improvement Advisory Committee, \textit{Performance Information and the Management Cycle}, p11.
\textsuperscript{173} D. Fuller & B. Roffey, "Improving Public Sector Accountability and Strategic Decision-Making", \textit{Australian Journal of Public Administration}, vol.52, no.2, June 1993, p158; for a more comprehensive discussion of performance measures and evaluation see Wanna et al, Ch.14.
consumers has been recognised as legitimate performance information, consumer involvement in determining how performance is to be measured has been limited.174

Another element of making performance count and focussing on leadership was the devolution of control to program managers, under the slogan ‘let the managers manage’. It has been argued that this was only made possible through the increased centralised control in determining service goals and objectives and that the increased autonomy available to managers has been limited in scope.175 Accountability of managers became determined in accordance with the centrally stated objectives and goals.176 While this may be an advantage in overcoming ambiguity about what is expected of the program and the manager by the central body, this model does not incorporate the flexibility to accommodate specific local needs. As well, there has been a decreased emphasis on the need for both administrative discretion and adherence to administrative procedures that had been developed to ensure a measure of impartiality to the decision making process.

Taking a ‘client’ focus and improving service quality have been emphasised as part of making performance count and the continuous improvement cycle. The Management Advisory Board proclaimed, for example, that “a challenge for the Government and Public Service managers will be to establish more testing but realistic standards of client service and to devise means of delivery which are more client friendly”.177 Public officials were to provide services in a courteous and efficient manner. Guidelines and codes of conduct for


176. Fuller & Roffey argue that the development of management information systems and supporting organisational arrangements are essential prerequisites for management devolution to take place and that devolution to lower level managers lacks incentive unless these managers are made accountable to external bodies, Fuller & Roffey pp153-6.

public sector employees were drafted and distributed. Feedback from clients about their satisfaction with the services provided was to be encouraged. As well, a coordinated approach across departments to client services was suggested. The difficulty in defining exactly who constitutes the client/customer/consumer and the implications this has for service provision in the public sector, explored in chapter two, is glossed over in the discussions on improving client services.

Performance and productivity improvement were not considered a once-off occurrence. Through adopting a focus on continuous program improvement, it was held, public sector services could continue to pursue more efficient and effective ways of achieving the objectives of the organisation. Guided by management, a culture of continuous improvement was to become an integral part of an organisation’s activities. One way of achieving this “cultural change” was to direct staff development activities toward increasing the skills, capabilities and knowledge of public sector workers with the ultimate goal of providing “better services to the Government and the public”. Regular individual staff performance appraisals were also introduced and changes to public service employment awards reinforced the notion that ongoing employment was increasingly conditional on individual performance. Employment contracts specifying personal performance indicators, including bonuses for meeting these, became part of the arrangements for managers within the senior executive services. The focus on the performance of managers in terms of achieving results encouraged the application of the concept of ‘risk management’ to public sector services. The risk management process

---


179. Management Advisory Board & its Management Improvement Advisory Committee, Accountability in the Commonwealth Public Sector, No.11, AGPS, Canberra, June 1993, pp11-12.

180. Management Advisory Board & its Management Improvement Advisory Committee, Building a Better Public Service, p16.

accepts that some errors will be made and that the manager’s role is to identify these and to take immediate remedial and preventive action. However, the political nature of much public service activity “encourages managers to allocate more resources to disguising errors” that to locate, acknowledge and remedy them. A continuous improvement approach allowed for the identification and examination of areas where problems could potentially occur, and for risk management strategies to be set in place.

Reforms to the management practices of public sector services continue as the ideas and concepts about management in the public sector evolve. While the original push for reform came from external sources, many people in what are now usually identified as senior executive management positions have become the chief advocates for the implementation of the changes. As formal training through courses, such as the Master of Business Administration, is becoming almost essential for public sector managers it is not surprising that the theories of private sector business and management techniques are being applied to the public sector. One of the most notable current management theories, still gaining ascendancy in both the public and private sectors, is that of total quality management. Total quality management (TQM) requires some further discussion as the emphasis on quality and a customer focus in TQM has been influential in creating an atmosphere within some organisations that is more conducive to listening to consumer concerns and addressing consumer complaints. The specific application of TQM to health services and link with ideas about quality assurance in the health sector are discussed in the next chapter.

182. Fuller & Roffey, p155.
183. Fuller & Roffey, p159.
6.4.2 Total Quality Management.

Total quality management (TQM) encompasses a set of ideas, concepts and beliefs about the management of organisations to obtain the highest quality of product with the most efficient use of resources. Central to the philosophy underlying TQM is the idea that there may be several ways of achieving efficient quality outcomes and that an organisation can continuously improve its performance through identifying and utilising these different ways of working.\(^{185}\) It involves the whole organisation, its staff, structures and processes and responsibility falls on all staff to actively participate in improving performance. To this end management must be prepared to delegate appropriate authority to those workers who are in the best position to make quality improvements.\(^{186}\)

A key assumption in TQM is that all the activities of an organisation should be directed towards the pursuit of quality. Hence, the notion of quality is fundamental to the implementation of TQM. Quality has been defined in differing ways but generally encompasses the concepts of excellence, satisfying wants in the most desired way and achieving best value for money.\(^{187}\) Morgan and Murgatroyd, drawing on the work of other authors about TQM in their discussion of quality in the service industry of which public sector services are a part, note that comparisons between the manufacturing industry process and the service industry process reveal some specific differences that impact on the interpretation of quality.\(^{188}\) In particular the stages of production, selling and consumption are separate in the manufacturing industry process, whereas in the service industry selling occurs first, followed by production and consumption occurring concurrently. Three


\(^{188}\) Morgan & Murgatroyd, pp9-10.
features of service industries have an impact on how quality is defined and achieved by
different service providers: “intangibility” recognises that services are actually
performances so they cannot be tested for quality prior to their delivery or stored for a
“final quality check”; “heterogeneity” recognises that consumers have disparate needs and
variable priorities when using the same services; “inseparability” recognises that the
production and consumption of services are simultaneous.189 In service industries “quality
occurs during the delivery of the service ... [and] ... the consumer’s input becomes critical
to the quality of the service performance”.190 In any case, the consumers’ evaluation of
quality will include perceptions about both the processes used and the outcomes obtained.
Morgan and Murgatroyd go on to suggest that a simple model, the “Triangle of Service
Quality”, provides a framework for considering quality in the service industry with the
quality of a service being determined by the balance between three components
(interpersonal factors, process/environmental factors and technical/professional factors) in
the provision of the service.191

As a management theory, TQM had its origins in quality control systems developed
for manufacturing industry. Building on aspects of earlier management theories, such as
the importance of the collection and analysis of data in developing systems associated with
scientific management theory, the focus on employee skill development highlighted in
human relations theory, and the use of teamwork from the socio-technical systems theory, a
number of different models of TQM have emerged in more recent years.192 Books
outlining the TQM process frequently contain case study examples of how the ideas have
been implemented with successful results in business and service organisations.193 The key

192. Dawson & Palmer, pp40-41; Morgan & Murgatroyd, p34.
193. For example, see S. George & A. Weimerskirch, Total Quality Management. Strategies and Techniques
Proven at Today's Most Successful Companies, John Wiley & Sons, New York, 1994; B. Whitford with
J. Mcaulay, N. Patton, J. Goerke & D. Argus, Success through Excellence. How Companies in Australia
are Seeking and Attaining Excellence, Prentice Hall Beaumont Publishing House, South Perth, 1992;
Dawson & Palmer; Morgan & Murgatroyd.
ideas of customer focus, employee participation, strategic planning and performance evaluation have been given variable emphasis and interpretations when put into practice, with cross cultural differences apparent. Morgan and Murgatroyd argue that

"TQM has a core philosophy, some core concepts and some generic tools which can be applied to significant advantage within all public sector provision". Many of the ideas of TQM are evident in the changes to management practices discussed in the previous section and would suggest that a particular model of TQM as applied to public sector service provision in Australia is unfolding.

The focus on meeting customer expectations in relation to their needs and preferences is fundamental to TQM. However, the term ‘customer’ is used in a broad context that includes customer/supplier relationships internal to the organisation. Regardless of the position held in an organisation, all employees are seen to be both suppliers and customers in the work chain; as suppliers they will seek to meet the needs of their customers (colleagues and other departments in the organisation) and as customers they will make their needs, preferences and expectations known to the suppliers.

Whether internal or external, it is the customers who make judgements, based on their needs and expectations, about the quality of the service/product provided by the suppliers. This is not a static process as customer “quality perceptions” occur whenever there is contact between supplier and customer. Some instances of the perceptions of quality are

195. Morgan & Murgatroyd, p59, their emphasis.
considered more critical to the final judgement of quality that customers make. It is the way these instances, called “perception points” or “moments of truth”, are managed that is significant according to TQM theory:

"a response which exceeds the customers expectations will create a delighted customer, leaving the customer as an advocate for the supplier’s goods and/or services".199

For organisations providing goods and services in a competitive market the benefits of customers ‘advocating’ on the organisation’s behalf and remaining ‘loyal’ to the organisation are obvious. This customer focus also entails assessing the requirements and expectations of the customer through market research and satisfaction surveys. Being “customer driven”, it is claimed, is instrumental to organisations achieving success in obtaining and retaining a share of the competitive global marketplace.200

It is in this context of retaining a competitive edge and the loyalty of the customer that the way complaints are handled by organisations becomes important. A complaint indicates that at some “moment of truth” the service/product has been judged less than satisfactory, so much so that the customer has chosen to use their ‘voice’ and make a complaint. In Hirschman’s terms the maximum degree of loyalty of a customer to the organisation will be maintained if the ‘voice’ is acknowledged and a resolution satisfactory to the customer is obtained. (See ch2.2.1.) Expressions of dissatisfaction are to be encouraged to enable the organisation to improve the customers’ perceptions of quality (so the customer will continue to use/buy the service/product). As well, the information provided by the complaint can be used to help in “getting it right, first time, every time”.201

The elimination of error and reworking is another TQM concept, along with a “commitment to constant improvement by integrating customer feedback into redefining the design [of the product/service]”.202 Interestingly, although some of the earlier writers

199. Department of Industry, Technology and Commerce (Commonwealth), p34, their emphasis.
highlighted the point that “complaints can be golden” a number of the more modern texts on TQM do not list complaints as an index item or contain detailed guidance on the handling of complaints. In an era where multinational companies increasingly dominate world markets, Hirschman’s idea that where quasi monopolies exist, dissatisfied customers will be easily absorbed by competitors, may partly explain this lack of emphasis on complaints. However, the international standard for quality systems, first released in 1987 and known as ISO 9000, and other assessments of quality systems, include specific mention of processes for resolving customers’ complaints and linking complaints data to performance improvements. To this end sophisticated information technology packages have been produced to manage complaints data. Ultimately, it is the benefits to the organisation that are paramount in considering the extent to which organisational resources are to be devoted to complaints handling and obtaining consumer feedback.

Employee participation in the quality improvement process is crucial in TQM theory. The whole culture of the organisation has to be directed towards the achievement of the organisation’s stated goals for the success of TQM to be assured. Senior staff need to demonstrate their strong commitment to TQM’s quality improvement process and to the devolution of control that this may entail. Teamwork is emphasised; teams of workers may be formed that cut across traditional functional boundaries and be self managing within the parameters of the organisation’s goals and objectives. Employees are said to become ‘empowered’ by these changes to control and relationship hierarchies and therefore gain a

203. The quotation “complaints can be golden” refers to the golden opportunity to win back the customer presented to the organisation when a customer complains. T. Peters & N. Austin, A Passion For Excellence. The Leadership Difference, Fontana/Collins, Glasgow, 1986, pp82-87.


205. For example the information technology packages produced by the international consulting organisation Technical Assistance Research Programs, Arlington, Virginia.
greater sense of ownership of their work processes, environments and outcomes. Employees are encouraged to take a critical approach to their work, highlighting deficiencies in processes and putting forward ideas for quality improvement. Proposed changes must be supported, however, by the necessary performance data and measurements and scrutinised within the teams. The increased data on performance now available can be accessed by managers at all levels, making monitoring of the teams and their performance an easier task. This proved particularly useful to managers wanting to obtain better control over areas of work where they had little technical or professional knowledge.

The increasing popularity of TQM is evident across the spectrum of organisations in Australia. Training opportunities in “quality management” are advertised in publications directed at those working in the public sector. An Australian Quality Council has been formed, “quality trainers” can now be accredited and “quality awards” given. Many prestigious companies trading worldwide are renowned for having introduced TQM, and their representatives are called as speakers at seminars and conferences pitched at public service audiences. Together these activities indicate an increasing acceptance and legitimacy of TQM despite the faddish language, acronyms and slogans often associated with TQM, such as “zero defect”, “moment of truth”, and “just in time”. Because of the widespread acceptance of TQM it has been suggested that the ideas are now being adopted not necessarily to improve quality or performance but to gain cultural

206. For one interpretation of empowerment as it is used in TQM see K. Simper & W. Wilson, “Empowerment: A New Way of Doing Business” in Whitford & Associates, pp33-45. While there are some similarities to the ideas relating to industrial democracy, Dawson and Palmer argue that employee involvement as prescribed by TQM does not fit the industrial democracy model as participation in decision making is limited and often only advisory; “under TQM policies employees are not necessarily involved in strategic decisions or major areas of company policy making”. Dawson & Palmer, p52.


208. For example the one day seminar entitled World’s Best Practice in Quality Management. Is South Australia Ready? held in Adelaide on 20th June 1995 was sponsored by two government departments (the Office of Business and Consumer Affairs and the Office of Public Sector Management) and two associations with a large membership of public sector workers (RIPAA and SOCAP).

209. For example the seminar organised by SOCAP and the SA Office of Consumer and Business Affairs entitled Turning Complaints into Profit, held in Adelaide in July 1994, with speakers from Ford Australia and TARP (Australia).
legitimacy within management spheres.210 As already noted, the implementation of TQM within organisations shows considerable diversity and the extent to which improvements in complaints handling and consumer feedback are taken up as part of the culture of TQM still depends very much on the preferences of individual organisations.

One further concept, 'best practice', strongly associated with TQM, is relevant to discussions of changes to complaints and complaints handling. The notion of best practice has proved attractive in many different spheres and industries. The Australian Manufacturing Council, for instance, has defined best practice as

"the co-operative way in which firms and their employees undertake business activities in all key processes: leadership, planning, customers, suppliers, community relations, production and supply of products and services, and the use of benchmarking. These practices, when effectively linked together, can be expected to lead to sustainable world-class outcomes in quality and customer service, flexibility, timeliness, innovation, cost and competitiveness". 211

In the various service industries, definitions of best practice refer to processes used by, and behaviours of, service providers and have been linked with ideas about the development of competencies. Quality assurance activities within the health area have been used to determine protocols identifying best practice in particular areas of service provision. The related concept of benchmarking involves

"the comparison of a given business function across companies. It is designed to allow managers to understand how their organisation's functional performance compares with that of other companies, particularly those which excel in that function".212

Armed with this knowledge, managers can then take steps to enhance the performance of their organisations with the aim of becoming the best in that industry, usually interpreted in terms of economic success of the organisation. Outlining best practice in specific areas fits comfortably with notions of professional practice and expert skills and knowledge,

although there may be considerable disagreement about what constitutes best practice in any given area, and the best practice described may lack consumer input. The public articulation of best practice standards, however, potentially gives consumers the same information as the ‘experts’ about what can and should be expected from service providers in the provision of particular services, information that can be used by consumers to make comparisons with the services they actually receive and, where necessary, provide firm grounds for consumers to make ‘informed’ complaints.

6.4.3 Managers and Consumers

Citizens' Charters

The focus on performance indicators, customer service and best practice brought with it the idea of a citizens’ charter. It is not surprising that the nature, content and language of citizens’ charters reflects the corporate management rhetoric now espoused by public sector managers. This is perhaps best demonstrated in the Citizen’s Charter, announced in Britain in 1991. The introduction to the Charter document focused on the idea that increased choice and competition will, in turn, improve the quality of services provided and that “through the Citizen’s Charter the Government is now determined to drive reforms further into the core of the public services, extending the benefits of choice, competition, and commitment to services more widely”.213 It was proposed that more detailed charters would be developed for specific services, for example the National Health Service and the Local Education Authorities.214 The notion of the “Charter Standard” incorporated the key “principles” of: defining and publishing expected standards of service and actual performance achieved; consideration of user views in developing standards;

provision of information about the services available; services to be provided in courteous and efficient manner; "well signposted avenues for complaint" and independent review in some instances; performance against standards to be independently verified and "a commitment to improving value for money". Throughout, the Charter the themes of quality, choice, standards and value for money are reinforced but often narrowly interpreted in terms of comparative performance, market choice and lowest cost.

The rights outlined in the Citizen's charter refer predominantly to processes and procedures, such as waiting times, wearing name tags and providing clear information which, it could be argued, should be an integral part of good service provision. Thus, the Charter has been criticised for, amongst other things, only offering "procedural rights, not rights of accountability, and ... do[es] not yield control of resources". While attention is given to ascertaining users' views, consumer participation in other ways, such as encouraging formal consumer representation on planning committees and boards of management across the range of services, were not promoted in the Charter. The focus remains on consumers as customers rather than as participants to be included in decision making processes, other than at an individual level.

The influence of the market choice model on those framing the Charter is most evident in its claim that the "most effective form of redress is the right of exit". Hirschman's analysis reveals a much greater complexity of outcome in using the right to exit than is suggested by this statement. (See ch2.2.1.) In the Charter, complaints are seen in terms of putting things right when they go wrong and providing compensation in some instances where performance standards are not met. One of the most interesting proposals in the Charter, not pursued due to possible cost and policy implications, was the

idea of using voluntary “local lay adjudicators” to intervene to assist the resolution of minor complaints where the organisation receiving the complaint was not seen to be following through in addressing the complaint. A Complaints Task Force was appointed, by the Prime Minister, to advise, on the overall development of complaints procedures by individual organisations, through identifying best practices in complaints handling.\textsuperscript{220}

A Citizens’ Charter has yet to be developed at the Federal level in Australia, although several state examples exist. The Trade Practices Commissioner, Allan Asher, who is also Chair of the OECD Committee on Consumer Policy, stated recently “it is my view that Consumers’ Charters in one shape or another need to be, and in fact will become, a feature of the Australian landscape during this decade”.\textsuperscript{221} He went on to argue that a range of benefits could potentially be derived from consumer charters including greater dialogue between service providers and consumers about needs and delivery of services; the development of best practice benchmarks and service performance standards; improved complaints handling and redress mechanisms; and acting “as a substitute for some of the forces of competition where none exist”.\textsuperscript{222} The Commissioner noted, though, that for these benefits to be realised a number of factors need to be present in an organisation, such as the ability to undertake skilled analysis and interpretation of information gathered from consumers, the provisions of the Charter need to complement the strategic management plan, and the involvement of staff as well as consumers in the development of the Charter.\textsuperscript{223} To those supportive of the quality management approach, the Commissioner’s

\textsuperscript{222} Asher, pp4-5.
\textsuperscript{223} Asher, pp7-13; the point regarding skill in gathering and analysing consumer information is further made in L. Sylvan, “Exploring Unchartered Waters”, interview with D. Leabeater, UK National Consumer Council, \textit{Consuming Interests}, July 1993, pp12-16.
language, in speeches promoting the adoption of charters, would be appealing. Already the idea of charters for specific areas has been taken up, for example in health and the courts.

The development of charters has focused managerial attention on the existing complaints handling mechanisms in their organisations and the possible need for improvement. However, the action to be taken in relation to changing the complaints procedures is more likely to be determined by the perception of management about deficits to the complaints mechanisms than by consumers' stated concerns. The charters compatibility with the influential ideas of current management theory would suggest that they are easily regarded as management tools, controlled and directed by the organisational perspective. The benefit to consumers of the introduction of a charter may take second place to the benefit it provides to the management of the organisation. The rhetoric of the charters will then not necessarily reflect the reality experienced by consumers and may, in fact, prevent those in management positions from hearing consumers' voices from other sources.

**Consumer Representation and Consumer Consultation**

The "new public administration" of the 1970s did leave several legacies, notwithstanding the advent of corporate management. Of particular interest here are consumer representation and consumer consultation. Both provide the means for obtaining consumers' perceptions of and reactions to the organisation, its plans and policies, as well as to the delivery of the final service/product. Consumer feedback, according to TQM

---


225. See discussion of health consumer's charters in ch5.4 and statements of patients rights in ch4.3.5 & 7.4.2.; the Access to Justice Advisory Committee report included the recommendation that charters be developed for each part of the court and tribunal system (p370) and the *Justice Statement* confirms that $700,000 over two years has been made available for this purpose (p58).
principles, provides a valuable and legitimate source of information that can be used in measuring performance. Skilfully applied, consumer information can also be used to advance other, often more subtle, agendas, such as increasing managerial control over professional service providers. Perhaps for these reasons consumer representation and consultation have continued to be promoted by government agencies.

The concept of consumer representation on boards, committees and similar decision making bodies of public sector agencies has gained at least tokenistic acceptance by politicians, the bureaucracy and the public and many government documents now include statements espousing this. At the Commonwealth level the Federal Bureau of Consumer Affairs has begun an auditing exercise "to ensure consumer representation is adequate in the decision making processes of government departments and statutory authorities", following a specific request from the Minister for Communications for an audit of consumer representation on boards and committees in his portfolio.226 It is less clear how consumer representation works in practice and the impact that consumer representatives can realistically achieve, particularly when they are the sole consumer representative. Appointees may not necessarily represent an organisation; for example the Australian Consumers' Council makes a particular point that members of the Council are ministerial appointees, selected because of their individual skills and knowledge in the area, rather than as organisational representatives.227 Concern about appropriate guidelines for appointing consumer representatives and their training needs has been noted from a consumer perspective in chapter three and four. Co-option of the consumer representative into the 'culture' of the organisation or choosing representatives who are already familiar with organisational processes, such as those with professional training, gives the appearance of seeking the consumers' viewpoint but also has the potential to ensure

minimal disruption to established ways of working. Consumer representation on boards and committees has often been the primary form of consumer participation advanced by organisations.228

Consultation in the policy development process and the planning and implementation of service delivery has also become an accepted administrative practice in a number of areas of the public service. Who is consulted and how this process is conducted have been issues for the various interest groups and consumers in particular.229 Where consumers are not part of an easily identifiable interest group they are less likely to be included in consultation processes. As well, timelines for the consultation process are mostly set to suit bureaucratic requirements without full consideration of the difficulties consumers may face in meeting these, particularly as much consumer time is given voluntarily.230 Mandatory consultation with relevant bodies has been proposed in various areas of government decision making. For instance, the Access to Justice Advisory Committee recommended the introduction through “legislation or other appropriate means, of a general requirement for the Government to consult in the process of making legislation, subject to appropriate specific exemptions”.231 How this might be applied in practice is not defined.

The customer focus of the management cycle in the public sector has necessitated the use of mechanisms such as consumer representation and consultation. The


229. For example, in the development of the South Australian Youth Health Policy, the advisory committee comprised a majority of representatives from health service provider organisations; the ideas and opinions of young people were sought through a separate and not particularly extensive consultation process and not at all in the development of the implementation strategies.

230. An example of this lack of consideration for consumer circumstances was demonstrated in the consultation process used in drafting a consumers' health charter in South Australian: drafts were distributed a few days before Christmas with comments required by the last week in January, a time when most consumer groups are in recess. Alternatively the public consultation process used for the Adelaide 2020 Planning Review in 1992 included provision for childcare, reimbursement for transport costs and multiple meetings in various locations at different times of day over an extended period.

Management Advisory Board, the Commonwealth body responsible for a series of publications about management reform in the public service, recommends that public services find “better ways of keeping in touch” with the community and that organisations “must be prepared to consult openly and genuinely”. Satisfaction surveys have grown in sophistication and frequency, with an increasing expectation that such surveys will be used in assessing the achievement of objectives and targets. Customer relations and marketing experts have found a new status in being seen to be in touch with customer needs although their links with consumers may be tenuous. Obtaining and controlling consumer information can provide managers with some useful advantages. Consumer data may be used to justify managerial change agendas, particularly if these are opposed by other well established powerful groups with specialist knowledge necessary to the primary functioning of the organisation, such as in the provision of health services. (See ch7.2.) How consumer information is generated and then used may not result in direct benefit to consumers who provided the information but instead increase the legitimacy and influence of the managerial or professional groups controlling the process. The extent to which consumer consultation and representation can produce better outcomes for consumers is still largely dependent on the goodwill of the organisation initiating these processes.

6.4.4 Managerial Reforms and Complaints Handling

The implementation, over the past decade, of the managerial reforms described above has resulted in a different way of organising and viewing public sector service provision. Along with the influential rhetoric about the decreasing role for government in

233. An example of this is the satisfaction survey conducted by the Commonwealth Ombudsman’s Office, mentioned in this chapter, the Ombudsman.
235. For discussion of this point in the context of the National Health Service in Britain see Harrison & Pollitt, pp125-134.
direct service provision, the focus of the reforms on public sector performance and productivity have led to changing work practices across many services. Strategic planning, defining performance measures and target groups, developing standards and identifying quality service have been adopted in an attempt to demonstrate that public services provide value for money. While this has certainly contributed to the enhancement of managerial positions within organisations, the real benefits to consumers are less clear. However, the reforms have contributed to an environment within public sector service provision that accepts consumer feedback, and in turn consumer complaints, more willingly than in previous times.

With the introduction of the managerial reforms, the attention on improved performance and productivity has meant greater definition of exactly what is being provided to whom, by whom, in what way and at what cost but a change in emphasis has also crept in. The new practices are more likely to be described in terms of the benefit to the organisation, with the implicit assumption that this will in turn benefit consumers. The rights of consumers are identified largely in terms of procedural rights that can be included, or for that matter just as easily withdrawn, with the next round of reforms to service provision. A good example of this shift in emphasis is provided by the documents of the Home and Community Care (HACC) Program. In 1989, there was agreement amongst the Ministers responsible for the HACC Program that a consumer rights strategy would be developed and to this end a Statement of Rights and Responsibilities was issued in 1990, which stated that “respect for and promotion of the rights of consumers is integral to the HACC Program”. The aim of the 1990 Statement was “to ensure all consumers are

236. A joint Commonwealth and State/Territory initiative, the Home and Community Care Program (HACC) funds a myriad of predominantly community based organisations to provide services to elderly people and younger people with disabilities to enable them to live at home rather than being forced into institutional care. M. Fine, “Community-Based Services and the Fragmentation of Provision: A Case Study of Home and Community Care Services in A Suburban Community”, Australian Journal of Social Issues, vol.30, no.2, May 1995, p146.
aware of their rights and responsibilities and can be confident in exercising them”. The key consumer rights outlined and the responsibilities of service providers were very much about ensuring the interactions between consumers and service providers in the delivery of services were fair and respectful. In 1992, a further document was published, called *Getting it Right. Guidelines for the HACC Program National Service Standards*. The format of this 1992 Standards document reflected the new managerial way of describing services in terms of objectives, outcomes and performance measures. The Foreword stated that

"the standards do more than merely reinforce the commitment made in 1989 to protect and promote the rights of HACC consumers. Rather, the standards will provide service providers with a common reference point for internal quality control, monitoring, evaluation and ongoing development".

The consumer rights of the 1990 Statement document have been subsumed into a set of objectives for HACC program service providers to strive towards to achieve a quality service and against which services are to be evaluated. Consumer outcomes, service standard principles and measures of progress are identified for each objective in this second document. Thus the 1950 Statement of “the right to pursue any complaint about service provision without retribution” is translated, in the 1992 Standards, into “Objective 6: Complaints and Disputes. To ensure that each consumer has access to fair and equitable procedures for dealing with complaints and disputes”. The emphasis on upholding rights had shifted to an emphasis on complying with standards. This is not to suggest that outlining standards is unnecessary. In fact, because of the 1992 Standards, the HACC Program devoted significant resources to improving complaints handling amongst the services it funded, and it is one of the few Programs to recognise and actively support the

---

240. Home and Community Care Program, *Getting It Right*, Foreword.
role of advocates for those wanting to make a complaint. The 1992 Standards document does, however, highlight the pervasive influence of the managerial reforms in the way the standards for HACC services are constructed and performance measured. The implications of the change in language describing complaints mechanisms are significant: the handling of complaints has become a service objective of the organisation, with a more passive role assigned to consumers of providing the complaints that the organisation can then handle to its satisfaction and profit.

The managerial reforms have had a mixed impact on the availability of information, an important factor in successfully making a complaint. On the one hand, the outlining of standards and the striving to improve quality have increased the potential for new and more comprehensive information about services to become more widely available to consumers, through annual reports and other publicity material. Conversely, the creation of government business enterprises and the increased focus on providing services in a competitive market have worked against an increased information flow, particularly at the planning and development stage, and have removed some areas of public sector activity from the safeguards provided through the administrative law reforms such as the jurisdiction of the Ombudsman. While consumer participation in decision making processes has been acknowledged, the managerial perspective tends to regard this input in terms of benefit to the organisation rather than from an altruistic motive of benefit to the consumer. Services are likely to be described in terms of what customers’ are perceived to want, rather than what they may be entitled to.

The new emphasis on continuous improvement and a customer focus has prompted a focus on complaints handling, although this is likely to be described in terms of

---

242. HACC has not only recognised the necessary role of advocates for complainants but has also funded independent advocacy agencies specifically to assist complainants with disabilities in making complaints about HACC or any other service. As well, HACC employed consultants to produce a detailed training manual and video, to assist HACC funded services in developing their complaints policies and procedures at the local service level. Home and Community Care Program, Managing Complaints. A HACC National Service Standards Training Package, The Change Agency Pty Ltd Canberra, HACC, Dept of Health, Housing and Community Services, March 1993.
opportunities for the organisation rather than consumers’ rights. However, some organisations have taken complaints handling more seriously and worked towards developing more effective policies and practices, sometimes where none had previously existed.243 It is now common place to see pamphlets advising consumers of the steps to take if they want to make a complaint. Almost all such documents advise the complainant to try to resolve the complaint direct with the service provider or organisation in the first instance, before proceeding to a more central body.

As complaints handling gains status as an integral part of world class business practices necessary to achieve international competitiveness, it is likely that managers will pay greater attention to complaints policies and procedures. The high attendance by management representatives of government agencies at quite costly seminars and workshops about complaints handling suggests that there is interest in this area already even if the goal of that interest is unclear.244 The introduction of standards as statements of best practice, such as the quality systems standards, at national and international levels has increased the prestige of adopting such systems and complying with these standards. The lead of successful multi-national businesses in doing so has added considerable credibility to the notion of total quality management.

The managerial reforms already witnessed within Australian public sector services provide a fertile ground for further expansion of the methods of quality management and the adoption of “best practice” standards. Complaints systems have taken on new meaning as an indicator of a progressive world class organisation and the information provided by


244. For example, the seminar organised by SOCAP and the SA Office of Consumer and Business Affairs entitled Turning Complaints into Profit, held in Adelaide in July 1994, and similar seminars sponsored by SOCAP in Melbourne and Sydney over the following twelve months.
complaints have become a tool to be used to advance managerial agendas. This acquisition of information was particular important in work areas where managers had previously had little control because of the dominance of professional and technical expertise, for example in the health sector. The emphasis in introducing and improving complaints systems remains firmly on the benefit to the manager and the organisation. As management experts take over the role of consumers in advising managers on how best to set up complaints handling mechanisms, consumers are again consigned a passive place in the system.

6.5 CONSUMER AFFAIRS BUREAUX AND COMPLAINTS SYSTEMS

Government involvement in consumer affairs issues has been long standing, as already noted in discussion of the consumer movement in chapter three. It is not surprising that with the increased interest in consumer rights of the early 1970s, governments also became more active in this area. New consumer protection legislation was introduced which has been revised and reformed over the following years as different political and economic agendas came to dominate. Consumer affairs portfolios have since included responsibilities for educating consumers about their rights and dealing with disputes between producers/providers and individual consumers, as well as enforcement of the requirements of the legislation through special tribunals and the courts by the Commissioners and Ministers of Consumer Affairs. The work of the consumer affairs officers has provided another model of complaints handling, significant because the producer/provider parties to the disputes do not have to be from within the public sector but need only fall within the jurisdiction of the relevant consumer protection legislation. The greater emphasis on self regulation and the development of standards and codes of

245. This use of complaints and complaints systems by managers for their own ends should not be surprising given that a recent major official report, Enterprising Nation, defines managers as "those who achieve enterprise goals through the work of others". Industry Task Force on Leadership and Management Skills, Enterprising Nation. Renewing Australia's Managers to Meet the Challenges of the Asia-Pacific Century, D. Karpin Chair, Research Report Vol.1, AGPS, Canberra, April 1995, p4.
practices by industries and professional groups point to a new direction for consumer affairs agencies as facilitators of these processes rather than enforcers of regulations.

The creation of consumer affairs portfolios by governments around Australia in the 1970s was symbolic of the growing awareness of the diversity of issues that had arisen with the increasing complexity of consumption within society. The ambit of consumer affairs is extensive and has been described as

“covering all aspects of the supply of goods and services to individuals and households, and their consumption. Supply may be either by direct transaction or by indirect transaction as in the supply of goods and services by government paid for through the tax system”.246

A consumer’s right to complain and seek redress has been supported by the establishment around Australia of Commissioners for Consumer Affairs or similar positions at the state/territory government level, with a specific brief to uphold the public interest and enforce consumer protection legislation.

The thrust for the development of legislation and policy in the consumer affairs area has been largely based on three, at times conflicting, premises.247 The first has been that, in order to maintain consumer sovereignty and therefore consumer choice, market failures must be corrected; consumer laws provide a vehicle for doing this, for example by restricting anti-competitive practices. The second has been that numerous research studies had confirmed that less affluent consumers consistently paid more for a variety of goods and services than their higher income counterparts; thus consumer laws have the potential to achieve redistributive goals, for example by protecting vulnerable consumers in the hire purchase market.248 The third premise has been that, with the vast amount of goods and services available, consumers are not able to make their own assessments about, for

---


Page 278
instance, the safety of products and need the assistance of expert advice independent from the producer; consumer laws can provide the mechanisms necessary to take on this role.\textsuperscript{249} While the arena of consumer affairs encompasses a broad range of legislation and government agencies, the discussion in the following sections specifically focuses on consumer protection legislation and the consumer affairs bureaux because of the direct link with handling consumer complaints about goods and services in Australia.

6.5.1 Consumer Protection Legislation in Australia

There has been a long, varied history of attempts to invoke some protection for consumers as controlling bodies, such as religious organisations and governments, sought to provide some balance in the trading relationship between sellers/providers and recipients of the goods or services.\textsuperscript{250} The right under common law to seek recompense for fraud and misrepresentation has been dominated, from the eighteenth century, by the notion of 'caveat emptor' or 'buyer beware'. Consistent with influential libertarian political and economic ideas about free trade, market choice and a limited role for government,

"caveat emptor incorporates the spirit of individualism into the law of market relations by expressing an ordinary rule of prudence: the consumer must use his/her own faculties to assess the worth and quality of the goods s/he purchases and must not expect remedies or protections against unsatisfactory, deceptive, or misrepresentative transactions."\textsuperscript{251}

However, legislative activity in other areas resulted in specific government measures to protect consumers from the sale of goods that may have had life threatening consequences.\textsuperscript{252} The events that have prompted the cycles of increased consumer activity over the past century (discussed previously in chapter three) highlighted the vulnerability of consumers in the market place and the need for some form of legislation or regulation to control, at minimum, the worst abuses and most dangerous practices.

\begin{itemize}
  \item 249. Ramsay, pxi.
  \item 250. Silbey, p429.
  \item 251. Silbey, pp427-428.
  \item 252. For example, there was a series of statutes in the late 1800s and earlier this century relating to the production of clean, unadulterated foodstuffs and drinks, particularly milk. See C. Reynolds, \textit{Public Health Law in Australia}, The Federation Press, Sydney, 1995, pp148-159.
\end{itemize}
The concession to consumer rights in the United States of America in the early 1960s led to a new wave of legislative activity that focused more specifically on the issues that had emerged with increasing mass consumption in mass markets, such as the need for "truth in packaging" and "truth in lending". Legislation in the commercial business area, particularly, have formed the basis for what is generally identified as the consumer protection laws, although a range of other legislation may have a significant consumer protection component, such as in the environmental protection area.\(^ {253} \) Laws that provide the consumer some degree of protection are numerous and it is not surprising that, given the diversity and rapidly changing nature of issues facing consumers, "no single statute provides a comprehensive code of consumer protection".\(^ {254} \) The reliance on private civil law for the enforcement of consumer protection provisions has meant that consumers often must initiate legal action as individuals to use the redress mechanism available.\(^ {255} \) The barriers to taking legal action through the courts, noted in regard to administrative law issues, also apply to consumer protection issues.

The development of standards and codes of practice has received renewed emphasis with the most recent push for regulatory reform spurred on by economic considerations. There has been a move away from industry specific regulations to broader, more generally applicable, consolidated and simplified regulations. In addition, industry and professional groups have been encouraged to become self regulating, setting their own standards and codes of practice and identifying procedures for handling complaints and the sanctions that might be imposed.

The past two decades has seen a rapid development in consumer protection legislation in Australia, exemplified by the introduction in 1974 of the Commonwealth government's Trade Practices Act 1974 (TPA). Part V of this Act sets a precedent in that

its provisions contained “useful tools for protecting the rights of consumers” across a range of commercial and business transactions still applicable today.256 All states and territories have introduced and changed various legislation within the ambit of consumer protection over this period. Consumer protection legislative reform in Australia has reflected the different political ideologies of the time: the emphasis on consumer rights in the 1970s produced a significant overhaul of much existing legislation and the introduction of new legislation; the emphasis on self regulation of businesses and the professions in the 1980s resulted in substantial reforms to occupational licensing provisions and a focus on drawing up standards for industries and products; the emphasis on economic prosperity through competing in global markets, reinforced by the national competition policy, in the 1990s, has led to a merging of business and consumer interests by governments. Much of the consumer protection legislation has been prompted by unfair and deceptive trade practices, such as had occurred in the credit and insurance industries in Australia.

In a similar way to the Commonwealth administrative law reforms, the Commonwealth TPA, provided a significant legislative model for the states/territories to follow. With the emphasis on promoting competition and therefore maximising quality and standards while minimising price, the TPA gave greater legitimacy to certain consumer expectations in the consumption of goods and services, such as goods being suited for the purpose described and free of defects and services being provided with reasonable care and skill.257 The key elements of the consumer protection provisions encompassed by the Commonwealth TPA were not fully incorporated by the various state/territory consumer legislation until the second half of the 1980s when most states/territories introduced fair trading legislation.258 Earlier efforts to increase consistency across the nation were fraught

256. C. Cameron, A Fair Deal for Consumers in Australia, Speech delivered by the Australian Minister for Science and Consumer Affairs at a Meeting with Consumer Representatives in Sydney on 1 August 1975, p.5.
257. Goldring et al, pp15-16. The consumer protection provisions of the TPA were strengthened in 1986, particularly in relation to safety and misrepresentation where there is the potential for harm.
with difficulties because of the multiple political and economic agendas, for example in the credit transaction area.259

The reform of consumer protection laws has raised considerable debate. Opponents point to the added costs attributed to compliance with particular standards or regulations. Proponents justify increased consumer protection legislation as

"a necessary response in order to prevent human suffering and unjustified economic exploitation of consumers which either free market forces cannot prevent, or which more commonly, result from manipulation of markets - in reality are never totally free - by those with economic power".260

The threat posed by the potential for individual consumers to take legal action against businesses for wrongdoing often has not been sufficient incentive for businesses to make consumer protection issues paramount. The difficulties facing consumers in proving negligence, for example, highlight the limitations of civil law and "cast doubt on the effectiveness of private law to protect consumers".261 The barriers to using civil legal procedures in seeking redress for wrongdoing whilst receiving health care, for example, has been a motivating factor in the establishment of independent health complaints units with the powers to investigate and conciliate such complaints. (See ch7.5.)

Consumer protection legislation, often devised in response to a particular set of circumstances can, in turn, become dated with two results: consumers may no longer be protected in the way intended; and the industry must continue to comply with regulations and standards that may seem irrelevant.262 Inappropriate and cumbersome legislative requirements have been used to support the push for deregulation of a number of industries.

The greater protection of consumers by consumer protection laws cannot be taken for granted. Goldring and colleagues state that

261. Cranston, pp67-68; For a discussion of the law of negligence as it relates to public health see Reynolds, pp127-129.
262. Trenowden, p278.
“the system of product liability law which has been established in Australia is by no means complete and leads neither to the optimal levels of safety of goods nor to desirable levels of compensation for those who suffer loss and damage”.263 They also suggest that the consumer protection laws have often served business interests better than consumer interests as “the majority of those bringing action in the courts for relief under the TPA have been business rivals of the alleged contravener of the Act rather than consumers”.264 The regulation of the professions is another area where the benefit to the professionals themselves has been great, and sometimes worked to the detriment of the consumer. Other critics have argued that the effectiveness of consumer protection legislation generally has been limited because it does not address sufficiently the power imbalance between consumers and the providers of goods and services but only serves to further legitimise the status quo in business transactions.265 These critics do not suggest that consumer protection laws be abandoned but, rather, that they have not gone far enough and that “government controls are the best protection for consumers and that other techniques like the free operation of market forces, business self regulation and the private law are only of limited effect”.266 The question then becomes what form and shape consumer protection legislation should take.

The prevailing political and economic forces seem to be more influential determinants of the kind of legislation is adopted than the particular consumer protection issue of concern. While “the ‘new’ protections of the 1970s have become the expected protections of the 1980s” many of the reforms proposed in the early 1970s were never adopted by conservative governments less inclined to pursue the more ambitious proposals, possibly more costly to business, in allegedly declining economies.267 More recently, fair trading legislation was introduced in a number of Australian states/territories to consolidate a number of existing laws in an attempt to streamline administrative and regulatory
practices and to address some of the criticisms, particularly by the business sector, about the unworkability of some aspects of the legislation. In the 1990s reducing the complexity and inconsistency of consumer protection laws across Australia has become a priority as the rhetoric of political economy requires the achievement of greater efficiency and competitiveness at a national and international level. To this end inter-governmental agreements and the amendments to the TPA have already been made so that new “competitive conduct rules” apply to nearly all businesses around Australia. Consumer protection legislation, which included the creation of a commissioner for consumer affairs or similar body, opened a role for government officials in assisting complaints handling between individuals and businesses, public and private.

6.5.2 Consumer Affairs Agencies

Consumer affairs agencies have become a recognised part of government services but their form and functions has been determined by the broader agendas already identified, as well as portfolio changes, inter-departmental shifts and limited resources over the past two decades. Consumer affairs agencies have had three primary purposes: to advise the government on consumer affairs issues, particularly policy and legislation; to oversee the administration and enforcement of the provisions of the legislation; and to advise consumers of their rights under consumer protection legislation, including assistance with resolving complaints. The Federal Bureau of Consumer Affairs, for instance, outlines its program objective as “to provide protection for consumers in commercial and service transactions and to promote the representation of consumer interests in Government decision making”. This reflects the first premise underlying government agencies’

268. Trenowden, p277.
270. For example, federal ministries responsible for consumer affairs have included Science and Consumer Affairs, Business and Consumer Affairs, the Attorney-General and most recently the Minister for Consumer Affairs (Minister assisting the Attorney General). NCAAC, para3.1-3.26.
involvement in consumer affairs: to counter balance and rectify market deficiencies. However, much broader objectives for consumer affairs bureaux have been envisaged by others such as "the promotion of social justice through protection and education of consumers and traders (and in some places tenants and landlords) with respect to their rights and obligations" recommended by the National Consumer Affairs Advisory Council (now ACC).272

Consumer protection law has involved the establishment of a complex myriad of agencies and boards, each with responsibility for different aspects of the numerous provisions of the various legislation.273 These aspects include

- prescription of standards for goods and services;
- establishment of machinery to receive, investigate and act upon complaints by consumers, and to assist consumers in pursuing those complaints;
- prohibition of conduct which impedes consumers from enjoying their rights, or regulation of conduct so that it does not encroach on those rights;
- regulation of agreements entered into between consumers and suppliers, either as to the whole agreement, or as to specified parts of them;
- dissemination of information both as to rights and as to particular goods and services, so that consumers may exercise their rights; and
- occupational licensing”.274

At the Commonwealth level, the Trade Practices Commission's move to the Treasury foreshadowed the amalgamation, in 1995, of the Trade Practices Commission with the Prices Surveillance Authority to become the new Australian Competition and Consumer Commission (ACCC) with a mandate for the "enforcement of the competition and consumer protection provisions of the TPA and the provisions of the Competition Code”.275 This could also be seen as move away from an emphasis on consumer rights to an emphasis on business practices, where compliance with standards and other regulations

---

272. NCAAC, para2.7; see chapter three for discussion about the ACC.
273. NCAAC, para2.8.
is primarily assessed in terms of benefit to the market economy rather than the consumer. A similar shift is also discernible to varying degrees at the state/territory level.276

The diversity of the State/Territory statutes and the multitude of organisations have created a maze for consumers to unravel when wanting to make a complaint or pursue redress. All the organisations have mechanisms of some kind to deal with disputes relevant to their jurisdiction, often comparatively formal, such as the residential tenancies tribunal for adjudicating disputes between landlords and tenants.277 In recent years there have been major attempts to amalgamate some agencies and streamline procedures in the interests of administrative efficiency and possible increased effectiveness but also in the context of changing ideas about the role of government agencies and activities undertaken. The consumer protection legislation of each state/territory has included the formation of a Commissioner for Consumer Affairs, or similar position, vested with the power to oversee and enforce the consumer protection laws. As well, there are identifiable units, within the consumer affairs agencies, whose primary function is to advise consumers of their rights under the different legislation and the mechanisms available to pursue complaints. Where it is suspected that there has been a serious breach/s of the legislative requirements by the trader/provider of goods or services, the Commissioner has the power to investigate and prosecute under the terms of the relevant statute.278

276. In SA this was typified by the change of name, under a new Liberal government, to the Office of Consumer and Business Affairs. The rationale given for this change more clearly indicates this shift: "the creation of the Office of Consumer and Business Affairs acknowledges the importance of the business community to fair trading in South Australia and represents its inclusion as a customer group of the Office. This inclusion means that strategies for sound business practices can be developed and value adding can occur without diminishing consumer protection provisions", Attorney-General’s Department (South Australia), Annual Report 1993-94, Attorney-General’s Department, 45 Pirie St, Adelaide, p15; throughout the Annual Report of the SA Commissioner for Consumer Affairs for the same period customers are emphasised rather than consumers. Commissioner for Consumer Affairs (South Australia), Annual Report 1993-94, Office of Consumer and Business Affairs, Grenfell St, Adelaide, 1994.

277. In line with current practices of most Tribunals, the South Australian Residential Tenancies Tribunal does use alternative dispute resolution processes; in 1993-94 27% of the applications received were resolved by conciliation. Commissioner for Consumer Affairs (South Australia), Annual Report 1993-94, p31.

The complaints handling function of the consumer affairs agencies is well developed and used, and most states have regional offices to increase accessibility to consumers. When contacted by a consumer wanting to make a complaint, the first step taken by the consumer affairs officer is to spell out the consumer's rights under the appropriate legislation. Consumers are then encouraged to make their complaint direct to the provider of the goods or services. If the complaint is not satisfactorily resolved at this stage, the consumer is advised to re-approach the consumer affairs agency for further assistance in gaining a resolution; in South Australia "the Office [of Consumer and Business Affairs] will try to negotiate a lawful settlement which is fair and reasonable to all parties". Of the 34,284 enquiries received by the SA Office of Consumer and Business Affairs in 1993/94 just under half (16,540) led to further investigation.

The limited resources available to consumer affairs agencies to deal with the vast number of enquiries and complaints received has meant that encouraging consumers to seek direct resolution with providers/suppliers became, through necessity, the preferred practice. Even if resources were increased dramatically, it is unlikely now that this practice would change as it fits with the more recent, increasingly dominant, ideology that government agencies should not need to or even be expected to intervene in private business affairs that can be managed by other processes, for which businesses and individuals take responsibility. The difficulties facing consumers in tackling suppliers/providers on their own has been acknowledged by some consumer affairs agencies, who have taken further steps to provide consumers with more extensive advice on how to go about this task, such as talking to someone in a position of authority, keeping


281. Goldring et al. note that the annual reports of the various consumer affairs agencies around Australia mention "lack of resources for activities which the agencies consider to be in the interests of consumers". Goldring et al, p381.
notes about what transpires, putting forward the complaint clearly and what resolution the consumer might find satisfactory.282

If the consumer has not been able to gain sufficient resolution by the direct approach to the supplier/provider and appears to have a legitimate complaint, the consumer affairs officers may become involved in investigating the complaint and negotiating a settlement. Many of the complaints are resolved relatively promptly, by telephone contact with the business concerned, reminding the supplier/provider of their obligations under the relevant legislation. While the role of the consumer affairs officer is determined by the provisions of the legislation, “consumer affairs officers see themselves primarily as mediators rather than law enforcement officers, and see standards of ‘fairness’ as their guiding light more than legislative standards”.283 In seeking a resolution satisfactory to both parties, the consumer affairs officers use alternative dispute resolution (ADR) processes such as mediation and conciliation. However, the resolution is not usually legally binding. For this to happen the consumer must take the matter to the relevant court or tribunal. Small claims courts have been set up by most states/territories to handle applications about minor matters. When taking the matter further in the court system, it is likely that the consumer will be asked to participate in the ADR processes of that court. While attempts have been made to make this process as accessible as possible, it is still a significant step requiring additional resources and energy on the part of the consumer.284 In South Australia, for example, the Commercial Tribunal has been the major vehicle for determinations under a number of acts relating to consumer protection matters, operating in a similar fashion to other tribunals.285 However, the multiple, and potentially conflicting,
functions assigned to the Tribunal, such as granting licences and registrations, as well as
determining disputes, appeals and disciplinary actions in regard to these, has been a source
of criticism by businesses, and also consumers, and it is proposed to transfer these
functions to newly developed areas of the court system, particularly as it also fits with the
South Australian Liberal government’s policy of ‘streamlining tribunals’.

Once seen as potential advocates for the consumers’ position, particularly when the
interpretation of the law was made in the consumers’ favour, the role of the consumer
affairs officers takes quite a different form using ADR processes: “it is a private process of
negotiation with government officials acting as ‘information’ brokers and playing a
negotiating role”.286 The use of ADR processes in consumer affairs has been emphasised
and adopted throughout the different stages of complaints handling.287 Goldring and
colleagues suggest that the low number of cases brought to court on behalf of or by
consumers indicates the success of the ADR approach.288 However, Ramsey, looking at
the use of ADR in the USA, suggests that mediation usually results in a compromise of the
rights of the consumer and “defuses consumer problems by fragmenting them and keeping
them out of public view”.289 (See also discussion of ADR in ch2.2.3.) Many consumers
have little choice but to accept the compromise of obtaining some redress through more
informal, less costly, channels, rather than pursuing private legal action, at their own
expense, where the possibility of redress may be uncertain but, if successful, more
extensive. The imbalance of resources, knowledge and influence in favour of large
businesses places consumers in a vulnerable position in ADR processes, even with the
weight of the legislation on their side. Familiarity with ADR processes, awareness of the
various requirements (and loopholes) of the legislation and even acquaintance with the

286. I. Ramsey, “Consumer Redress Mechanisms for Poor Quality and Defective Products” in Ramsey ed,
pp416-417.
287. The Justice Statement, for example, reinforces the use of alternative dispute resolution in the consumer
affairs area, as well as other areas. Justice Statement, pp142-144.
consumer affairs officers can give the business representatives a significant advantage.\textsuperscript{290} The difficulties already faced by less advantaged consumers in seeking redress for faulty goods, unconscionable conduct and incompetent services, will not necessarily be overcome by the use of ADR processes, despite the seeming optimism of the \textit{Justice Statement}.\textsuperscript{291}

The Commissioner for Consumer Affairs in South Australia has a number of powers to investigate and take action in relation to the various statutes, in a similar way to his interstate counterparts. These powers go further than those of the Ombudsman, for example, as the Commissioner can take disciplinary action when there has been a breach of the requirements under the consumer protection legislation such as requesting that a license be suspended or a fine imposed. The Commissioner for Consumer Affairs may demand an ‘assurance’ from the business that they will take mutually agreed upon actions, rather than institute disciplinary action through the Commercial Tribunal; the sanction for non-compliance is direct referral to the Tribunal.\textsuperscript{292} In 1993/94, the SA Commissioner gave 679 warnings, required that assurances be given in 28 instances, successfully prosecuted 20 cases and took disciplinary action in 30 instances, relatively few actions considering the large number of complaints made.\textsuperscript{293} The Commissioners and/or Ministers of Consumer Affairs around Australia also have the power to issue public warnings, ban products and monitor voluntary recall notices. The requirement by most statutes that the Commissioner table an annual report in Parliament is seen as an avenue for publicly identifying transgressors, with the resulting negative publicity encouraging others to comply. The effectiveness of the threat of adverse publicity as a deterrent to non-compliance would seem speculative rather than substantiated.

\textsuperscript{290} Genn’s observations about tribunal processes, discussed in relation to the Administrative Appeals Tribunal, would also seem pertinent here.
\textsuperscript{291} \textit{Justice Statement}, pp24-25, pp139-140 & pp144-145.
\textsuperscript{292} With the proposed legislation changes, disciplinary charges will be taken to the relevant area of the court system.
\textsuperscript{293} Commissioner for Consumer Affairs (South Australia), \textit{Annual Report 1993-94}, pp46-49.
A major part of the work of consumer affairs agencies has been the development and provision of educational activities to inform the community of the rights provided by the consumer laws. However, public understanding of the consumer’s legal position in the ‘market place’ of goods and services is still limited, particularly amongst the more disadvantaged groups of the Australian community. Most Ministers in the consumer affairs area have appointed ministerial advisory bodies for their portfolio but appointees representing a purely consumer perspective remain in the minority, outnumbered by appointees with considerable business and government connections.

The operations of consumer protection agencies have not been without criticism, with commentators suggesting that the agencies have become subject to “bureaucratic procedures, capture by interests, career considerations, and a tendency to follow traditional approaches rather than find new ways to tackle problems”. Reflective of the criticisms made about administrative law agencies discussed earlier in this chapter, the concerns stem from differing ideas about the appropriate role for government in the consumer affairs area, and the political nature of many of the issues. Investigating consumer protection issues with potentially long term, but not immediately obvious, consequences may be neglected in the face of more immediate and specific issues which have captured the media’s attention, and generated public outcry demanding government action. The extensive restructuring and amalgamation of several agencies and departments into the new SA Office of Consumer and Business Affairs resulted from changed political agendas about consumer protection legislation and managerial reform agendas. The crucial role of consumer

295. For example the Australian Consumers’ Council discussed in chapter three.
298. The SA Commissioner notes that the new Liberal government gave him the brief “to completely restructure the organisation, conduct a comprehensive review of all consumer affairs legislation and establish new and improved relationships with industry and professional groups”. Commissioner for Consumer Affairs (South Australia), Annual Report 1993-94, p1. To this end amendments to numerous Acts were put before Parliament and a program of strategic planning and total quality management was introduced into the agency over an eighteen month period.
affairs agencies in the effective implementation of consumer protection legislation is summed up by Whitford, who maintains that “experience teaches that the commitment of the agency to enforcement of the legislation is far more important in determining levels of compliance than the enforcement powers of the enforcing agency”. While the amendments to the Commonwealth Trade Practices Act scheduled for implementation by 1995, are said to provide an increased “enforcement armoury” for the Trade Practices Commission (or new Australian Competition and Consumer Commission) but preference will remain for seeking “administrative settlements” rather than “judicial sanctions”. In the current political and economic climate favouring self regulatory practices such as the articulation of standards, codes of conduct and best practice, the enforcement role of consumer affairs agencies is being overshadowed by a monitoring and facilitative role in ensuring these alternative strategies are in place. The encouragement of the development of industry based “ombudsmen” is part of this process. (See ch6.3.1.) While a comprehensive analysis of the regulatory reforms is beyond the scope of this thesis, in examining the development of complaints systems it is useful to briefly discuss some of these changes.

6.5.3 Regulatory Reforms, Mutual Recognition of Standards, and Codes of Practice

The driving forces underlying the regulatory reforms of the past decade have mirrored the administrative and managerial reforms in that economic rationalist considerations have been paramount. In the search for ways to decrease government expenditure, government administered and enforced regulations were identified as costly

299. Whitford, pp480-1.
300. Trade Practices Commission, Annual Report 1992-93, AGPS, Canberra, 1993, p7. These administrative settlements are described in another part of the report as “the implementation of more innovative and cost effective remedies for breaches of the law”. (p1)
301. This change in focus is noted, for example, in the Trade Practices Commission, Annual Report 1992-3, pp1-2.
and reforms necessary if there were to be cost savings in this area.\footnote{302} The costs of complying with existing regulations were seen as a burden on businesses, hampering economic prosperity.\footnote{303} From a consumer perspective it appeared, at times, that government agencies responsible for developing and enforcing the regulations had become ‘captive’ to the industries they regulated and that the interests of the industry were then interpreted as synonymous with the public interest.\footnote{304} Further impetus for regulatory reforms came from the introduction of the National Competition Policy by the Commonwealth government and the declaration that the regulatory practices of government could by their nature restrict competition.\footnote{305} The subsequent amendments to the TPA have renewed efforts to change regulatory practices identified as anti-competitive and where sufficient public benefit has not been demonstrated.\footnote{306} How sufficient public benefit is determined is open to debate, of course.

The regulatory reforms have encompassed a process of both ‘deregulation’, where existing regulations are dismantled, and ‘reregulation’, where new regulations are set in place which are seen to be more specific and manageable by governments, businesses and consumers.\footnote{307} The abandonment of regulations altogether has rarely been advocated; as already noted, they can benefit industry as much as the public interest but often a different combination and kind of regulation has been proposed. The focus has moved from regulation that requires government agency intervention and policing to encouraging greater voluntary compliance and monitoring of accepted standards and codes of practice.

\footnote{303}{Goldring, p193.}
\footnote{306}{For example, certain practices of the legal profession and the medical profession, such as restrictions on advertising and recommending fees and charges, have come under scrutiny. For the legal profession see Trade Practices Commission, \textit{Annual Report} 1993-94, p5 and \textit{Justice Statement} pp37-53; for the medical profession see Trade Practices Commission, “Forum: National Competition Policy and the Medical Profession”, \textit{TPC Bulletin}, no.82, 1995 pp11-13.}
\footnote{307}{Kay & Vickers, p223; Martin, p99.}
by the industries and professions themselves. Legislative provisions are then confined to establishing the framework in which this occurs - and then only if absolutely necessary.\footnote{308}

Voluntary adoption of standards or codes of practice may lead, in some instances, to better products and services but who determines the standards and codes and for what purpose is fundamental to whether this prevents complainable situations from arising. Once legislation is weakened it may be very difficult to reinstate the government controlled enforcement options if voluntary compliance is not forthcoming or does not provide consumers with the protections promised.

Standard setting and the development of codes of practice are not new processes. Standards Australia, for example, has been in existence since 1922 and, in collaboration with industry, government and other interest groups, has produced numerous standards which it describes as “national benchmarks for products and services so as to enhance quality of life and industry efficiency”.\footnote{309} Most established ‘professions’ have outlined their own code of practice or conduct (often the major part of what is generally called their ‘code of ethics’) and the processes by which complaints about individual member’s practice can be dealt with and the sanctions that can be applied.\footnote{310} Industry or professional groups possessing a credible reputation have been able to persuade governments to delegate the responsibility for regulating their field to themselves, often with the support of relevant legislation. The medical profession presents a prime example: medical registration boards, set up under acts of parliament but dominated by the medical profession, control entry to the profession through restrictive registration criteria, hear complaints about colleagues’ conduct and determine disciplinary action to be taken. (See ch7.3.)

\footnote{308. Martin, pp96-97.}
\footnote{309. Standards Australia, Complaints Handling, AS4269-1995, Standards Association of Australia, 1 The Crescent, Homebush NSW, 1995, back cover.}
\footnote{310. This is discussed further in regard to the health professions in chapter seven.}
More recently there has been an increasing trend towards fostering self regulation in other areas as an alternative to government regulation, particularly in industries or professions where there has been a history of major disregard for consumers rights or where there is the potential for this to occur, for example in the superannuation industry and the telecommunications industry. This was underscored by the establishment of separate Ombudsman positions specifically for both of these industry.\textsuperscript{311} Self regulation has been promoted as providing considerable benefits, such as minimising the costs of regulation and enforcement to governments and therefore the public; greater voluntary compliance with the code or standard set as it is ‘owned’ by the industry; and the ability to respond faster and more appropriately to changing circumstances.\textsuperscript{312} Part of the self regulation process is the identification of industry specific standards and codes of practice, as well as the complaints procedure available, but there is no obligation to include consumers in this process.\textsuperscript{313} Self regulatory processes are generally not legally enforceable and apply only to those businesses or professionals who actively join the relevant association. Whitford, who studied the matter at the beginning of the 1980s, argues that without appropriate sanctions compliance with standards will not be a priority and private sanctions alone, such as the ability to sue for damages, are not sufficient.\textsuperscript{314}

An important part of the process of regulatory reform in Australia has been the development of national standards, regulations and codes of practice in a number of areas, such as food production and occupational health and safety. Attempts to achieve uniformity across Australia have always been complicated by the differing responsibilities of Commonwealth, state and local governments and the complexity of legislation and regulation that has resulted from this federal system. The process of developing national

\textsuperscript{313} Cranston argues that the lack of consumer involvement in the development of standards and codes is a significant flaw in the adequacy of self regulation. Cranston, p63.
\textsuperscript{314} W. Whitford, “Structuring Consumer Protection Legislation to Maximise Effectiveness” in Ramsey ed, pp481-2. Whitford commented “it would seem that provision for public remedies is crucial to any effort to achieve compliance"
standards, regulations and codes of practice is arduous and lengthy involving extensive discussion and compromise between the different government bodies; consultation and compromise with the relevant industry or professional group and unions and in some cases consumer groups; and ratification by Commonwealth/State agreements. While this structure prevails, an alternative approach of ‘mutual recognition’ has also been adopted. Mutual recognition encompasses the idea that several jurisdictions may come to an agreement whereby satisfying the regulatory requirements in one jurisdiction will be ‘recognised’ as sufficient by the others. The implications for some of the health professions, such as occupational therapy and physiotherapy, where registration of the profession was not universally required by all states/territories, is still being determined but could result in the registration boards being dismantled in favour of self regulation of these professions. The obstacles in the path of the implementation of mutual recognition policies has already led to a waning of commitment and political interest in pursuing these policies to the full.

Publicly available standards and codes of practice can prove useful to consumers in judging whether the service or product they have received is comparable with the quality or behaviour that should be expected. Only relatively recently, though, have consumer representatives been included in any part of the process of development of these documents, and consumer involvement is still not widespread. Therefore, the documents produced generally reflect producer or provider perceptions of sufficient quality or suitable behaviour and may not be detailed or expansive enough to cover many of the situations with which consumers are faced. Cranston warns that the impression often created, that the public interest is the primary consideration in the development of

316. Carroll, p44.
standards and codes, can lull consumers into complacency and mask other undesirable behaviours.318

The managerial interest in the concepts of best practice and benchmarking, already discussed, fit well with the identification of standards and codes of practice. In areas where the manager may not have the necessary expert knowledge, once established, the standards and codes decrease the manager’s reliance on expert advice and allow greater managerial scrutiny of processes and practices once largely inaccessible and the domain of the professional. The adoption of total quality management has given greater credence to consumer concerns as part of the best practice and benchmarking process and, through this, to inclusion of consumer feedback in the development of standards and codes, although, as already noted, consumer concerns may not by defined by consumers themselves. The pursuit of best practice and self regulation has led many organisations and associations to update their standards and codes. As part of this process complaints handling procedures have also come under review and more explicit and sophisticated systems developed. However, these systems, appearing on the surface more comprehensive and ‘user friendly’, can be just as difficult for the consumer to negotiate as earlier systems.319

6.5.4 Consumer Affairs and Complaints handling

Through the complaints handling function of the consumer affairs agencies a legitimate role has been established for government officials to intervene in disputes between consumers and other parties, not confined just to government agencies. This was an important factor in the development of the independent central health complaints agencies, for a number of reasons outlined in the next chapter. Consumers are able to gain advice about their rights and how to make a complaint. The brief of consumer affairs

319. A good example is the new complaints procedures identified in the revised Code of Ethics produced by the Australian Association of Social Workers. While the complaints process is much more detailed and the steps more clearly set out, the diagrammatic representation of the steps reveals the complexity still inherent in the system. Australian Association of Social Workers Ltd. Code of Ethics, By-Laws on Ethics, AASW Ltd, PO Box 84, Hawker ACT, 1994, pp8-16.
officers has been not only to assist the consumer with obtaining a resolution for their complaint but also to investigate the grounds for the complaint, with a view to prosecution by the Commissioner for Consumer Affairs where there has been contraventions of the Acts in which s/he has jurisdiction. Preference for “administrative settlements”, though, has meant that prosecution has been used as a last resort. The spread of alternative dispute resolution techniques has offered a new and cost effective way for consumer affairs officers to deal with the situations that confront them. For consumers, the benefits of using this process offset against the disadvantages have not been so clearly established. However, the alternative of trying to pursue private litigation may offer consumers no real choice but to use the newly devised alternative dispute resolution procedures.

Consumer protection legislation and consumer affairs agencies have helped create an environment where the notion of consumer rights is better recognised and acknowledged. Consumer protection legislation has provided benefits not only to consumers but also, in many instances, to the industries concerned. Changing ideas about the most effective form of legislation has led to review and reform; most recently there has been renewed emphasis by governments in Australia on competitive markets providing consumers with the best protections. The degree to which consumers themselves are aware of their rights varies and it is still difficult for consumers to exercise these rights, for example through private litigation. The independence of the consumer affairs agencies has, at times, appeared to be compromised by the multiple roles assigned to them, including devising and enforcing legislation and regulations. However, the existence of the consumer affairs agencies has provided a focus for consumer issues and complaints handling within government bureaucracies.

The consumer protection legislation, consumer affairs agencies and the regulatory reforms have had a significant combined influence on public awareness of consumer issues and established a role for governments in consumer affairs. Consumer rights have become explicitly identified and supported, in some instances, by relevant legislation. The direct
involvement of government consumer affairs officers in complaints handling and resolution in the commercial business area has become formalised and established. Although the move towards greater use of alternative dispute resolution processes has potentially mixed benefits, for consumers advice and support in making a complaint has become more readily available.

In many ways consumer affairs is fast becoming the province of governments and businesses rather than consumers, as consumer issues are identified as increasingly important but secondary to economic considerations. Governments have been looking for ways to cut expenditure and activity on consumer protection enforcement issues and to decrease regulatory restraints on businesses: at the same time, businesses have begun to recognise that attention to consumer issues may increase their competitive edge. The internalisation by industries of standards and codes of practice and the pursuit of best practice may help consumers if consumers’ viewpoints are adequately reflected. The compatibility of management notions of benchmarking and best practice with the concepts of standards and codes of practice have ensured the acceptance and use of these in many areas. The full effect of these changes on the position of consumers in the market place remains to be seen but it is clear that agendas other than those generated by consumers will be more influential determinants of the outcome. In looking back at the history of government involvement in consumer affairs it is likely that the cycles of fluctuating government activity already experienced will continue as issues of public safety, consumer protection and commercial interest escalate and recede in the political and public eye.

6.6 AUSTRALIAN STANDARDS FOR COMPLAINTS HANDLING

As various government departments and business organisations introduced new complaints systems into their agencies, and in line with the move to identify standards and best practices, there was a call for standards in complaints handling to be defined. The Access to Justice Advisory Committee, for example, saw the development of industry
based complaints mechanisms as providing "additional dispute resolution bodies", which potentially increased access to justice for some.\textsuperscript{320} These centralised complaints mechanisms were thought, by the Committee, to have advantages over the court system in resolving disputes because they could operate at a lower cost, attend to matters more speedily and use simplified procedures that did not require legal assistance. The Committee went on to note that minimum standards were necessary if consumer confidence in industry-based complaints mechanisms was to be maintained.\textsuperscript{321} To this end the Committee recommended a number of principles for incorporation in such standards:

- independent and impartiality: the complaints mechanism should be independent of the relevant industry with sufficient resources; accountable to an organisation/board not controlled by the industry;
- accessibility: the existence of the complaints mechanism and its processes should be well publicised (visible); complaints could be lodged orally and at no charge to the complainant; that legal assistance should not be required to negotiate the complaints procedures; and non-English speaking background (NESB) complainants should have access to an interpreter;
- efficiency and effectiveness: the complaints mechanism should be able to deal with complaints speedily but fairly; its jurisdiction should include all industry participants and all the main activities of the industry; it should be able to adjudicate on disputes including directing an industry participant to pay compensation; and its role should include the identification of industry wide (systemic) problems and recommending solutions;
- openness and accountability: the complaints mechanism should be open to public scrutiny through the publication and wide distribution of sufficiently detailed annual reports;
- use of the term Ombudsman: complaints mechanisms should not be entitled to use the term unless the above criteria are met.\textsuperscript{322}

These broad principles are compatible with the components already identified in the consumer model for health complaints systems in chapter five, although less comprehensive. Missing here are the consumer components emphasising advocates; a broader interpretation of accountability; and consumer participation in the design and evaluation of the complaints pathways. The Committee recommended that the

\textsuperscript{320} Access to Justice Committee Report, p313.
\textsuperscript{321} Access to Justice Committee Report, p313.
\textsuperscript{322} Access to Justice Committee Report, pp314-316.
Commonwealth government take a lead role in “prescribing minimum standards for industry-based consumer complaints bodies” and then, once these had been established, in monitoring compliance with the standards. If voluntary compliance was not achieved, then, if possible, regulatory action was to be taken instead.

Work had already begun on developing a set of standards for complaints handling by the time the Access to Justice Advisory Committee reported in 1994. Standards Australia had taken up the brief and circulated a draft for public comment in mid 1994. The preparation of a standard for complaints handling was overseen by a committee comprising representatives from peak business organisations, government agencies, professional associations and consumer groups. By February 1995 the finalised Standard document, entitled Complaints Handling, had been approved by the Council of Standards Australia and published. The preface states that the Standard had been developed

"in response to the call from professional and other organisations for assistance in what is now accepted as an essential component of quality management. It is also regarded as one of the components of competitiveness in domestic and international markets".

The point that complaints handling is now regarded as an integral component of "best practice for international competitiveness" was reiterated by the Federal Minister for Consumer Affairs, Ms Jeannette McHugh, at the official launch of the Standard in March 1995. Complaints systems had acquired a new status, no longer merely mechanisms to appease disgruntled customers but now an indicator of progressive and ‘world class’ organisations, thus gaining a prestige that had not existed previously.

The Standard focuses on the organisational management of complaints and complaints handling; that is the internal handling and local resolution of complaints by the agency concerned. Many of the points made in the Standard are equally applicable to

324. Standards Australia describes itself as “an independent not-for-profit organisation, established in 1922 ... has recognition as the peak Standards body in Australia through a Memorandum of Understanding with the Commonwealth Government”. Standards Australia, Complaint Handling, back cover.
325. Standards Australia, Complaint Handling, p2.
central industry complaints bodies, the subject of the Access to Justice Advisory Committee recommendations. The *Standard* is divided into five sections: scope and purpose; essential elements of effective complaints handling; implementation of the essential elements; complaints handling procedures; and disputes. The purpose of the *Standard* is described as providing "a complaints handling framework for the complainants as well as complaints recipients". To this end it is suggested that "any complaints handling policy should include a positive attitude towards consumers and commitment to resolving complaints". It may indicate the state of complaints handling and attitudes towards consumers that this needed to be stated so explicitly.

The thirteen essential elements of effective complaints handling identified by the *Standard* are outlined in Table Three. The importance of commitment by senior executive staff to dealing with complaints and the sufficient allocation of resources, in staff time and facilities, are highlighted. Consumer groups and those already undertaking complaints handling, such as the Ombudsman, have repeatedly emphasised these points. Also in common with the consumer model, the *Standard* specifies that policies and procedures need to be documented, available to all and identified as fair and respectful of the rights of both complainants and the subject (organisations or persons) of the complaint. Making known time lines for dealing with a complaint and keeping the complainant informed of progress is recommended. The key elements of visibility and accessibility are explained in some detail in the *Standard*, including reference to the use of various strategies to publicise the existence of the complaints mechanisms and for flexibility in the procedures for making a complaint. While there is mention of printing information in different languages and "special arrangements for people with disabilities or specific needs", the *Standard* does not sufficiently address some of the other barriers to complaining experienced by certain groups in the community.

TABLE THREE

Essential Elements Of Effective Complaints Handling


| 2.1 | Essential Elements. A complaints handling process shall, as a minimum. Satisfy the requirements below. |
| 2.2 | Commitment. There shall be commitment to efficient and fair resolution of complaints by people in the organisation at all levels, including the chief executive or ruling body. This is shown by an organisational culture which acknowledges consumers’ rights to complain and which actively solicits feedback from consumers. The policy on complaints handling shall be in writing. |
| 2.3 | Fairness. A complaints handling process shall recognise the need to be fair to both the complainant and the organisation or person against whom the complaint is made. |
| 2.4 | Resources. There shall be adequate resources for complaints handling with sufficient levels of delegated authority. |
| 2.5 | Visibility. A complaints handling process shall be well publicised to consumers and staff, and shall include information to consumers about the right to complain. |
| 2.6 | Access. A complaints handling process shall be accessible to all and ensure that information is readily available on the details of making and resolving complaints. The complaints handling process and supporting information shall be easy to understand and use, and be in plain language. |
| 2.7 | Assistance. Assistance shall be available for complainants in the formulation and lodgement of complaints. |
| 2.8 | Responsiveness. Complaints shall be dealt with quickly and the complaints shall be treated courteously. |
| 2.9 | Charges. Complaints handling shall be at no charge to the complainant, subject to statutory requirements. |
| 2.10 | Remedies. A complaints handling process shall have the capacity to determine and implement remedies. |
| 2.11 | Data Collection. There shall be appropriate systematic recording of complaints and their outcomes. |
| 2.12 | Systemic and Recurring Problems. Complaints shall be clarified and analysed for the identification and rectification of systemic and recurring problems. |
| 2.13 | Accountability. There shall be appropriate reporting on the operation of the complaints handling process against documented performance standards. |
| 2.14 | Reviews. A complaints handling process shall be reviewed regularly to ensure that it is efficiently delivering outcomes. |

The Standard contains no reference to offering advocacy on behalf of the complainant or support for the complainant whilst going through the complaints process, key components in the consumer model. Instead, the Standard does suggest providing
some assistance to complainants to ensure that terminology used in detailing the complaint presents the complaint in a form which organisations find acceptable. The idea that no charge should be incurred by the complainant in using the complaints handling process is linked to the idea that feedback from consumers may be missed otherwise. The other ‘costs’ to consumers in making complaints are not mentioned. Amongst the list of possible remedies to be offered in resolving a complaint is an interesting suggestion that consideration should be given to “offer[ing] remedies to others who may have suffered in the same way as the complainant but did not make a formal complaint”. This would indeed be a significant shift: as discussed previously, consumer experience suggests that it has often been hard enough for the individual complainant to obtain an appropriate remedy, let alone for those who did not complain.

The issue of accountability is addressed in the Standard by stating that “all organisations should have an appropriate culture of accountability” but what this actually means is not further defined. It suggests that performance criteria for the complaints procedure be determined and monitored by the designated manager for each area or level and that management reports about meeting this performance criteria be compiled. However, there is no item in the Standard suggesting that this information should be made publicly available. While it is recommended that review of the complaints handling process be made regularly, how this might be done, by whom and for what purpose is not discussed. Conspicuously, the specific inclusion of consumers in any review or evaluation activity, essential from the consumer perspective, is not stressed or even commented upon. Similarly, there is no detail about the form that the advised independent audit of an organisation’s complaints handling system should take. In contrast, the setting up of a complete data system is outlined in some detail, along with suggested ways of using the data to the profit of the organisation.

330. See chapter two, particularly litigation and health care.
331. Standards Australia, Complaint Handling, p10.
The fourth section in the Standard provides step by step guidelines on managing interpersonal interactions with complainants and ‘good’ behaviour on the part of those dealing with complaints. It suggests that handling the complainant skilfully will prevent the complaint “degenerating into a dispute”. For consumers, though, what seems like genuine concern may in reality only be the charade learnt by those dealing with complaints at a training session, particularly if false hopes are raised that the resolution of the complaint is likely to be in favour of the consumer. The Standard notes that an unresolved complaint can “escalate into a dispute”, the subject of the fifth and last section. Potentially costly for the organisation, disputes are to be resolved using the “least interventionist” mechanism first, progressing through more formal mechanisms to finally the court system. This interpretation is reflective of the linear model of complaints to litigation. (See ch2.2.) Gaining resolution through the least interventionist mechanism is urged on the grounds that greater control over the outcome is accorded to the disputing parties. However, at this early stage consumers, proceeding without an advocate or comprehensive knowledge of their rights, may be easily intimidated into agreeing to a less than satisfactory compromise resolution.

The development of the Standard indicates the interest in complaints handling in the early 1990s, and the problems associated with complaints handling in the past. Although the Standard does not meet all the criteria of the consumer model, and is presented in a way that is more in tune with producers of goods than providers of services, it is a significant step in acknowledging not only that attention to complaints is necessary but also that the way complaints are actually handled is important. The local resolution of complaints has become an area for ‘best practice’ in complaints handling.

332. Standards Australia, Complaint Handling, p11.
333 This has been termed “cooling out” the complainant, the idea being that if the complainants anger is dissipated sufficiently, they will no longer pursue the complaint. See S. Lloyd-Bostock & L. Mulchay, “The Social Psychology of Making and Responding to Hospital Complaints: An Account Model of Complaint Processes”, Law & Policy, vol.16, no.2, April 1994, p123-148.
334. Standards Australia, Complaint Handling, p12.
6.7 CONCLUSION: GOVERNMENTS, PUBLIC SECTOR MANAGERS AND HANDLING COMPLAINTS

Governments and public sector managers have developed a considerable stake in complaints handling activities for a number of different reasons, as the preceding sections in this chapter have demonstrated. In an era of increasing pressure to move from traditional ways of providing public services and rapidly changing ideas about the role for government agencies in service provision, the incentive for public sector agencies to become involved in establishing complaints handling mechanisms has been great. The form and operation of these complaints mechanisms have generally been reflective of the different interests within the government bureaucracy than consumer needs. A common theme has been present throughout: the emphasis on dealing with complaints individually.

A major pressure for developing complaints systems has been to overcome criticisms about the lack of accountability of public sector services. The volume and extent of government service provision had created, by the 1970s, an image of all powerful bureaucracies seemingly impervious to both political and public demands for greater accountability and caught up with inflexible rules and procedures that often favoured certain groups over others, despite claims to abide by the principles of impartiality, integrity and probity. While the series of administrative law reforms was thrust upon government agencies, it was in their interest to be seen to be doing something to address the increasing disquiet and dissatisfaction with publicly provided services. It is not surprising that the Ombudsman, with the least independence, was the first reform taken up by all states/territories. The Ombudsman provided a much needed avenue for complaints about public sector services that potentially also acted as a “safety valve”, as suggested by Hirschman, to prevent stronger calls for more extensive systemic changes. (See ch2.2.1.) The Ombudsman has dealt with complaints on an individual basis. The potential has been there for the Ombudsman to take a significant role in addressing broader structural issues in the provision of public services but this has been discouraged and largely controlled
through administrative means, such as restricting the Ombudsman’s resources. Government agencies could always choose not to follow the Ombudsman’s recommendations if it really did not suit them. Other administrative law reforms creating independent mechanisms which may have had more far reaching and unpredictable impacts, such as general administrative appeals tribunals and freedom of information legislation, have met with much stronger opposition from government agencies. When other, more potent mechanisms have been established, agencies have sought ways around them by seeking agency exemptions, or making processes costly and difficult to negotiate for the individual consumer.

The insistence on greater accountability of public sector services took a different shape with the managerial reforms. The political agenda that focussed initially on gaining greater political control over spending on public services, then to decreasing that spending, required an alternative management style that directly related expenditure to outcomes. Achieving maximum efficiency from available resources became the managerial goal. Accountability of public service providers was firmly located with senior management and the portfolio Minister, rather than the general public. The private business sector was seen to provide the model for public sector services to emulate, including private sector management practices. Influenced by the dominant economic theory that the most efficient use of resources is achieved through free markets, a further political agenda of ‘downsizing’ government services through contracting out and privatisation has been promoted. Public sector services which wished to survive have had no choice but to adopt the new managerial practices, including such notions as total quality management and best practice. The consumer, now called the customer, has been given a status not previously accorded to public sector service users. Consumer dissatisfaction with service procedures has been used to advance managerial agendas in the guise of enhancing customer service and information gathered from customers has provided managers with the opportunity to collect data to challenge existing professional and administrative practices. Handling
complaints has become part of this process of gaining greater managerial control over the public sector workforce, particularly professional groups. The interest in complaints handling stems from its perceived value as a tool for monitoring performance and achieving corporate goals rather than for the intrinsic value of the consumer perspective.

The complaints mechanisms set in place by the various reforms have not remained static. The advantages over the court system of some of the more formal central grievance mechanisms, such as the tribunals, have not necessarily been as great as originally thought, as procedures have become more complex and formalised. While the mechanisms have been less costly and able to hear matters more speedily than the courts, questions as to whether accessibility has really been increased for many and whether natural justice has in some ways been compromised remain unanswered. Assumptions about the benefit to consumers of new processes such as alternative dispute resolution need to be tested and justification of their adoption based on more than merely being something that was not offered previously. The continued focus on handling complaints individually and in an informal and less public way ensures that the information contained in complaints remains inconspicuous and of little challenge to the systems already in place.

Central complaints units have lost some of their attractiveness for governments looking to cut back services and reduce government intervention where ever possible. The greater emphasis on local resolution of complaints fitted well with these changing agendas. Complaints handling requires resources and financial constraints have been a major factor in the systems developed. Possible altruistic motives underlying support for the reforms, such as respecting consumer rights, increasing access to justice and social justice considerations, and genuine attempts to enhance the position of the consumer have been overshadowed by managerial expediency and demands for cost savings. A noticeable shift has occurred away from the advancement of consumer entitlement in the 1970s, to consideration of what is the cheapest alternative for the government or what is most profitable for the organisation, in the 1990s. The customer focus of corporate management
highlights the need for consumer feedback. However, this has not often resulted in increased liaison with consumer groups and consumers generally: instead, public relations personnel, coming from a marketing perspective, have promoted their own positions by putting themselves forward as representatives of the interests of consumers and in touch with consumer need.

The complaints and dispute resolution mechanisms discussed in this chapter have been typical of government and bureaucratic solutions for dealing with complaints about their decision making and actions. In complex ways their development has been important to the development of complaints mechanisms in the health system as the next chapter reveals. While there have been genuine attempts, in some areas, to address consumer issues and enhance the rights of consumers in dealing with public services, this has generally occurred only when it coincided with other reform agendas of governments and public sector managers. The more recent move away from developing independent, externally based mechanisms to internal review and handling of complaints suggests that complaints will continue to be seen as individual problems to be addressed individually. Lessons for the broader public sector and governments, exposed by the complaints, are then either missed or ignored. The individualisation of complaints and their resolution continues to presents little threat to the agendas of governments and public sector managers. Given the unique aspects of the individual health care relationship between consumers and service providers and the dominance of the professions in health service provision what mechanisms then had been developed to handle health complaints?
CHAPTER SEVEN

THE HEALTH SYSTEM AND COMPLAINTS HANDLING

7.1 INTRODUCTION

The provision of health services has been the source of a myriad of complaints from consumers. The mechanisms in place to deal with these complaints have been limited and often ineffective. Traditionally, complaints were rarely taken seriously until the threat of a damaging public scandal forced some action to be taken. Some hardy consumers doggedly pursued satisfactory resolution of their complaints through the traditional complaints pathways of the professional registration boards, the health services, the departments of health and the Minister, and sometimes the courts, if there had been significant and obvious physical injury. The complaints handling mechanisms created by the administrative law reforms, such as the establishment of the Offices of the Ombudsman, while usually covering the public health services, were reluctant to take on handling health complaints, which were perceived to be somehow different from administrative complaints and deemed to be a matter for professional judgement and adjudication. The deference to professional knowledge and expertise has kept complaints handling in the health area firmly in the hands of the professions.

By the early 1980s several inquiries, such as the Report of the Inquiry into Hospital Services in South Australia and the Social Development Committee Report on Complaints Procedures against Health Services in Victoria, highlighted the difficulties facing consumers in trying to get complaints heard. This evidence was supported by other agencies, such as the Ombudsman and the Consumer Affairs Bureaux, who saw it as the role of the health departments to take greater responsibility for the handling of complaints about the health sector. Coinciding with demands for increased accountability of the health services and health professions, largely stimulated by financial considerations, and the
changing nature of health service provision, the need for widespread reform in the way the health system dealt with complaints managed to slip onto the political agenda.

The development of complaints mechanisms along the three paths discussed in the previous chapter, were mirrored in the development of complaints mechanisms in the health system, although these changes often occurred at the same time, or even preceded, the changes occurring more generally. The professional registration boards and disciplinary tribunals had the power to adjudicate on complaints and impose sanctions on the professional, whose actions had been the subject of the complaint, under the terms of the registration acts. While independent of the health departments and health services, these bodies were dominated by the relevant profession and professional culture in their approach to complaints handling, and were often perceived by consumers to be more interested in professional matters than consumer concerns. Reforms to the procedures of registration boards, and even composition of the boards, have been conceded to by the professions in the interests of preserving a system in which they retain control and maintain professional autonomy, particularly in the face of the new political agendas of deregulation, mutual recognition of standards and reducing restrictive trade practices.

The health services' handling of complaints at the local level were also ripe for reform. In a similar way to other areas of government service provision, the organisational restructuring and new managerial practices presented an environment where complaints data and the handling of complaints could be used to advantage the position of managers or professionals in the new structures. Accreditation of health services, statements of patients' rights and Complaints Liaison Officer positions contributed to changes in complaints handling at the local level but reform has proceeded incrementally and still has some way to go before consumers can have confidence in using these mechanisms.

The most significant reform in the handling of health complaints has been the establishment of specialist central complaints units specifically to deal with complaints about health service provision. Through new legislation in some states/territories, statutory
authorities, under the direction of a commissioner, have been created with the authority to advise, investigate, recommend remedial action and, in some instances, prosecute before the relevant disciplinary body, rather akin to the arrangements in the consumer affairs area. Despite the inclusion in the revised *Medicare Agreements Act 1992* of the requirement that all states/territories across Australia establish such mechanisms, by early 1995 only half had done so; the complex interaction of professional, bureaucratic, political and consumer agendas has consistently hampered their development. The work priorities of the complaints mechanisms that had been established were determined by available resources (usually insufficient), high demand and the limitations of their mandate. In a similar way to other central complaints handling mechanisms, local resolution of complaints has been the preferred first step, although it was partly due to dissatisfaction with local resolution procedures that the central units were originally established. Some of the central mechanisms are currently more explicitly and actively moving towards restricting their involvement in complaints handling to the most serious and complex of complaints, placing the focus back on reform of the local mechanisms. The early central health complaints mechanisms established in New South Wales and Victoria have provided important models for other states/territories and other sectors. Independent, statutory based central complaints mechanisms have been, and will remain, a crucial part of an overall comprehensive health complaints system, providing an important counter balance to those forces opposed to, or uninterested in, hearing and addressing consumer complaints in the health sector.

Overall improvements in complaints handling processes have been slow and still predominantly controlled by the professional groups. The diversionary search for ‘rotten apples’ and blaming ‘unrealistic expectations’ still continues. While quality assurance and risk management practices, developed as part of the accreditation process and new management style, have helped to broaden the view of the value of complaints data, the notion prevails that the handling of complaints is nothing more than an individual problem
requiring an individual solution. The dominant service providers and health bureaucrats within the health system continue to retain significant control over reform to health complaints handling mechanisms.

7.2 THE CONTEXT: RESTRUCTURING HEALTH SERVICES AND HEALTH SERVICE PROVISION

The health departments and health services provided by governments around Australia have not been immune to the government reforms discussed in the previous chapter. As one of the major areas of government spending at state/territory and Commonwealth levels, calls for reduced spending, greater efficiency and accountability in the health area were obvious. However, there were a number of factors that made this push for reform in such a politically sensitive area as health care proceed at a different pace and with its own particular nuances compared with other areas of government. Cost containment and better management of the large health services, typically the public hospitals, were not the only reforms that were implemented over the past two decades; greater accessibility to health services through a universal health insurance style scheme and a small but increasing emphasis on primary care and preventive strategies were also part of the health policies pursued by different states/territories and the federal government.

The rise of the large metropolitan hospitals as the mainstay of the public health system in Australia, and the increasing need for government subsidy to maintain these institutions, have helped shape debates about contemporary medical practices and philosophies of health care. The provision of health care had undergone a metamorphosis by the middle of the twentieth century with the introduction of new technologies such as x-rays, diagnostic testing and surgical treatments that required more specialised attention than could be offered by the local doctor and the smaller local hospitals. Increasingly, the specialist medical services, provided in the larger, usually metropolitan based, public hospitals became the focus of health care provision. The charitable institution status of the
public hospital gave way to an image of a centre at the forefront of medical knowledge and practice developments and in the training of future medical practitioners. Public hospital bed numbers, access to and affordability of hospital care became major political issues that continue to dominate government health policies. Consuming extensive resources, the hospital system has consistently demanded a large proportion of state government budgets.

Hospital bed numbers have been a central feature of health service planning and budgeting. Efforts to find alternative sources of revenue to meet burgeoning hospital costs had resulted in the development of a mix of ‘private’ fee paying beds with public beds, particularly in the large teaching hospitals renown for their most up-to-date treatments. The variable ratio of those being treated privately in public hospital facilities, often to the detriment of public patients, has been a contentious issue influenced by many factors, including the greater financial benefit to medical specialists in treating patients privately. The more recent ‘privatisation’ of public hospital services has added a new dimension, further blurring the divisions between public and private health care provision. Hospital bed numbers in Australia rose to a peak in the late 1970s, before decreasing and plateauing to a rate of 5.0 beds per 1000 population, still a relatively high rate by world standards. The tightened fiscal environment of the early 1980s contained the further growth of bed numbers and, increasingly, attention was directed at bed occupancy rates and length of hospital stay. The length of stay in hospital became a critical factor in hospital cost saving

4. See Gillespie for descriptions of the inequitable conditions accorded to public patients compared to private patients prior to 1960. This is still noted as an issue thirty years later in the National Health Strategy, Hospital Services in Australia, p45.
6. S. Sax, Health Care Choices and the Public Purse, Allen & Unwin, Sydney, 1990, p74, pp79-81, Sax indicates that this reduction in bed numbers only occurred in the public hospitals in the 1980s.
strategies as shorter stays ultimately resulted in the need for less hospital beds, even while the demand for hospital admissions was still increasing. The shorter stays were, in turn, made possible with changing treatment practices as a result of new technologies in a number of areas, such as less intrusive surgery requiring shorter recovery times in hospital, and the expansion of home nursing services. The increase in the availability of nursing home places also reduced the number of 'nursing home' type patients cared for in acute hospitals. By the end of the 1980s, specific financial incentives encouraging day surgery and early discharge were included in hospital funding arrangements.

Consumer expectations about hospital care had not necessarily kept pace with these more recent changing practices and have fuelled suspicions that hospital care was being compromised by economic considerations.

In the 1960s, the greater complexity of services offered by the hospitals had required the employment of staff skilled in operating the new equipment, implementing treatment regimes, and generally maintaining these high rise institutions. Allied health and ancillary services grew in size and prestige, followed by burgeoning numbers of administrative positions within the hospital system. New medical specialist services emerged contributing to the pattern of modern health services provision typified by contact with multiple service providers, often unknown to the consumer. The professional autonomy accorded to the medical profession allowed doctors to largely control the direction and nature of their own work in the hospital environment; the honorary system of visiting medical officers and the subsequent system of sessional, or fee for service, visiting specialists and salaried specialists with rights to private practice, compounded by the lack

---

10. The medical benefits list identifies around 40 medical specialist categories, but these can easily be divided again into sub specialties. Palmer & Short, p164.
of adequate hospital information systems, made any oversight of their work difficult. To a lesser extent this autonomy was also extended to the work of other occupations, such as physiotherapists and occupational therapists. The desire for increased occupational autonomy has been a major factor in the more recent professionalisation moves of other health service providers, for example nurses. As the professional groups largely controlled entry to and continued registration for each group, loyalty of the professionals tended towards these bodies rather than the organisations in which they worked. Complaints about the professional practice of individual professionals working in hospitals were seen to fall firmly within the ambit of the authority of these bodies, external to the hospital system.

The growth in the size and number of services provided by the hospitals brought with it other changes, for example in the administrative area. The position of medical administrator had already undergone a transformation as the honorary system of visiting doctors and specialists gave way to full-time salaried appointments and sessional payments for visiting medical officers. The diversity of specialist departments and medical staff within the hospital structure required the medical administrator to take a greater coordination and administrative role; similarly for senior nurses. The management tasks clinicians in administrative positions performed separated them from staff carrying out direct service functions, and a schism developed between the two groups, each claiming that the other lacked sufficient understanding of the difficulties encountered in carrying out their duties. The administrative structures and budgeting systems based on functions, such as nursing, cleaning and pathology, did not encourage the integrating of services nor curtailment of costs, often compounding the divisions between, and separateness of, individual departments. The hospital hierarchical organisational structure was still largely

11. For discussion of some of the implications of the occupational restructuring of nursing see National Health Strategy, Hospital Services in Australia, pp99-105.
13. Crichton, pp148-149; the honorary system was formally ended with the introduction of the Medibank scheme by the Whitlam government in 1974.
dominated by the health professionals, particularly medical specialists, well able to influence hospital boards and non-clinical administrators to concede to their interests.

By the 1980s, the huge resources consumed by the hospitals, with seemingly little accountability, led to demands that the hospitals be ‘better managed’ to ensure efficient use of resources and that those with management skills, rather than clinical expertise, were better placed to undertake this task.14 The introduction of business management techniques to hospital administration, similar to those describe in the previous chapter, has resulted in “a revolution taking place in health service management”, the long term implications of which are still to be fully realised and understood.15 As could be predicted from earlier discussions, the changes have been typified by redesign of organisational structures, the adoption of quality management, greater standardisation of hospital and patient care procedures and practices and the move to different funding arrangements. Strategic planning processes have become part of hospital management practices and organisational reporting lines have been restructured to incorporate the newer management ideas of ‘matrix’ and ‘product line’ organisational structures.16 Perceiving encroachment by management on their professional autonomy, clinical staff have often resisted organisational restructuring. Devolving responsibility for decision making in the hospital situation meant that clinicians were increasingly asked to make, and then held accountable for, administrative and budgetary decisions. This was, of course, still within the framework defined and controlled by senior management. Clinicians have not necessarily taken on this role with enthusiasm, particularly in a climate emphasising cost savings and balanced budgets, as it involves more clearly identifying the resource implications of clinical decisions.17 As well, clinicians have had to make considerable adjustments to their

14. For a brief discussion of the position of hospital administrators see Crichton, pp162-165. Crichton notes that, in the 1970s, medically qualified administrators held the top positions.
work practices in tackling the tasks required by their new management roles.\textsuperscript{18} However, the perceived divisions between senior management and clinical direct service staff remains and is likely to be further exacerbated by political moves to "outsource" the management of some public hospitals; this new management team is then required to contract with clinical staff to provide the services needed.

Quality assurance activities, already recognised by some health professionals as an effective professionally controlled response to calls for greater accountability, became more widespread and formally established within sections of the health system during the 1980s, particularly as quality assurance became a compulsory requirement of the accreditation process after 1988. Primarily located in the hospitals and health centres, rather than individual medical practices, the early quality assurance programs devised tended to focus on individual clinical procedures and processes, with outcomes expressed in terms of what had been done or happened, such as the number of treatments performed or infection rates after operations. Thus the notion of quality assurance became primarily associated with activities such as "checklists on clipboards".\textsuperscript{19} Assumptions that the treatment/ intervention provided had benefited the person receiving the service were implicit in many quality assurance activities, and consequently rarely came under scrutiny. While the introduction of clinical randomised control trials had gone some way to assessing the outcome of particular treatments and interventions, this was often interpreted narrowly in terms of clinical success: the bone mended, the particular organ was removed or the infection contained, rather than the actual real benefit to the whole person. Controlled by health professionals, the results of quality assurance projects were rarely made available to the public; confidentiality of patient information was sometimes used as an excuse to prevent this. The identification of clinical protocols and standardisation of

\textsuperscript{18} For further discussion of this point see G. Prideaux, "Making the Transition from Health Professional to Manager", \textit{Australian Health Review}, vol.16, no.1, 1993, pp43-50, and M. Tobin, "Transition from Clinician to Manager - A Case Study", \textit{Australian Health Review}, vol.16, no.1, 1993, pp50-59.

procedures specific to the institution under the mantle of “best practice” complemented quality assurance activities and the two were often combined. Other activities, such as peer review meetings, clinical audits and mortality reviews were also subsumed under the broad ambit of quality assurance.

The ideas of total quality management (TQM), however, brought a new perspective to definitions of ‘quality’ in the health care setting. This perspective required a move away from the limited emphasis on review of clinical procedures to encompass the whole organisation and its activities in the pursuit of the provision of quality service. Changes akin to those already described for the public sector took place in health care organisations, well demonstrated by the language used in the official documents of many health care organisations by the early 1990s. Coinciding with the introduction of the new management practices that demanded greater accountability of health care professionals now grouped into cost centres, TQM practices have been cautiously adopted by the different professionals groups, sceptical that TQM may have been another ploy to undermine professional control and decision making. TQM practices and terminology have become intertwined with quality assurance projects so that

“the emphasis is beginning to switch from the perspective of individual clinicians on the quality of patient care to a statistics-based measurement process which describes aggregate quality of care provided to large groups of patients”,

Books and journals about the specific application of TQM to health care organisations are multiplying at a rapid rate. As part of this move, patient satisfaction surveys have gained a new respectability as health managements and clinicians seek to demonstrate the virtues of their organisations and services as they compete for health dollars.

20. A good example of this is the document Royal Adelaide Hospital Strategic Plan 1994-1998. The influence of TQM is evident throughout but typified by the statement: “Our CUSTOMERS are everyone we deal with. They include government, the community, other hospitals and organisations, universities, medical practitioners and, of course, our patients, their relatives and carers.” [original emphasis] Royal Adelaide Hospital Strategic Plan 1994-1998, B. Sallis Chair, Royal Adelaide Hospital, North Terrace, Adelaide, 1995, p5.
22. For example, the journal Quality Management in Health Care first circulated in 1993.
The focus on the ‘productivity’ of health care organisations brought the issues of cost and quality together. Clinical epidemiological studies had shown marked differences in clinical practices according to where the services were provided, for example surgery rates for particular medical conditions. With sophisticated and fast information retrieval systems that could attribute cost more specifically to particular services, these differences became even more evident. Managers, keen to find new areas for cost savings, now asked questions about why there were different rates and lengths of stay for the same procedures. Increased ‘productivity’ of hospitals was seen to be directly related to reducing the cost per admission and the length of stay.\textsuperscript{23} Above average lengths of hospital stay and higher rates of certain treatments/ interventions became associated with the notion that these actions, as well as being economically inefficient, in some, usually unspecified, way represented a reduction in the quality of care. While the focus had moved to outputs, outcomes more indicative of the true quality of care provided were still largely ignored. The startling findings from the Harvard Medical Practice Study of the high rate of adverse events arising from treatment/ interventions, and confirmed by similar studies elsewhere, helped create a new emphasis on real outcomes for the patient, but this was driven more in the interests of self preservation of the organisation fearful of being sued, rather than altruistic concerns for the consumer’s health and wellbeing.\textsuperscript{24} Energy was directed towards developing risk management strategies and ‘defensive medicine’, such as increasing diagnostic testing, to ensure that compensation claims were kept to an acceptable level.

The systems of diagnostic related groups and ‘casemix’, already developed and in use in the United States of America, provided a mechanism for tying funding arrangements more closely to performance and outputs. Based on the notion that “patient treatments are the principle products of a hospital”, all treatments/ interventions were to be categorised into a series of defined diagnostic related groups (DRGs) that could then be equated with

\textsuperscript{23} National Health Strategy, \textit{Hospital Services in Australia}, pp62-70.
\textsuperscript{24} See ch2.5 for discussion of the Harvard Medical Practice Study.
resource usage determined by indicators such as typical length of stay. DRGs were seen to “provide a benchmark against which the performance of hospitals can be measured”. The mix of identified DRGs, linked to the complexity of conditions treated and the characteristics of the population using the services, provided the information on which the “casemix” of the hospital could be determined; this uniform system enabled more meaningful comparison between the various hospitals to be made. More importantly, in an era of market forces and competition, casemix was seen to “allow the determination of a fair and efficient level of reimbursement for the various types of hospital throughput”. Promoted initially by the Commonwealth government, through the Commonwealth Casemix Development Program, and despite the considerable debate amongst health professionals, managers and government officials about the advantages and drawbacks of such a system, casemix funding arrangements had been adopted by several state governments by the mid 1990s, with other state governments set to follow.

The introduction of casemix funding arrangements at the same time as cost containment and cost saving policies in hospitals has tarnished the image of casemix as a fairer way of redistributing health dollars. With ‘length of stay’ a key component in the casemix formula, and hospitals penalised financially for stays longer than the specified amount for each DRG, the issues of adequate discharge planning and the availability of community care have gained new meaning. The more personalised care, typically offered by community based nursing and domiciliary services and applauded by consumers, has

been threatened by the resulting increasing, and possibly overwhelming, demand for home care services, as hospitals are no longer considered to be, or funded as, a place to convalesce. Government policies espousing commitment to community care and improving health outcomes have proved useful to the economic arguments for shifting funding away from the hospitals. However, the strain of fiscal restraints imposed by governments on both hospital and community service has prompted media reports of “crisis” in various parts of the health system. Community based service providers complained that people were being discharged from hospitals ‘quicker and sicker’ under the casemix funding arrangements without adequate discharge planning and coordination with community care services, placing a greater obligation on the family, usually female relatives, to provide the necessary care. The implementation of ‘deinstitutionalisation’ policies, in areas such as physical and mental disability, has added to the burden and surveillance of women charged with providing primary care to family members living in the community.

The focus on hospital care had been at the expense of health promotion and illness/disease prevention activities. By the 1980s, it was evident that even with the massive spending on medical technologies and health services, there were still significant disparities in health status amongst various groups in the Australian community, and that rates of major illness and disease within the Australian population were not reducing. This, along with the ageing of the population, suggested the potential demand for health services, and thus health expenditure by governments, both immediately and in the future, would continue to rise. Attempts to shift the focus of government health policies to embrace issues of health promotion and illness/disease prevention have been made through programs such as the Commonwealth government’s Better Health Commission, Health for

30. A good example of this is the media coverage of major changes to the mental health services in South Australia as a new policy of psychiatric hospital closures and establishment of community care facilities (anticipated to result in significant cost savings to the state government) was implemented throughout 1993-4. See B. Hailstone for various articles in The Advertiser, Adelaide during this period.
All Goals and Targets and the National Health Strategy and related state/territory government projects. However, the major thrust of these programs has tended to reflect prevailing paradigms of illness and disease and “decisions about what is worth preventing have been determined largely by what is able to be recognised and/or treated by medical services”. As well, government sponsored media campaigns aimed at stimulating individual lifestyle behaviour changes to reduce risk factors associated with particular diseases or early death, have reinforced the notion of individual choice in obtaining good health, meanwhile ignoring the structural constraints to acting on such ‘good advice’.

While some attempts have been made to increase consumer participation in various aspects of health care planning and delivery as a strategy for improving health outcomes, the partnership approach advocated in the early 1990s has already been superseded by the ‘customer service’ and ‘customer focus’ notions of corporate management.

Other strategies have been introduced by state/territory and federal governments to try to reduce the dependency on hospitals as the main source of health care and the centre of health planning, for example by renewed emphasis on the role of primary health care, the integration of community based services with hospital services and area health management. But concerns about hospital organisation and funding have not meant a decrease in demand for hospital services. Although, as already mentioned, the way hospital services are provided has changed, with shorter lengths of stays now the hallmark

32. See ch4.2 for further discussion of these programs.
33. Health Issues Centre, Getting Off the Sickness-Go-Round. Are We on the Right Track?, Health Issues Centre, 3rd Floor, 148 Lonsdale St, Melbourne, 1988, p9. The report Goals and Targets for Australia’s Health in the Year 2000 and Beyond, prepared by D. Nutbeam, M. Wise, A. Bauman, E. Harris & S. Leeder for the Commonwealth Department of Health, Housing and Community Services, 1993, provides a good example of this more limited approach to health promotion.
34. For evidence of this see the document National Health Policy released by the Health Ministers’ Forum, Department of Human Services and Health, Canberra, 30 Sept 1994.
of an efficient hospital, and casemix funding arrangements introduced, the provision of hospital services remains a major cost to governments. In attempts to reduce and transfer some of the ongoing cost for hospital care, but also in line with the prevailing philosophies about government involvement in direct service provision discussed in the previous chapters, moves to "privatise" health services have begun across Australia. The well established private practice component already within public hospitals, and a long tradition of private hospitals, set precedents for private sector investment in public hospital services. However, the model of contracting private enterprises to provide services, such as catering and cleaning services and more recently management services, in the public hospitals was new and strongly opposed by the unions representing members previously employed by the hospitals to carry out these duties.37 The theories of managed competition and purchaser provider split, based on overseas experience, particularly New Zealand and Britain, were also promoted as mechanisms for increasing efficiency in the health sector, and therefore a way of reducing direct costs to governments.

The financing of the health sector in Australia has been a complicated arrangement between federal, state/territory governments and the private sector. Prior to the introduction of the universal health insurance scheme Medibank in 1973, health insurance arrangements had largely been determined by the influence of the medical profession on the governments of the day.38 The lack of ability by many people to afford health insurance, or pay for the health care they needed, had raised serious concerns about access to and equitable distribution of the benefits of modern medicine. The real cost of the latest medical technologies prohibited all but the very wealthy from fully financing their own health care.39 The alternative of a government financed universal health insurance style

37. For a general discussion of some of the issues about the moves toward privatisation of hospitals in Australia see K. Forde & A. Malley, "Privatisation in Health Care: Theoretical Considerations, Current Trends and Future Options", Health Services Review, vol.15, no.3, pp269-277; for examples of union stances on privatisation see the Public Service Review, the newsletter of the Public Service Association (South Australia), during 1994 when the South Australian government was contracting with a private investor to take over the Modbury Public Hospital.
scheme proved politically popular, even if increasingly difficult to fund without raising taxes or making cuts in other areas of government spending. The revised universal health insurance scheme, Medicare, introduced in 1984, covered the cost of consultations with medical practitioners, and made Commonwealth grants to state/territory governments to provide non means tested public hospital services. The information collected by the Health Insurance Commission, in the administration of the Medicare scheme, has gradually allowed greater scrutiny of medical costs and indirectly clinical practices. For example, aggregated data has revealed the huge salaries some specialists have been able to earn as indicated by the Medicare payments they receive. The Health Insurance Commission data has also focussed attention on the issues of fraud and overservicing by some medical practitioners that have somewhat compromised the reputation of the altruistic nature of the medical profession.

The Medicare agreements between the Commonwealth and state/territory governments provided the Commonwealth with a mechanism to implement national policy directions in the health area, often through funding incentives for special programs and activities. However, right from the first Agreements, there have been controversies about particular sections thought to threaten or encroach on state/territory and professional authority, and the Medicare Agreements have been subject to numerous amendments in between the formal quinquennial renegotiation. Section 17 of the amendments to the Health Insurance Act 1973 (Commonwealth), establishing the Medicare scheme and passed in 1984, for example, was the subject of intense criticism by the medical profession leading to industrial action by medical specialists in New South Wales. This dispute was to play a part, indirectly, in the early formation of the health complaints unit in that state. (See ch7.5.1.) In this instance, the strength of the medical lobby was demonstrated by the

41. For the Health Insurance Commission’s response to these issues see P. Backhouse, Medical Knowledge, Medical Power, PhD thesis, The University of Adelaide, 1994, ch4.
42. For detailed discussion of the Section 17 amendments see Committee of Inquiry into Rights of Private Practice in Public Hospital, Final Report to the Minister for Health (Commonwealth), Prof D Pennington, Chair, AGPS, Canberra, 1984, “The Pennington Inquiry”, and Backhouse, ch3.
passing of amendments to Section 17 in 1985, although at some cost to the credibility of the medical profession.\footnote{Backhouse, ch3, pp438-441.} The 1988 Medicare Agreements made changes to funding arrangements and included monies to encourage the greater use of day surgery and early discharge and to explore the application of casemix to the Australian hospital system. The most recent Medicare Agreements (1992) contain explicit statements about the development of public hospital patients' Charters and independent health complaints bodies. (See ch7.5.4.)

This changing context of health care organisation and service provision, set in the broader context of major reforms across governments, similarly provided an environment for greater interest in complaints systems. Within the new management paradigm, chief executive officers of health services were no longer confined to the administrative organisation of resources, and instead controlled the ‘whole organisation activity’ through strategic plans and revised organisational accountability structures. The domination of health service policies and procedures by health professional clinicians, which had been firmly in place since the rise of health professionals earlier this century, was under challenge. As already discussed in the previous chapter, complaints by consumers represented an area that could possibly serve managerial interests at the expense of professional interests. In health care organisations this was no less true, and consumer dissatisfaction with services was used to help management justify and implement changes unpopular with health professional staff. Continuing managerial demands for efficiencies and proven effectiveness called into question established professional practices and authority.

In response to this challenge by the ‘new’ health managers, professionals have further embraced quality assurance activities and devoted considerable energy to defining best practice, standards and protocols for their areas of expertise. Without these baselines and the clear recording of at least outputs, and better still outcomes it was difficult for
health professionals to argue their position in the new managerial environment. The health professionals, through adopting the language of the managers and adapting it to better serve their own positions, were able to regain some ground in controlling the health services.

The merging of some elements of the practices associated with quality assurance and the broader TQM placed a new emphasis on consumer feedback about services received. The way consumer complaints were handled by health care organisations became topical as a quality issue, and some organisations went as far as introducing reviews of existing systems and setting new complaints handling procedures in place. There were two other compelling reasons for management and professionals alike to take stock of their organisations’ complaints handling that had little to do with providing better complaints services to consumers. The extensive changes and complexity of the organisation of service provision in health care had placed many health service organisations in a position of increased compensatory liability for the actions of health care providers: the potentially financially crippling extent of which was highlighted and compounded by the adoption of risk management practices. The popular linear model of complaints to litigation, discussed in chapter two, suggested that the initial handling of complaints could possibly influence the outcome of claims for compensation in the organisations’ favour. As well, complaints could provide an indication of potential ‘risk’ areas, although the action taken to reduce the ‘risk’ many not necessarily improved the situation from the perspectives of consumers. The desire to meet accreditation guidelines was the other compelling reason.

The uneasy relationship between professional health service providers, the managers of health organisations and governments in the rapidly changing and unstable environment of health care provision of the early 1990s had given rise to questions about responsibility and control over health complaints mechanisms. Traditionally left to the professional registration boards, individual health services and health departments, all had acquired reputations for inactivity and poor complaints handling practices. By the mid 1980s, several state governments had taken on a greater role in handling health complaints.
by setting up central complaints handling mechanisms. The work of these new mechanisms, government initiated reviews and consumer groups revealed the extent of unsatisfactory complaints resolution using the traditional mechanisms, and highlighted the need for overall reform in health complaints handling. But progress has been slow and conservative as the entrenched power of the health professionals, particularly the medical profession, has been used to oppose any changes to complaints handling seen to threaten professional autonomy. Professional control over the adjudication of health complaints about professional practice has largely been retained through the mandate accorded to the professional registration boards and disciplinary tribunals, still dominated by the relevant professions.

7.3 THE PROFESSIONS AND COMPLAINTS HANDLING

The handling of complaints about professional practices has been the domain of relevant professional registration bodies and professional associations for most of this century. With the rise of professionalism within society, many of the health professions have managed to gain community and government sanction, through the necessary legislation, to maintain this control over complaints handling relating to professional matters. The procedures and mechanisms put in place to deal with complaints by many of these organisations have been an additional source of criticism and complaint by consumers. However, even with the advent of alternative health complaints bodies and increased access to the courts, in most instances it is the registration boards and associations who ultimately determine the outcome of complaints about professional conduct, and the penalties to be imposed on the erring professional, such as the requirement to attend training courses or, at the extreme, deregistration. It is not the intention here to discuss in detail the roles of the professions in society, or theories about

44. The use of the term professional associations in this thesis includes the medical and specialist colleges.
the professionalisation of occupations, but to focus specifically on the issues surrounding complaints and complaints handling by the professions.

The growth in status and influence of workers referred to as professionals are phenomena of the twentieth century. The application of rational and scientific principles to many aspects of community and domestic life, under the direction of the scientifically trained expert, was thought to offer a new approach to addressing the issues facing modern society, particularly in relation to the domestic sphere; the management of the home, the upbringing of children, the care in the home of infants, the infirmed and the elderly. The professionals offered ‘expert’ knowledge and guidance on many aspects of community life; the knowledge and experience of ordinary people were devalued as unscientific and unreliable. The new professions, such as social work, nursing and home economics, drew their members from, and reflected, the culture and values of the middle classes in a modern consumer society. The complexity and specialisation in health service provision led to the creation of many occupations within health organisations requiring highly skilled, and often university trained professionals, who offered their services, rather than products, in return for a fee or salary. The archetype of professions was medicine, and the study of the various aspects of the profession of medicine has been influential in theories about the professions and the powerful position the professions hold in the organisation of society.45

The relative importance of the monopoly over a body of knowledge comparative to the ability to organise as a pressure group has been debated in the search for explanations of how the professions have obtained and retained this powerful position, often using the medical profession as the example.46 Both components help explain the professions’ control over complaints handling about professional practices.

To be identified as a profession an occupation has to demonstrate three primary elements: a body of theoretical knowledge only acquired through an extended period of

---

45. See, for example, E. Willis, Illness and Social Relations. Issues in the Sociology of Health Care, Allen & Unwin, Sydney, 1994.
46. For a concise overview of these debates see Backhouse, ch2.
education; competence in practice skills through the application of the theoretical knowledge allowing autonomy over decision making; and a code of ethics, emphasising altruism and dedication to service above self interest, and monitored by a self regulating association.47 ‘Ownership’ over various areas of knowledge relating to health and illness have been hotly contested amongst professional groups over the years. For example, in South Australia a proposed amendment to the registration act for psychologist relating to therapeutic interventions was successfully challenged by a number of other professions on the grounds that the knowledge and skills involved were not the exclusive domain of the psychologists. The struggle between doctors and midwives over what constituted legitimate knowledge relating to childbirth, and the right to practice arising from this, is another example.

Perhaps even more important than the body of knowledge was the ability to apply this knowledge in the way the individual professional thought most appropriate, that is, to have a significant degree of ‘autonomy’ over one’s work and how it was to be performed; in the health area commonly known as exercising ‘clinical judgement’. Freidson argued that autonomy over the professional’s work was critical to the determination of a profession, and that certain conditions could enhance a profession’s ability to achieve autonomy, such as the legal sanctioning of the occupational territory and control over the production and application of the professional body of knowledge.48 In this way the knowledge and decision making processes of a profession were placed beyond the reach and criticism of others. The people with the authority to understand and make judgements about a professional’s work could only be another member of the same profession. The public could trust this reliance on professional judgement because the professions had declared, through their code of ethics, a commitment to working in the best interests of the

'patient/client'. The perceived affront to the integrity of the individual professional on receiving a complaint was keenly felt and most were outraged, responding in a defensive and punitive way, shifting blame back onto the complainant for not understanding the intricacies of the situation. Writing in 1970, Freidson noted that, in the doctor-patient relationship,

"the client, lacking professional training, is thought to be unequipped for intelligent evaluation or informed cooperation with his consultant. To question one's doctor is to show lack of faith and is justifiable grounds for the doctor to threaten to withdraw his services".49

The deference to expert knowledge and judgement, promoted by the professions, became pervasive throughout society, from early in the twentieth century onwards, and professional opinion was sought, and directed, many aspects of community life. Complex social and political problems were taken out of the public arena and reframed as technical problems falling into the closed domain of particular professional groups, whose knowledge and expertise then determined the solutions, leaving little room for comments and criticism from those outside the profession.50 In some instances, one profession achieved a considerable degree of control over the work of another profession, such as the medical profession over the nursing profession.51

Control and scrutiny of professional work and behaviour occurred by the process of peer review, where the review and evaluation of an individual's work was undertaken by other member/s of the same profession and based on standards set by that profession. Traditionally, this has been through the registration boards and professional associations, primarily when an individual member's work or behaviour has allegedly not meet the professionally determined standards, but the process of peer review has also been increasingly applied in a variety of settings where greater accountability of professional activities has been demanded. The concepts underlying peer review, such as the idea that

49. Freidson, p142.
50. See, for example, Backhouse on the medical profession and health policy in Australia.
51. See, for example, the account given by E. Willis, *Medical Dominance. The Division of Labour in Australian Health Care*, Revised Edition, Allen & Unwin, Sydney, 1989.
practice standards can only be determined by the profession and that the exercise of reasonable professional judgement in any particular situation can only be assessed by other like professionals, were also imbedded in the legal interpretations of professional negligence and duty of care. The widespread acceptance of peer review as a necessary and fundamental feature of professional practice was supported by structures in which the professions operated. For example, in relation to the medical profession, Backhouse comments

"medical peer review has never been explicitly contested or seriously challenged in Australia as a primary means by which to assess and evaluate the clinical decisions of doctors. Indeed it is widely regarded as the only technically and politically feasible means of such an assessment".

But professional taboos against criticising a colleague’s work, unless part of a formal supervision arrangement, were strong and longstanding, limiting the application of peer review, particularly amongst the medical profession. In hierarchical structures, where promotion and future career prospects rested on the recommendation of senior colleagues, it was a brave subordinate who dared to even question the practices of superiors. Even more generally, amongst the medical profession for example,

"doctors tend to dislike complaining about each other or even passing on complaints about each other - not only do they tend to feel disloyal, but the process tends to be unpleasant, embarrassing, and all too easily leads to the reputation of a trouble-maker".

While it was common for professionals, amongst themselves, to discuss the possible courses of action to take with individual cases and to debate the merits of different procedures and practices, it was left to the individual practitioner’s professional judgement to decide which intervention to use in the circumstances before her/him. It was assumed

53. Backhouse, p16.
that the wisdom and experience of the professional would be sufficient to ensure the most effective intervention would be chosen.

The core of professional authority was challenged by the lodging of a complaint: the exclusive knowledge base; the correctness of the professional judgement; and the trust that the professional had acted in the clients best interests. The “objectivity of expertise and scientific truth”, on which professional actions were claimed to be based, encouraged a culture that did not routinely examine or question the true efficacy of day to day practices that had evolved or even clearly state the intended outcomes of the professional’s interventions, except in a very limited and narrow way.57 But this was not considered a concern as the competence of professionals could be taken for granted; their knowledge base, training in exercising professional judgement and dedication to service would ensure that “bad” practices were rare. Questioning of professional actions by ‘outsiders’ was unwelcome and discouraged. Freidson wrote “the very special social position of institutionalized privilege that is the professionals is threatened as well as demeaned by the demand that advice and action be explained and justified to a layman”.58 The prestige, social status and financial reward that went with recognition as a profession were at stake when the application of professional knowledge and judgement were questioned through the substance of a complaint. For professional groups to ensure retention of their claim over a particular area of expertise, and therefore their professional status, they needed to be able to control the determination of, not only what constituted knowledge and skills appropriate to their profession, but also how this should be applied in practice. Registration of the professions provided a way for consolidating the power of professional groups.

The legal sanctioning of professionally dominated registration boards or tribunals to undertake the task of evaluating the behaviour and actions of professionals on behalf of the

57. Freidson, p159.
58. Freidson, p143.
community has been a significant factor in reducing outside scrutiny of professional practice. Registration of professional groups had gathered momentum throughout this century (20th), particularly in the area of health service provision, until changing ideas about restrictive trade practices and mutual recognition of standards presented different options. The registration acts passed by the different state/territory parliaments around Australia, were not necessarily consistent or covered the same professions. But the central feature common to all was the power accorded to registration boards to determine who was able to call themselves, and work as, a member of a particular profession. The registration acts broadly defined the profession, its specific occupational territory, the minimum educational requirements as a prerequisite for registration and any requirements for professionals to remain registered, such as payment of the registration fee. The legislation allows for the establishment of a register and a registration board to oversee and make determinations about the registration of individual practitioners, the conditions upon which a complaint against a registered practitioner could be made and the hearing of the complaint by either the registration board or a specifically created disciplinary authority. The registration acts often provided penalties for those claiming to be and operating as a member of that profession without registration.

Registration boards, operating within strict criteria and following set procedures, have presented a daunting prospect to consumers wanting to make a complaint. A complaint needed to be seen to satisfy the terms under which a complaint could be made in accordance with the registration act before it could be accepted. The grounds for complaint were often not clearly defined and subject to further restrictive interpretation by the boards. There were two primary areas for complaint. The first related to the physical and mental capacity of the professional linked to the professional’s personal behaviour: addictions, criminal offences and debilitating physical and mental illness were all grounds for

59. The membership of registration board are largely drawn from the profession. For example, in 1994, the Nurses Board of South Australia, consisted of seven nurses, three doctors, 2 lawyers and a health manager.
complaint and if proven, reasons for limiting or suspending registration. These were the complaints that the registration boards tended to find easier to deal with and were more likely to take action on; undesirable characteristics and socially unacceptable behaviour amongst some members could potentially reflect on the reputation of all members, damaging community respect for the profession and threatening professional status.60

The second area of complaint related to professional misconduct in carrying out a professional intervention. Professional misconduct included situations where a professional had acted with a lack of knowledge or skill; made an ill informed or inappropriate judgement; was incompetent or negligent in performing a task; or acted in an unethical way. But it was the codes and standards of practice, developed and set by each profession, that defined what constituted misconduct or negligence for that profession, rather than complainants' perceptions of wrong or harm done. Generally, there needed to be an alleged serious or major breach of the act for the registration board to pursue the complaint to any extent. Sometimes, it was established that the professional may have erred in some way, but professional interpretation of misconduct and negligence was such that the action was not considered sufficiently serious for a breach of the act to have occurred and for disciplinary action to be taken, much to the frustration of the consumer making the complaint.

The processes for dealing with complaints developed by the registration boards are generally complicated and laborious. A typical pattern of the way registration boards deal with complaints persists, despite attempts to simplify the processes in recent years. Once the complaint is lodged with and accepted by the registration board, the professional named in the complaint (the respondent) is sent a copy of the letter of complaint and requested to

60. See Rosenthal; also Stacey’s account of the operations of the General Medical Council in Britain. M. Stacey, Regulating British Medicine: The General Medical Council, John Wiley & Sons, Chichester, 1992. While no similar comprehensive accounts are available for decisions of Australian medical registration boards and disciplinary tribunals, which are often kept confidential from the general public, the close relationship of the medical profession in Australia, with the British medical profession would suggest that a similar picture prevails.
respond to this within a specific time. On receipt of the respondent's reply, a sub-committee of the registration board considers the complaint to determined if the response has been satisfactory or if the complaint needs further investigation. It is the board (or sub-committee), not the complainant, who decides if the response is satisfactory, and the information contained in the response need not be provided to the complainant, other than to say the complaint has been investigated and did not breach the act. The professional concerned can be advised to take some remedial action, such as a letter of apology to the complainant, even though the complaint is not to be pursued further by the Board. The sub-committee may decide that more evidence is needed, such as seeking expert opinion from another member of the profession or requesting more information from the respondent. The complainant is rarely informed of the progress of the complaint, which often takes many months. The sub-committee decides whether there is a sufficient case for the complaint to be presented, usually by the registrar, before a disciplinary hearing of the board or the relevant disciplinary tribunal. The complainant may be called as a witness but otherwise, generally, has no formal place in the disciplinary hearings. If the breach of the act is found proven, the board or tribunal can impose sanctions on the professional, such as the payment of a fine, restrictions to practice or deregistration. In some circumstances, if not satisfied that the board will proceed with a complaint, and where a disciplinary tribunal exists, a complainant may be able to lodge proceedings directly before the disciplinary tribunal. But the complainant may have to present their own case, as legal representation may be restricted, and the complainant may then be liable for all costs incurred during the hearing if the matter is found not proven, which can amount to many thousands of dollars.

Where registration of the profession had not been achieved it fell to the professional associations to ensure that standards were upheld. Code of ethics and by-laws for the professions, developed by the associations, are used as the basis for determining professional misconduct. These codes, though, are often broad, difficult to interpret specifically and more reflective of professional etiquette, such as not poaching another
member's clients, than providing guidelines for ethical behaviour and decision making.\textsuperscript{61} The associations use similar processes to the registration boards when investigating a complaint, but lack the legal backing accorded to the boards when seeking information or imposing penalties.\textsuperscript{62} Membership of the associations is voluntary, and suspending membership may not prevent an individual from continuing to work in that profession. Even when a registration board exists, the professional association has also taken an interest in complaints handling, often intervening in some of the more minor complaints about their members.\textsuperscript{63} The relationship between the registration board and the professional association of the relevant profession has been strong, with members on the registration boards also holding (or have held) senior positions in the associations.

The major justification for the registration of professional groups has been the protection of the public from inadequately trained and incompetent practitioners. But registration has also served professional interests, by restricting entry to the profession and establishing monopolies over particular areas of work. The professions, particularly medicine, have generally had sufficient resources and political connections to organise themselves as powerful pressure groups and to persuade governments to legislate in favour of their interests. Professional interests have been seen to influence the ability and willingness of the professionally dominated registration boards (or related disciplinary bodies) to take effective action against misconduct or incompetent professionals. Freidson commented

\begin{quote}
"in essence, my position is that the delivery of medical care cannot be controlled by the profession, that its autonomy and its dominance must be tempered by
\end{quote}

\textsuperscript{61}. The author's own experience as a member of the SA Branch Ethics Committee, Australian Association of Social Workers Ltd., responsible for receiving complaints about social workers, highlighted the many gaps in the recently revised and much more detailed \textit{Code of Ethics}, limiting the lodging and investigation of complaints about social workers.

\textsuperscript{62}. Using the Australian Association of Social Workers, as the example again, the diagramatic representation of the revised process for handling complaints, while more clearly defined than previously, still involves many steps fully covering three pages of the document. Australian Association of Social Workers Ltd. 1994, \textit{Code of Ethics, By-Laws on Ethics}, Australian Association of Social Workers Ltd, PO Box 84, Hawker ACT.

\textsuperscript{63}. For example, the Australian Medical Association branch personnel report they play a role in complaints handling.
administrative or bureaucratic mechanisms that stress accountability for effective and humane services and must be in some way more responsive to the lay client himself". 64

The dual role of the registration boards in investigating actions of members and determining sanctions presented a possible conflict of interests, compromising the impartiality of the registration boards. The role of the boards in actively investigating complaints has not necessarily been clear or resources made available to this end. Complaints processes were often seen to be weighted in favour of protecting members, rather than consumers, particularly when the boards were comprised almost exclusively of other members. The primary purpose of the hearings, to ensure that professional standards were maintained, did not necessarily coincide with complainants' expectations. Consumers were often more concerned about the harm caused by, and consequences of, the professional's actions than whether particular standards had been met. Consumers found that once they had lodged their complaint with a registration board they had little control over the process or outcome.

There has been considerable pressure to change the registration acts and make the registration boards more open and accountable to the wide community, not just their members, over the past decade, an era of increased demands for greater accountability as already discussed. Economic policies, such as those emphasising competitiveness and free trade, questioned the continuing role of professional registration, particularly where registration requirements and procedures differed from state to state. Self regulation was proposed as the alternative to be adopted, unless it could be demonstrated that a serious risk to public health and safety would arise if registration was discontinued. The move towards mutual recognition of goods and services has demanded greater consistency of the

64. Freidson, p160.
terms of the state registration acts for the same profession, and simplified registration procedures to allow movement of professionals across state borders.65

Public confidence that professionals would provide advice that was objective and in the interests of the health, safety and welfare of the general public diminished as the self interest of professionals was exposed, and the deference to professionally constructed knowledge challenged:

"no longer does any profession enjoy the uncritical admiration or implicit trust from its clientele or the public at large. The new "social contract" between society and the professions that is in the offering will require that the professions take their duty to serve the public interest and the common good much more seriously than ever before".66

Attempts to improve the complaints handling processes of the registration boards have been made, although there has been little consistency in the changes introduced across the professions and across the states/territories. Some of the changes have included: the broadening of the membership of the boards to include members completely unrelated to the particular profession; greater clarity of the board’s procedures and timelines for dealing with complaints; linking investigations with the central health complaints units; and more detailed reporting of the outcome of the disciplinary hearings to original complainants.

While the changes have been welcome there is still a considerable way to go for the complaints handling procedures of the professional registration boards and associations to reflect the components of the combined consumer model for health complaints mechanisms. The powers and authority invested in the registration boards through legislation, although often quite extensive, have often only been used hesitantly and then only in the most serious cases. The specific criteria and the procedures developed to

65. For example, each state/territory will continue to keep their own medical registration boards, but in line with mutual recognition legislation, once registered with one board, a medical practitioner will gain automatic registration with another board on production of “a certificate of good standing from the board in their principle place of registration, where certain conditions relating to education and training are met”. A national register will also be established. Review of Professional Indemnity Arrangements for Health Care Professionals, Compensation and Professional Indemnity in Health Care. An Interim Report, Commonwealth Department of Human Services and Health, AGPS, Canberra, 1994, p197.

process complaints tend to alienate rather than involve the consumer/complainant. Many health professionals remain sceptical that the motivations of consumers/complainants in lodging complaints may include an altruistic desire to ensure that other consumers do not suffer similar negative experiences. Where changes have been made these have only came gradually and, in the eyes of consumers, have not gone far enough to redress the power differential between consumers and professionals. This can only occur if complaints handling mechanisms are outside the control of the professions. Consumer dissatisfaction with, and scepticism about, the ability of professionally dominated registration boards and disciplinary tribunals to impartially and fairly investigate and adjudicate on health complaints remains.

7.4 Health Services and Complaints Handling

Along with the registration boards and professional associations, health organisations generally did not have a good reputation for handling complaints about aspects of their services. The typical approach to complaints handling was adversarial and defensive, the priority given to protecting the reputation of the organisation, containing potential scandals and avoiding liability. The hierarchical system of accountability invoked an individual victim blaming attitude and response, usually directed at the most junior staff member involved, with little recognition or acknowledgment of organisational factors that may have significantly contributed to the situation. A number of staff were often involved in handling a complaint, either appropriately or inappropriately depending on who first received the complaint, and complaints were easily buried within the system. The functional structure of health services, with divisions between the independent departments, did not encourage an openness about complaints or cooperation in resolving them. For consumers it was often unclear who they could turn to with a complaint, and if they did manage to make a complaint, it was likely that, after many months, they would
only receive a short non committal response. In some instances, where consumers had persisted with their complaint, the consumers felt branded as trouble makers and "difficult patients". Other consumers were too fearful that they would be denied further services if they were to appear ungrateful by complaining. The managements of health service were seen to protect their organisations, rather than offer impartial investigation of complaints. Information about complaints received across the organisation was rarely collected, or analysed, and complaints data were little used, or acknowledged, as a basis for initiating changes to policies, procedures or practice.

The complex organisation of modern health services and care accentuated the inadequacies of the complaints handling processes. It was not always possible to attribute the complaint to one individual's actions. Nor was it possible to ignore the importance of organisational factors as new structures exposed old procedures to renewed scrutiny. A stronger consumer voice expressed through organisations, such as the Consumers' Health Forum, and the setting up of central mechanisms to handle health complaints brought pressure from outside the health services to improve the internal complaints handling procedures. But there were also pressures for change from within the health services. Many administrators and professionals had become interested in the different notions of quality service provision, of which complaints handling was seen to be a part, to enhance the 'business' of the modern health service organisation. Elsewhere in this thesis the advantages to the managerial agenda of quality management have been discussed. For managers, the opportunity to become involved in complaints handling about service provision was a possible means for increasing and consolidating their power, particularly in areas where managers had previously been excluded because of perceived lack of specialist knowledge. For professionals, the more established quality assurance type activities were seen to fit neatly with the newer ideas about quality and professional accountability.

67. For accounts of consumers' experience in making a complaint see chapter 8; also Health Issues Centre, Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus, Health Issue Centre, 1st Floor, 257 Collins St, Melbourne, November 1991.
ensuring the retention of professional control over these areas. Professional control over complaints handling meant that management generated policies and procedures could be highlighted as major factors contributing to the complaints, meanwhile safeguarding professional territory. This was particularly so when changes to health services had been made that were unpopular with health professionals, for example the introduction of casemix funding. If the handling of complaints resided in the managers’ hands, this advantage was lost to the health professionals.

There was another, perhaps more pressing, reason for both management and professionals to take complaints handling more seriously. The complex health service provision arrangements had increased the liability of the health care organisation to pay compensation for the actions of its staff where injury had occurred. Both the actual handling of the complaints and the information contained in complaints had the potential to benefit the organisation; the former by possibly avoiding lengthy and costly litigation proceedings through early satisfactory resolution of the complaint, and the latter by providing a unique source of information that might assist in the development of risk management strategies. If this information was to be obtained, consumers needed to be encouraged to complain and complaints ‘enhancing’ mechanisms, with at least some of the features of the combined consumer model for health complaints mechanisms, needed to be put in place. However, the assessment of the usefulness of the information contained in complaints to prompt changes to the health service organisation’s policies and procedures was to remain firmly with the organisation.

Real change to complaints handling practices at the local level in health services has been moderate and variable, as highlighted in chapter eight. Three factors, discussed in more detail below, have had an impact on complaints handling within health services: the accreditation of health services, the adoption of statements of patients’ rights and the appointment of Complaints Liaison Officers. As the accreditation of health services gathered momentum, the requirements of the accreditation standards forced many health
service to examine, and set in place, policies and procedures in line with those standards, including complaints handling. The development of statements of patients' rights, including the right to comment or complain, for each specific health organisation also drew attention to the complaints handling procedures available. The establishment of Complaints Liaison Officers provided a focus within the health service for complaints and complaints handling. While still evolving, the impact of these three initiatives on local complaints handling processes over the longer term could be substantial, if the initiatives are allowed to be fully utilised and benefits for consumers maximised. For a time, the focus had been taken away from the internal systems with the establishment of central health complaints units. (See ch7.5.) But, more recently, as the central health complaints mechanisms place increasing emphasis and reliance on local resolution of the majority of complaints, the mechanisms in place for handling complaints at the local level have again become significant for consumers, particularly if consumers are to gain satisfactory resolution to their complaints.

7.4.1 Accreditation of health services

The accreditation of health services is still a relatively new phenomenon in Australia, although the idea was first proposed in 1926, and repeated attempts were made to introduce accreditation programs during the intervening years.68 Under the control of the Australian Council on Healthcare Standards (ACHS), established in 1977, participation by health organisations in the accreditation process has been voluntary but increasingly expected. Just under two thirds of the available hospital beds in Australia (private and public) are in health organisations that have been accredited.69 The ACHS accreditation guide, updated yearly, provides the framework of standards that the health services need to

---


achieve to gain accreditation by the Council. Originally developed for the hospital context, the standards were not always appropriate or applicable to the vast array of structures and services provided by organisations falling under the health umbrella. Because of this, in 1987 for example, the Community Health Accreditation and Standards Project (CHASP) was set up under the auspices of the Australian Community Health Association, and funded by the Commonwealth government, to develop review procedures and standards specifically for the community health sector.70

The accreditation process requires documentation and accounting of services by health care organisations if standards are to be met. Policies and procedures in a range of areas must be clearly defined, written and available to staff and consumers. For example, the criteria for complying with Standard 7 for the Governing Body, which deals with patients' rights and special needs, requires that "there are written policies and procedures and physical facilities to protect the rights of patients" and goes on to list a series of issues that are to be addressed, such as the investigation of patient complaints.71 The standards have been regularly reviewed and revised, in line with changing trends in health service provision. The standards have, however, predominantly focused on health service functions, administration and organisation rather than clinical interventions. The introduction of "clinical indicators", developed by the Care Evaluation Program of the ACHS, in collaboration with the medical colleges and the Commonwealth government, as part of the accreditation process, from 1994, goes some way to redressing this.72

With increasing emphasis on accountability and evaluation of health services, quality assurance activities had taken on a new importance as already discussed. By the beginning of the 1990s, the ACHS had made "quality assurance" a specific standard for

each area and introduced a policy whereby an organisation could not gain full accreditation without demonstrating a commitment to the evaluation of their services through servicewide quality assurance programs. The ACHS’s purpose for introducing quality assurance as a required standard was to

“encourage facilities to achieve
(i) excellence of care (by assuring that selected criteria are satisfied);
(ii) cost containment (by ensuring the efficient and effective allocation and use of resources)”.

The quality assurance process had to be a planned and systematic approach to monitoring and assessing the services provided, identifying areas for improvement and taking the necessary action to implement these improvements, evaluating the outcome of changes made and providing feedback on the outcomes to all those participating in the process.

The move towards accreditation of health services in Australia had been supported, and promoted, by health service providers, in particular the Australian Medical Association (AMA) and the Australian Hospitals Association (AHA), but much more hesitantly by governments. As the major provider of funds to hospitals, setting and monitoring of hospital standards gave governments greater control over budget demands for increased funding. The introduction of new standards, through the accreditation process, by a body independent from government and dominated by health service providers, was likely to result in undeniable requests for funds to meet the required standards, a point acknowledged by both the AMA and AHA as a reason for their support for accreditation.

The proposal that the process be overseen by the Australian Council of Healthcare Standards (originally Hospital Standards) ensured service provider control, particularly medical control, over the standards devised. The ACHS, as a non government, non profit organisation, but receiving some government funding to support its activities, comprised representatives drawn predominantly from the professional associations. This model fitted

75. Duckett, pp397-402.
with subsequent government policies promoting self regulation and the adoption of national standards.

The adoption of quality assurance as a central component of the Australian accreditation standards suited both professional and managerial agendas. For professionals, already familiar with designing and implementing quality assurance programs, it meant continued control over assessment and monitoring of aspects of their work. The accreditation assessors were health service providers from other organisations, and the process resembled the peer review model favoured by health professionals. For managers, accreditation provided justification for more complex and systematic information systems and greater surveillance over the operations of all staff within the health service. As the ideas of total quality management (TQM) were merged with ideas about quality assurance in health care settings, the advantages of accreditation to managers, faced with balancing and defending health services budgets, became even more pronounced. Scrivens identified four primary reasons for management support for the accreditation process of external monitoring and review: it provided standards against which the performance of the organisation can be impartially measured; it provided impetus for changing practices in line with the standards; it provided information and advice for achieving standards; and it helped identify areas of potential risk (and liability). 76 Although the current accreditation system in Australia does not compare one service with another, instead assessing each service against established criteria, the act of achieving accreditation may prove to be a competitive advantage, as competition between services for health dollars becomes more common.

Accreditation has primarily served the needs of health service providers and, more recently, managers but it has offered several things for consumers. Written policies and procedures, and the emphasis on better information provision generally, has enabled

consumers to gain information about aspects of health service provision that had previously only been known to the professionals. Quality assurance activities offer the potential for improvements in standards of care that could directly benefit consumers. The development of clinical indicators and clinical practice guidelines further challenge the mystic of clinical knowledge, and make available comprehensive information to consumers, allowing informed involvement in making choices about health care alternatives. More specifically, the Australian accreditation standards support the notion that patients’ rights are to be protected including the right to complain, and that consumers’ views about services received are to be sought as part of service evaluation. Health service providers, managers and professionals, have no option but to pay greater attention to these issues if bids for accreditation of their organisation are to be successful.

7.4.2 Statements of Patients’ Rights

The production of statements of patients’ rights by individual health service organisations was given impetus from three directions: the requirements of accreditation; the demands of consumer groups; and the managerial changes focusing on customer service. The statements were never intended as an outline of rights enforceable by law, but rather reflected service providers’ ideas about what consumers could reasonably expect when using that particular health organisation. The need for such statements, making explicit often quite basic expectations that should be an automatic part of professional service provision, was perhaps indicative of the increased dehumanisation of service provision and the professional culture within health care organisations that has been

77. The National Health and Medical Research Council state “the main purpose of [clinical practice] guidelines is to achieve better health outcomes by improving the practice of health professionals and by better informing consumers about treatment options”, National Health and Medical Research Council, Guidelines for the Development and Implementation of Clinical Practice Guidelines, Quality of Care and Health Outcomes Committee, 1st Edition, AGPS, 1995, p2.

78. The revised CHASP standards include clear and more detailed criteria for complaints handling under the standard 5.3 entitled “Fair Investigation of Complaints”. Community Health Accreditation and Standards Project, Manual of Standards for Community and Other Primary Health Care Services, 3rd Edition, Australian Community Health Association, PO Box 657 Bondi Junction NSW, 1993, p36.
common place in the second half of this century. The statements were not necessarily well publicised and staff, as well as consumers, were often not aware of their existence; many statements were not much more than documents filed away in policy and procedures folders, out of sight and out of mind. (See ch8.2.3.) But by the end of the 1980s, the notion that consumers had rights was much more widely accepted amongst health service providers, and statements of rights had been revised and made visible within some organisations.

The development of statements of patients' rights has been closely linked with the idea that consumers needed to have better information about the different aspects of health service provision. This idea became more tenable as the, sometimes conflicting, reasons of the protection of consumers and the protection of the health service providers gained credence. Consumers needed better information about the health services provided so they could truly give informed consent. Health services needed to state more explicitly what services they offered so they could contain criticism arising from 'unreasonable' consumer expectations, and reduce the likelihood of becoming the subject of litigation, particularly as constricting budgets and strong demand for services meant that some forms of 'rationing' of services were likely. The more generous provision of information was also part of the newer public health strategies, aimed at promoting health, more effective use of health care and encouraging greater individual responsibility and action for improving health.

In the 1960s, attention to civil rights and consumer rights, compounded by dissatisfaction with health care practices and competition between health services in the United States of America had provided a climate that fostered the development of statements of patients' rights.79 (See ch4.2 and ch4.3.5.) Several of the most prestigious general hospitals in the USA developed their own statements of rights of patients and, by 1972, the American Hospital Association had adopted a twelve principle statement.

Although this list "seemed to contain little that was not already the legal and ethical responsibility of hospitals and health professionals" it reinforced the existing obligations on service providers to ensure that their practices met certain standards. It was recognised by some, though, that the statements alone offered little unless other mechanisms were also set in place capable of imposing sanctions when the conditions were not met. As well, and perhaps more importantly, a significant change amongst the professional health service provider culture was also necessary; statements of patients' rights "can only work if all medical personnel accept for themselves the professional ethical values inherent in the concept of patients' rights".

In Australia, professional and bureaucratic acceptance of statements of patients' rights was less forthcoming than in the USA. Some organisations did write their own statements of patients' rights and responsibilities, particularly as it became part of the accreditation requirements, but few consumers were involved in the process, and even regular users of the services were often unaware that the statements existed. The statements were sometimes included in the general information booklets about the service, but often these were only available in the bedside locker, not to be removed. The statements were highly variable in content, were often couched in passive terms, such as 'should be treated with' rather than the more definitive 'have the right to', and the points expressed were sometimes vague and ambiguous. Again the statements predominantly reflected little more that good professional etiquette, such as treating people with dignity and respect, and already well established legal rights, such as the assurance of confidentiality. The statements also frequently emphasised the responsibilities of the consumer using the service, such as agreeing to follow the instructions of the health service.

---

81. See for example Annas, p9, and W. Christian, "Protecting Clients' Rights in Mental Health Programs", *Administration in Mental Health*, vol.11, no.2, winter 1983, pp121-122. The role Christian proposed for his "human rights committee" seems to have been taken on by ethics committees and quality assurance committees in Australia.
82. Curran, p33.
provider. Even where the statements identified access to interpreter services as one of the rights, rarely were the statements available in languages other than English. The Task Force on Patients' Rights in South Australia, for example, found that, even though a directive from the South Australian Health Commission had been sent to all hospitals and health services several years earlier, in 1991 not all services had developed the recommended statements of patients' rights, and publicity and knowledge about the statements were limited.

By the early 1990s, the statements of consumers' rights proposed by health consumer groups, and the accreditation standards covering statements of patients' rights, provided new models for the locally generated statements of rights to follow. As discussed in chapter four, groups of consumers advocated vigorously for greater recognition of the rights of individuals in their interactions with health care systems. Many consumers were no longer prepared to unquestioning accept the professional advice offered, or that professional interests should be given priority. Explicit statements of consumers' rights were seen as fundamental to the provision of health services and to redress some of the imbalance in the consumer/service provider relationship, particularly for consumers with limited knowledge and choice. The vulnerability of consumers in the health care relationship had been highlighted in many different forums. Considerable effort went into identifying the most important elements for inclusion into the model statements of consumer rights. (See ch5.4.) In health services, such as the community health centres, where there was greater support for the idea of consumer involvement in health service


84. Discussions by service providers of the need for statements of patients' rights often fail to acknowledge the considerable service provider rights already well entrenched, often in law, for example through their professional status, clinical privileges, special industrial awards, peer review and registration boards.
provision, the elements of the consumer generated statements were more likely to be reflected in the organisations' statements of consumers' rights.  

The more recent government drafted patients' charters have provided the latest models of statements of consumer rights, but with a different emphasis to that of the statements developed by consumer groups. (See ch6.4.3.) Often developed for political ends and managerially driven, these statements tend to stress that services be provided in a courteous and efficient manner rather than emphasising respect and dignity; information provision and participation but at an individual service delivery level only; quality service; and maintenance of professional and administrative standards. Legislative changes have also occurred over the past decade that have helped reinforced the notion that consumers using health care services do have rights and can hold some expectations about what the encounter will entail. Reforms to mental health legislation in particular, an area of health service provision where abuse of rights has been most obvious, have often included more explicit statements of rights specifically relating to the provision of psychiatric treatment. Other health services legislation has included principles or broad statements about how health services should be provided, for example the various legislation establishing the health complaints mechanisms in some states/territories. (See ch7.5.) Informed consent and freedom of information legislation has also forced changes to practices, although not always to the advantage of consumers as already discussed.

85. See, for example, the pamphlet Know Your Health Rights given and discussed with all young people using the Second Story Community Youth Health Service, Adelaide. The pamphlet was produced in 1993 in consultation with young people using the service.

86. The Medicare Public Patients' Hospital Charter, for example, was developed by the Commonwealth Government in a bid to curb attempts by some state governments to restrict public health service provision, which may have resulted in a political backlash against the Commonwealth Government's universal health insurance scheme Medicare. Commonwealth Department of Human Services and Health, 1994. Public Patients' Hospital Charter: What you can expect under Medicare in Australian Public Hospitals, leaflet, Department of Health, Housing and Community Services, Canberra, February.
Health professional support for, and advocacy of, the statements of health consumers' rights have been mixed.87 The quality assurance and patient care committees, generally, have taken on the task of updating and reshaping their organisations' statements to bring them in line with the model statements, and taken a monitoring role in their implementation. But the concept of the statements has also been turned to furthering professional interests. For example, in response to restructuring and budget cuts to the public hospital system in Victoria, the Australian Nurses Federation (Victorian Branch) and the Australian Medical Association (Victorian Branch) combined to draw up a “charter of minimum standards of patient care” declaring that their members would be reporting incidents of unsatisfactory patient care attributed to these systemic changes.88 In another instance from Britain, reflecting a more cynical attitude towards the statements, a group of senior doctors demanded a “consultants’ charter” be implemented to stem the loss of their hospital privileges.89 Some health service providers have taken seriously the challenge, implicit in the statements, to tackle organisational and professional cultures and attitudes resistant to acceptance of consumers’ rights.90

The local generation of statements of patients’ rights did open up the area of complaints, despite the shortcomings of the statements. Most statements include the right to complain, and some go so far as to included information about who to contact. Because the statements outline information about what could be expected from the service, consumers are better able to gauge whether the service they receive matches this, already noted as important in decision making about whether to complain. As consumers become

87. For example, the Public Health Association of Australia, in its Policy Statements 1995, does not include a statement on health consumers’ rights, despite having policies and statements on numerous, often controversial, health issues.
89. The article, in the British Medical Journal noted details of the charter which included “to expect a professional lifestyle, and not to be expected to perform routinely tasks which were easily within the competence of less highly trained doctors or paramedical or nursing staff”. L. Beecham, “Meeting Calls for a Consultant’s Charter”, British Medical Journal, vol 308, 18 June 1994, p1644.
90. See for example the consumer consultancy project conducted at the Adelaide Medical Centre for Women and Children (later the Women’s and Children’s Hospital) reported in K. Alexander, People, Power and Professionals. Partners for Health, Adelaide Medical Centre for Women and Children, North Adelaide, May 1992.
The effectiveness of the statements will ultimately be determined by the impact on organisational culture and professional changes; when the rights are automatically accorded consumers in everyday practice, the statements will have achieved their purpose. Until this time statements of patients' rights will continue to be on the consumer agenda.

7.4.3 Complaints Liaison Officers

Some health organisations recognised the need to improve access to complaints procedures as part of their commitment to the statements of patients' rights. As already noted, the difficulties experienced by consumers wanting to make a complaint direct to the service provider or health care organisation concerned often seemed insurmountable. The idea of a Complaints Liaison Officer (CLO) working within the health service to assist individual consumers in upholding their rights and accessing complaints procedures was proposed. The creation of such a position had several advantages, particularly for larger organisations, by: providing a focus for complaints and complaints handling; helping to free senior clinical staff from the task; encouraging the earlier lodgement of complaints when resolution may be easier; and more comprehensive complaints data collection and

91. Numerous titles refer to positions with this function such as Patient Advocate, Patient Adviser and Patient Representative. The term Complaints Liaison Officer, coined in Victoria, has been chosen as the preferred title throughout this discussion because it most aptly reflects the major function of this position, that of liaison between the health service and consumer over a complaint.
In several of the largest hospitals in New South Wales, Victoria and South Australia, CLO positions were piloted in the late 1980s and, by the mid 1990s, the larger health organisations throughout Australia had increasingly come to accept the CLO as a necessary member of staff.

The role and functions of the CLO has become more clearly defined through the experiences of the positions over the years. By 1994, the CLO role was described as

"ensur[ing] that the rights and legitimate interests of patients and the hospital are protected by facilitating the resolution of complaints, and to use what is learned to improve the hospital’s service and image".93

The CLOs has primary responsibility for the handling of complaints within the organisation, which involves a wide range of tasks including assisting consumers in making a complaint; liaising with clinical staff; investigating the complaint; recommending policy and procedural changes; and reporting on the outcome to the relevant committee of the health service. Making explicit the links between patients’ rights and complaints handling has been an important part of the CLO’s job from their inception, and the CLOs have often been influential in the development of patients’ rights statements and the dissemination of this information to staff and consumers.94 In a similar way to other complaints handling mechanisms, the tasks taken on have been restricted by the resources available to the CLO, such as access to secretarial assistance and well located office space. As well, the CLO position may not be regarded as full time and exclusive of other, potentially conflicting, duties.

92. Of course it is not only consumers who may wish to complain about the hospital services and personnel. The idea of an ‘ombudsman’, located within the health organisation, to work across departments and hierarchies to resolve internal disputes and conflicts amongst staff and over administrative practices has become accepted in the USA. See for example M. Waxman, “A Non-litigational Approach to Conflict Resolution: The Medical Centre as a Model”, The Arbitration Journal, vol.42, no.1, March 1987, pp27-34.


The job of the CLO is not an easy one, treading a precarious path between clinical staff, administrators and complainants in trying to obtain resolution of complaints. Organisational factors often limited the CLO role. Without commitment of the senior executives to complaints resolution, and reporting responsibility to the Chief Executive Officer, the CLO is unlikely to be able to do much more than offer platitudes to complainants. The co-operation and goodwill of the clinical staff is necessary to be able to investigate complaints satisfactorily. The CLO also needs ready access to medical records, clinical and legal advice and preferably to be able to disclose certain information from the records to the complainant. If the organisation is to take seriously the information generated from complaints, indicating areas for change and improvements to services, the CLO needs to be able to promote this, through membership on the organisation’s patient care and quality assurance committees. These are not functions that could be performed by junior clerical staff, and the CLO position needs to be classified to reflect the seniority, knowledge and skills necessary. However, the above conditions have often not been met, and the CLOs have frequently not been accorded the status, or financial remuneration, commiserate with their responsibilities, consigning the CLO to little more that a basic public relations position.

To date, the Australian CLO model calls for the CLOs to be directly employed by and responsible to the specific health organisation. Although the CLOs have sometimes be seen by clinical staff to take the ‘side’ of the complainants, the CLO is not, and cannot, be a consumer advocate in the way envisaged by consumer groups. Organisational interests ultimately take precedence in the CLO’s work. An early American model suggested that independence from the organisation was fundamental to the success of such a position. In England and Wales, the Community Health Councils had often provided information, assistance and support to consumers wanting to make a complaint about the local health

95. Health Services Liaison Association, pp5-6.
Similarly, the Disability Complaints Service in South Australia offers advice and support to consumers wishing to make a complaint and advocates on the consumer’s behalf, but without the authority held by the Community Health Councils. Workers in the Disability Complaints Service also experience many of the same difficulties as consumers because, only with direct access to the health organisation’s staff and records can complaints be satisfactorily investigated and resolved. It is this ‘inside’ access to, and knowledge of, the many aspects of the organisation that is the strength of the CLO position. But the CLOs can also be personally vulnerable when criticising aspects of their organisation, particularly if powerful interests within the organisation are potentially threatened by the exposure. In the Australian context, whether this access and knowledge could be retained if the CLOs are employed by, and report to, another organisation within the health umbrella, such as the central health complaints units, is yet to be tested. Officers of some of the central health complaints unit already have considerable access to the records and staff of health organisations under the terms of the relevant legislation, but are not specifically allocated to work on site at particular health organisation or to become involved in activities, as a matter of course, that extend further than the investigation of individual complaints. The sensitive nature of complaints information suggests that organisations would be keen to keep this information ‘in house’ and would not necessarily welcome an ‘outside’ appointment, particularly as competitive tendering for the provision of health services gains pace. While it may be complaints information that provokes organisations to undertake reviews and reforms of particular aspects of their service, there may be reluctance to acknowledging this source, particularly to a critical external audience. The important ongoing influence of the CLO in changing the culture of the organisation in relation to complaints handling may also be reduced if the CLO is not seen as part of the organisational ‘team’.

The CLO positions have been an innovative mechanism to improve complaints handling at the local level, but the CLO role has been constrained by organisational factors from reaching their full potential in demonstrating considerable benefits for consumers and health service providers. A small satisfaction survey conducted by one CLO in SA revealed strong consumer support for the position, although approximately one third of the complainants did not think that a satisfactory outcome had been achieved for their complaint. Few consumers knew of this CLO’s existence until referred there after initially making a complaint to another staff member.98 The increasing prevalence of CLO positions in health service organisations does suggest that health organisations are beginning to take complaints handling more seriously, but in a similar way to the statements of patients’ rights, unless the CLOs are given sufficient resources, authority and recognition, they will remain little more than a public relations exercise. The renewed focus on the local handling of complaints may provide the impetus for health organisations to reconsider the potential benefits of an expanded CLO position.

Changes to complaints handling practices by health services had come incrementally and have been largely forced upon the organisations as a result of other factors, rather than an altruistic desire to improve the situation for consumers. Some health services have made serious attempts to improve their complaints handling practices by incorporating a number of the components of the combined consumer model for health complaints mechanisms, particularly increasing visibility and accessibility of the complaints service and updating written complaints handling policies and procedures. For many health services, though, devoting resources to complaints handling has not been a priority, and the piecemeal approach continues. Perhaps because attention has been diverted to the development of central complaints mechanisms, the importance of reform to local mechanisms has sometimes been dismissed as no longer necessary. But as the central systems struggle with increasing demand and limited resources, the need for viable,

98. Source: information provided to the author in the study described in chapter 8.
consumer friendly complaints handling processes at the local, health service provider level has again become clear.

7.5 **Central Health Complaints Handling Mechanisms**

While the handling of many health complaints was largely acknowledged as the province of professional registration boards and associations, it was common for Ministers of Health and the relevant health departments or statutory authorities to receive a steady stream of complaints, from the general public and interest groups, about various aspects of the health system and health care delivery, including the way the professional registration boards and associations dealt with matters. Sometimes, the more serious and persistent of the allegations eventually led to the establishment of public inquiries and royal commissions, particularly when the media coverage and accompanying public outcry were strong.\(^99\) The ability of health departments to effectively investigate and respond to complaints, and then to take action to prevent recurrences of the events, and the practices of the registration boards, were criticised not only by consumers who had tried to have complaints resolved, but also by other government agencies dealing with complaints, for example the Ombudsman and Consumer Affairs bureaus. A number of specific developments in the 1980s fostered an environment where, by the beginning of the 1990s, governments across Australia seemed set to take greater responsibility for involvement in the resolution of health complaints, through legislative and administrative reforms to health complaints handling at a central level.

The questionable objectivity of the advice provided to a Minister and the difficulties facing a Minister in calling to account public servants in their portfolios had led to widespread dissatisfaction with established processes and calls for the greater

---

accountability of government services discussed in the previous chapters. The usual processes used by government administrative bodies, when providing briefing notes and responses to Ministerial requests in regard to correspondence the Minister had received, often meant that the subject(s) of the complaint was/were called upon to draft the response.\textsuperscript{100} In the health departments, the influence of medical professionals, often in the most senior positions, had shaped the responses of the departments to health complaints. Keen to keep on side with their professional associations and not to incur the wrath of medical colleagues, the medical administrators had resisted departmental involvement in complaints that touched on issues of professional practice and judgement, seen as the appropriate responsibility of the registration boards, and referred such matters on. Instead, the health department officials dealt with complaints classified as relating to administrative issues such as the physical state of the hospitals and other administrative arrangements that more readily fitted with the mainstream work of the health departments. The handling of complaints was not necessarily undertaken by any particular officer, and was often added to an already full workload. Complaints were perceived as an unwelcome chore and the significant amount of time that was frequently needed to follow up complaints tended to be resented. Often, it was difficult to establish whose responsibility it was to attend to a complaint, particularly if the complaint involved several departments and issues, and it was easy for complaints to become ‘lost in the system’. Even when complaints had been the basis for a public inquiry, there was no assurance that action would follow from the recommendations of such inquiries.

The need for reform of the complaints handling processes of health departments had long been advocated by consumers and consumer groups. The establishment of the Offices of the Ombudsman, in the 1970s, had set precedents for the better handling of complaints about government services. However, health complaints, although often falling within the jurisdiction of the Ombudsman, were still considered to be more appropriately

\textsuperscript{100} This is still the case in many situations.
handled by health department officials and health professionals because of the perceived specialised and sensitive nature of the information connected to, and contained in, health complaints. The question then became what complaints handling mechanisms should be established by the health departments that could best deal with the complaints? From the evidence already presented in this thesis it should not be surprising that consumers, governments (politicians and administrators) and health professionals (particularly the medical profession) had differing ideas about the magnitude of the problems with existing health complaints mechanisms, and the appropriate responses needed. By examining the developments, that began during the 1980s, using the three states of New South Wales, Victoria, and South Australia as examples, the agendas of the different groups are evidenced by the influence these groups had on the proposals and solutions that were put in place for health complaints handling at a central level. For a brief period in the early 1990s, it seemed that there was sufficient convergence of the differing agendas to lead to significant reforms in health complaints handling. But the momentum for change was not to last, and the establishment of independent health complaints mechanisms, supported by legislation, across Australia has still only been partially achieved by early 1995.

7.5.1 New South Wales Health Department Complaints Unit

The Complaints Unit (CU), established by the NSW Health Department in January 1984, is generally acknowledged as the first complaints unit in Australia set up specifically to deal with health complaints.101 The CU did not arise from negotiation with either health professionals or consumers but from the directive of the NSW Minister for Health at the time, Mr Laurie Brereton:

101. This discussion draws heavily on the accounts of the establishment of the Complaints Unit provided by S. Donnelly, Making Doctors Accountable: An Examination of the Complaints Unit of the NSW Department of Health, Thesis submitted as partial requirement for the Master of Social Work, University of Sydney, March 1990, and the Royal Commission into Deep Sleep Therapy (NSW) 1990, Report of the Royal Commission into Deep Sleep Therapy, The Hon. Mr Acting Justice JP Slattery, AO, Royal Commissioner, Volume 8, The Departments -2, Ch9 “The Complaints Unit”, pp279-315. Justice Slattery pays tribute to the thoroughness of Donnelly’s research into the establishment of the Complaints Unit and both documents include extensive quotes from evidence presented by key players.
“The Minister directed the Chief Medical Officer: Dr Wells, on 4 Feb 1983, to establish a health complaints unit to deal with allegations of fraud, overservicing and malpractice as a matter of urgency within existing financial resources”.102

Appointed Minister for Health eighteen months earlier, distrust between Brereton and Health Department officials had contributed to Brereton’s concern about the lack of a structure within the Health Department to follow up complaints.103 Brereton was particularly concerned about the ability and willingness of Department officials to pursue allegations of fraud and overservicing in the public hospital system by their colleagues in the medical profession, and he envisaged the primary role for the CU would be to investigate such allegations. This was reflected in the composition of staff initially appointed to the CU, who included a seconded police officer and a lawyer. The investigative, adversarial role and primary focus on the public interest that the CU became renown, and criticised for, stems from this original role.

There had been earlier attempts to introduce more systematic complaints handling procedures within the NSW Health Commission, for example in 1977, but these efforts were largely ineffective or ignored, and were compounded by the regionalisation of services, with each region handling the complaints it received.104 Despite recommendations by the Health Advisory Committee of the time for greater involvement by head office in complaints handling, disparate systems continued to operate at the regional level. The medical profession, through the Australian Medical Association (AMA), had put forward a proposal for a Health Commission based Quality Assurance Committee, endorsed with statutory powers but professionally dominated, to handle some categories of health complaints but this was rejected as cutting across the work of the Consumer Claims Tribunal.105 However, the Department for Consumer Affairs, reporting an increase in complaints from the health area, was critical of the mechanisms available

102. Donnelly, p55.
103. In 1982, the Health Commission had been restructured back to a Health Department, a move perceived by many in the health area to greater centralised and political control over the health system.
104. Donnelly, pp48-49.
105. Donnelly, p57.
within the health sector to deal with these. Although there was genuine concern amongst some Health Department officials to improved procedures for complaints handling, this did not necessarily extend to the idea of setting up a unit or work team specifically dedicated to this purpose. The situation was further inflamed when a non medical person, Ms Phillipa Smith, was appointed as the first manager of the CU by the Minister, even though a medical appointee had already been announced.

Smith was influential in reorientating the CU to take notice of consumer concerns. She suggested terms of reference for the CU that reflected

"a much broader view of consumer perspective as opposed to the criminal view, a consumer perspective of complaints, and to look at broader issues of quality of care, matters of administration and matters of policy, as they affected consumers and the way that was taken". 106

About her appointment Smith said

"I came with a strong consumer perspective and credibility from amongst a broad range of consumer groups, that if a complaint was lodged with the Complaints Unit it would be dealt with sympathetically and seriously and not somehow discounted". 107

This strong concern for the consumers' position was repeatedly criticised over the years by medical groups such as the AMA. 108 However, although consumer groups, for example the Medical Consumers' Association (New South Wales) and the Australian Consumers' Association, had been advocating and lobbying for changes to health complaints handling for some years, they were not consulted when the CU was finally announced.

There was vigorous opposition to the idea of a specialist complaints unit from medical groups, who had not been consulted either on the proposal or included in its establishment. 109 It was claimed that there was no need for such a unit, and that the

107. Smith cited in the Report of the Royal Commission into Deep Sleep Therapy, p303. Ms Smith later became the first Chair of the Consumers' Health Forum, and is currently the Commonwealth Ombudsman.
108. For example, as recently as 1993, the Secretary of the NSW AMA, Dr M. Nicholson, in supporting suggestions for reductions in the power of the CU, commented "it (the CU) has been formed on the grounds that when complaints are made the health care provider is always wrong". H. Wiseman, "Power Cut Proposed for Complaints Unit", Australian Doctor, 8 October, 1993, pp1-2.
109. See Donnelly for quotations from local papers at the time. Donnelly, p56.
existing legal avenues provided sufficient mechanisms for consumers to air their grievances. The medical profession was particularly wary of any moves by government that might result in greater control over, or increased regulation of, the profession by bodies outside the profession. The situation between the Minister, the Health Department and the medical profession was already tense as the Minister had challenged the autonomy of the health system with the restructuring of the statutory authority, the NSW Health Commission, into a government department the previous year and proceeded to introduce “a series of rationalisation measures within the State’s hospital sector”.\footnote{113} Added to this, at the Federal level, a Labor government was returned with a majority in March 1983, whose stated policy was to reintroduce a universal national health insurance type scheme within the first twelve months of office. By July, the Commonwealth and State Health Ministers had agreed on substantial amendments to the Health Insurance Act 1973 creating the Medicare scheme, including amendments to Section 17 that made payments of medical benefits for services to private patients in public hospitals contingent on certain conditions.\footnote{111} Opposition from the medical profession to the Section 17 amendments in particular, which were seen by the doctors as conferring too much power on the Federal Minister, led to an intense dispute between the AMA, representing the medical profession, and the Federal government during the last months of 1983 and well into 1984. While the dispute was largely contained at the Federal level on the establishment of the Committee of Inquiry into Rights of Private Practice, in NSW the dispute escalated with hospital specialists threatening, and some finally taking, industrial action.\footnote{112} A number of visiting medical specialists resigned from their public hospital posts (the ‘NSW Doctors’ Strike’) creating a shortage of specialist services in some areas of the public hospital system and raising concern about the availability and quality of care that public patients could

\footnote{110. Backhouse, pp157-8.} \footnote{111. Committee of Inquiry into Rights of Private Practice, pp1-4.} \footnote{112. This was known as the Pennington Inquiry. For a detailed analysis of events see Backhouse, pp156-197.}
expect. As the doctors’ strike continued public support for the doctors’ actions wanned as the major issues were increasingly perceived as relating to financial self interest. The still new CU was a useful mechanism for the Minister to demonstrate to the public that the government was taking action to increase the accountability of the medical profession, and ensured ministerial support for the CU, even after a change of Minister.  

Initially the CU was not necessarily able to offer a new process for handling complaints, even though it was a new unit with a non-medical manager, and, in many respects, the old system of referring the majority of complaints back to the regions for handling continued. The small staff and volume of work (80-180 complaints a month in the first year) made this necessary for survival rather than the preferred option, in the same way as had happened with the Offices of the Ombudsman. The new team set its priorities as the investigation of complaints that seemed to be of a serious nature, that would set precedents or have a demonstration effect, and made by particularly vulnerable complainants. The move away from the previous “administrative” approach to complaints handling to an “investigative” approach evolved over the early years, but was accelerated by the complaints relating to Chelmsford Hospital, a private hospital where a number of people had died soon after receiving ‘deep sleep’ treatment for psychiatric conditions. By 1984, the investigation of the Chelmsford deaths were beginning to dominate the work of the CU and extra staff were seconded to the CU for that purpose. The police presence in the CU led to other staff gaining much needed skills in investigative processes in the initial period. However, the secondment of police officers was ceased in mid 1985 because of tension created by the police focus on detection of criminal

114. Donnelly, pp60-61.
116. The handling of the various complaints relating to Chelmsford hospital doctors and treatment by the NSW Health Department eventually became the subject of a Royal Commission inquiry, the Royal Commission into Deep Sleep Therapy.
117. Donnelly, p62.
offences and other difficulties in terms of line supervision and work direction. The move to more comprehensive assessment of complaints, rather than purely relying on regional responses, was precipitated by an investigation of the CU’s procedures by the NSW Ombudsman in 1985. Donnelly argues that, gradually, over the first five years of operation the CU’s credibility with the Health Department, the medical profession and the public grew through a series of high profile investigations of complaints by the CU.

The CU remained an administrative unit within the NSW Health Department. While the original proposal had been for an independent unit reporting directly to the Minister, this was deemed unworkable (and potentially uncontrollable) by Health Department officials and a compromise was agreed to whereby the Manager reported through the Deputy Secretary to the Secretary of the Health Department, rather than the Chief Medical Officer. This changed in later years, with further restructuring of the Department, and the Director of the CU began reporting directly to the Minister for Health (and other relevant Ministers), only reporting to the Director General of the NSW Health Department for administrative matters. Smith had argued for, and won, inclusion in the Executive Committee of the Department during her time as Manager, but there was still criticism that insufficient structures had been developed to feed complaints information back into the policy and standards development processes of the Department. From the beginning, the CU could pursue matters relating to private practitioners, as long as the approval of the Health Department Secretary had been given. As well, the CU could pursue matters without the lodgement of a formal complaint if it was considered of sufficient importance to the public interest. The CU’s authority came from the delegated statutory powers of the Director-General of the NSW Health Department, delegated to the

---

Director of the CU. The registration acts of the health professions in the state were gradually amended to give the investigatory function for complaints to the CU, for example amendments to the *Medical Practitioners Act 1987*.  

With the strategic support of the different Ministers for Health, the CU managed to achieve a considerable degree of independence in its operations and flexibility with regard to its role. But the CU lacked its own legislative base. This placed the CU in a precarious position, reliant on Ministerial patronage and unable to take on other functions, such as formal conciliation, that were increasingly seen as necessary for the effective operation of a complaints body. The change of state government in 1988 did not bring about the immediate demise of the CU as some health professionals had predicted. Although the medical profession had strong links with the Liberal/National Coalition government, the new Minister for Health ordered an independent review of the CU’s operations by external consultants. The Review, critical of a number of aspects of the CU’s operation, did acknowledge the difficulty of operating without a statutory base and proposed the introduction of a formal conciliation function that would require legislation. In 1990 these recommendations were overshadowed by the numerous detailed recommendations about the role and function of the CU contained in the *Report of the Royal Commission into Deep-Sleep Therapy*, including the recommendation that a complaints commission be established as a statutory authority, completely independent from the Health Department. By this time there was considerable interest in health complaints units by governments across Australia, and the Victorian Health Services Commissioner provided a new model with statutory powers and a formal conciliation function. (See following section.) In the 1990 Annual Report of the CU, both the Minister for Health and Director of the CU

121. Donnelly, p58; Consumers’ Health Forum of Australia, p16.  
122. The CU provided a form of conciliation but did not have the legal protection necessary for proceedings to be regarded as truly confidential and privileged.  
foreshadowed the introduction of legislation providing a statutory base for the CU’s functions.124

By 1990, the volume of work had again forced the CU to review its procedures, with over 3,700 enquires and complaints in that year, and a preliminary inquiry section was set up to “screen all complaints with the intention of culling those complaints which can be resolved directly by the parties”.125 This change coincided with the prevailing political agendas advocating the reduced role for government agencies discussed in the previous chapters. Formal complaints, requested in writing, lodged with the CU requiring investigation had reached 1,373 in 1990. Complaints about individual practitioners accounted for 58% of the total, 79% of these were complaints about medical practitioners, and 41% of the total complaints involved complaints about hospitals and institutions, 61% of which related to public hospitals. The largest category of complaints related to treatment received (45% of total complaints listed under 20 categories) followed by professional conduct (8% of total), incorrect diagnosis (7% of total) and communication (7% of total).126 While this picture of types and categories of complaints remained similar over the next few years, the total number of complaints investigated increased to 1,783 in 1992/3, before falling the following year to 1,475. This decline was attributed to the Area and District Health Services again taking a greater role in the resolution of complaints at the local level.127

Forty of the 187 substantiated complaints in 1990 had resulted in disciplinary action.128 However, it was not the CU that decided on the disciplinary action to be taken but the disciplinary tribunal or professional standards committee of the relevant

128. For comparison, of the 754 investigated complaints finalised in 1990, 179 (24%) were terminated, 299 (40%) not substantiated and 147 (20%) substantiated but no action taken. Complaints Unit, Annual Report 1990, pp3-4.
professional registration board under the terms of the various registration acts. Despite a common perception that the CU had this power, the CU had always clearly stated

"the investigation carried out by the Complaints Unit is FACT FINDING, not disciplinary in nature. The task of the investigation is to establish whether there is sufficient evidence to substantiate the complaint and whether the complaint is sufficiently serious to be referred to a professional review body".129

Even though the investigation of complaints was undertaken by an independent body ultimately it rested with health professionals to determine what action would be taken, reviewing their peers' practices in terms of predominantly professionally derived standards of practice and care. The Medical Tribunal, for example, took disciplinary action in 1990 against 15 medical practitioners in NSW, including removal of names from the medical register, suspension of practice for several months, and restricting practice.130 The CU was able to become the nominal complainant in the disciplinary hearings, with the original complainant (consumer) becoming a witness for the prosecution, thereby relieving the consumer of the responsibility and potential and real costs involved, particularly if action led to further appeals, in a similar way to the process used in the consumer affairs area. (See ch6.5)

Consumer groups, by the early 1990s, were critical of other aspects of the CU's operation: the lack of focus on improving local complaints mechanisms; the non availability of local advocates to assist consumers when trying to make or resolve a complaint direct with service providers; the inability to provide financial redress; and the lack of an independent statutory base, all essential components of the combined consumer model for health complaints mechanisms. Consumer expectations that, in response to their complaint, the CU would be able to order some punitive action were misplaced. The emphasis of the CU's work on investigating breaches of professional standards, rather than

129. NSW Health Department Health, Complaints Unit, Information Sheet for Health Professionals, The Complaints Unit, Level 5, 28-36 Foveaux St, Surrey Hills NSW, July 1991, original emphasis. Similar wording is found in the Complaints Units Information Sheets Witness Information Sheet and What Happens When a Complaint is Made Against You.
transgressions of individual consumers’ rights, added to consumer frustration with the process. The investigative process was often lengthy, out of the consumers hands, and only occasionally led to prosecution of the service provider or change within the system.\textsuperscript{131} The CU did demonstrate several of the components of the combined model for consumer health complaints mechanisms: visibility and accessibility of the CU were comparatively high; private providers were also included; internal CU policies and procedures were fully developed and written; an appeals body existed; and a Consumer Advisory Committee to the CU had been formed in 1988, comprising representatives from the major consumer groups. But there seemed to be few ongoing mechanisms to assess and evaluate consumer satisfaction with the CU’s procedures.\textsuperscript{132} In fact, there had been a steady stream of complaints about the CU’s procedures to various other bodies, such as the Ombudsman, over the years. Although, from reporting of these events in the CU’s Annual Reports, it is unclear whether the complaints originated from consumers or service providers.

In late 1992, the Minister for Health introduced the new Health Care Complaints Bill (1992) into the NSW Parliament. The objects of the new Bill were:

- to facilitate the maintenance of standards of health services in NSW;
- to promote the rights of clients in the NSW health system by providing clear and easily accessible mechanisms for the resolution of complaints;
- to facilitate the dissemination of information about clients’ rights throughout the health system;
- to provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration acts.\textsuperscript{133}

The Bill outlined the establishment of two new statutory authorities, the Health Care Complaints Commission (HCCC), to replace the CU, and a Health Conciliation Registry, to provide a conciliation service for complaints referred by the Commission.

\begin{flushleft}
\textsuperscript{132} Consumers’ Health Forum of Australia, p20.
\textsuperscript{133} \textit{Health Care Complaints Bill 1992} (first print), New South Wales, pp2. The objects remained unchanged in the amended Bill that became the Act.
\end{flushleft}
needed to be lodged as a statutory declaration to be investigated, and automatic notification of the complaints was to be made to the relevant health professional registration authority.

The legislative authority for the CU would be achieved but the new Bill included other shifts in emphasis from the perspectives of consumers. Although the Minister stated, in his speech introducing the Bill to Parliament, that there had been wide consultation with a variety of relevant groups during the drafting of the Bill, a number of consumer groups found themselves in the difficult position of not being able to give unconditional support to the Bill.\(^\text{134}\) Some of the consumer concerns about the proposed Bill included potential bias favouring the health professionals; the extensive screening of complaints reducing the number finally investigated; the potential for coercive use of conciliation; the relationship of the Commission to the Health Department; and the accountability of the Commission’s work.\(^\text{135}\) The consumer groups were not united in their criticisms of the Bill and it took a succession of meetings to finally gain consensus and a unified consumer position on a series of recommendations for amendments.\(^\text{136}\) Important changes were made to the Bill, for example to broaden the accountability of the HCCC, provision was made for the establishment of a Parliamentary Joint Committee, the Committee on the Health Care Complaints Commission, to monitor and review the work of the Commission (but not in relation to individual complaints). Perhaps because of the disastrous findings of the Royal Commission into Deep Sleep Therapy exposing the inability of the medical profession to take action against its members in that situation, the medical profession did not mount a major media campaign opposing the legislation.\(^\text{137}\) The Bill was finally passed in


\(^{136}\) Petrie, pp.23-24; publications specifically for the medical profession, such as the *Australian Doctor*, did however maintain a running commentary of criticism of the Complaints Unit and proposed changes throughout this time.
November 1993, and the HCCC and the Health Conciliation Registry commenced operation in July 1994. The caution in introducing new legislation mandating greater government intervention in the current political climate was reflected by building into the legislation a review of the validity of policy objectives and terms of the Act, with the outcome of the review to be presented to both Houses of the NSW Parliament by December 1998. The Health Care Complaints Commission Act 1993 was not the only legislation to do with complaints systems before the NSW Parliament that year. The Community Services (Complaints, Appeals and Monitoring) Bill 1993 was introduced to establish a statutory based complaints system for the community service area, under the authority of a Commissioner for Community Services, and covering all agencies and projects funded through the Community Services Department, as well as the Department’s own services. This legislation, also passed in the second half of 1993, went further than the HCCC Act by including other alternative dispute resolution methods, as well as conciliation, and made provision for representative action (similar to the notion of class action) in dealing with complaints.

The small administrative unit that began with a directive of a Minister had grown, survived review and criticism, to finally emerge as a statutory authority enshrined in legislation. The CU had been established at a time when the political arm of government, the Minister for Health, was seeking greater control over, and accountability of, government spending on health services and the health bureaucracy. The CU was seen to provide a mechanism to further this agenda and fitted comfortably with the new corporate management style emphasising accountability through outcomes. The influence of the first Manager helped to introduce a consumer perspective into an arena that was largely dominated by the interests of health service providers and health bureaucracies, particularly the medical profession. The medical profession saw the CU as a potential attack on the autonomy of the profession, and strongly criticised the CU’s approach to complaints handling, which they perceived to be biased towards trying to find evidence to prosecute
rather than resolve the complaint between consumer and service provider. The need for an independent CU was continually questioned as the majority of complaints made were considered of little consequence by the medical profession because the actions of the doctor did not constitute major professional misconduct or negligence as interpreted by the profession. 138 The Director, Ms Merrilyn Walton, in the final Annual Report of the CU commented that it

"ends an era during which the Complaints Unit was involved in heated debate with the medical profession. The Complaints Unit’s role in the debate centred on the public interest in having an independent mechanism for consumers to resolve their complaints. At times this was interpreted by some sections of the medical profession as ‘doctor bashing’." 139

Consumer groups have not necessarily found the CU to work in their favour and also have been critical of the CU: “its [the CU’s] near exclusive focus on the public interest... occurred at the expense of protecting and defending individual consumer rights” 140

While a focus on “clients rights” is clearly stated in the objects of the new Health Care Complaints Commission Act 1993, the detail of the Act, and the previous history of complaint handling in NSW, would suggest that the interpretation of rights is likely to continue to be in terms of standards of professional conduct and care. One consumer group has gone so far as to say “the Medical Consumers Association [NSW] feels that complaints commissions cannot offer a rapid way for consumers to get action, information or justice”. 141 In NSW, the agenda for the development of complaint systems had not been primarily about giving individual consumers a voice but instead calling to account health service providers in the public interest. Under the new legislation this is likely to continue.

---

138. For example, when an increase in complaints against doctors has been reported, the AMA, NSW Branch responded by calling for a “cost/benefit analysis” of the CU “to see whether it is worth the cost to run the service when the yield is so small in terms of serious problems”, H. Wiseman, “Complaints about NSW Doctors Rise”, Australian Doctor, 15 October 1993, p2.
140. Consumers’ Health Forum of Australia, p20.
The passing of the *Health Services (Conciliation and Review) Act 1987* by the Parliament of Victoria in 1987 was the result of quite a different process from the NSW experience. This Act was the first of its kind in Australia and provided a legislative base for an independent health complaints mechanism to be established under the authority of the Health Services Commissioner. The first steps had been taken some years earlier when, in 1982, the Social Development Committee of the Victorian Parliament began an investigation into complaints mechanisms in health care. The recommendations of this Inquiry, and persistent lobbying by the Health Issues Centre (HIC), an advocacy organisation specifically formed to put forward consumer perspectives in health debates, had placed the notion of a central complaints mechanism with statutory independence on the political agenda in Victoria by the mid 1980s.142

The Social Development Committee, a joint house all party Committee of the Victorian Parliament, had a mandate to inquire into and report on any matters concerning the lives and welfare of the citizens of Victoria and to make recommendations about the role of the Victorian government in such matters. The Committee investigated a range of topical issues including road accidents, therapeutic goods, alternative medicine and the health food industry. In 1982, the Committee took up the issue of complaints handling in the health area, conducting an inquiry which spanned two years before the final report was tabled in the Victorian Parliament in September 1984. In an attempt to increase consumer input into the Inquiry, the Committee held a phone-in, as well as calling for written submissions; over eight hundred calls were received over a three day period. The final report presented a picture of confusing and inadequate processes in the handling of complaints in the health area, with many gaps and little likelihood of satisfactory resolution.

---

142. The role played by the Health Issues Centre (HIC), has already been detailed in the discussion of the HIC's approach to complaints mechanisms. See chapter five.
of complaints, as far as consumers were concerned.\textsuperscript{143} The Committee recommended that a comprehensive multifaceted approach was needed to address the complexity of issues in handling complaints in the health area. Although the Interim report had included a recommendation for the establishment of an independent health complaints authority, in the final report this had been modified to the idea of a health services complaints office, located within the Ministry for Health, and able to take on preliminary investigation, conciliation and telephone advice functions.\textsuperscript{144} The Committee also recommended a major review of the functions and processes of health practitioner registrations boards, and extending membership of the Boards, or at least the sub committees responsible for dealing with complaints, to include consumer representatives. At the local level, the Committee recommended that all health services and hospitals identify a staff member responsible for handling complaints within their organisation and for greater consistency in complaints data collection methods across health organisations.

The Cain Labor government in Victoria, elected two years earlier, had come to office with a broad reform agenda for a number of areas of government; in the health area “its reform agenda was imbued with sentiments of ‘community’, ‘participation’ and a sympathy for consumer rights in health”.\textsuperscript{145} Several contentious reforms, such as regionalisation and the establishment of the district health councils, had been implemented in the first term in office by the Minister for Health.\textsuperscript{146} With a state election out of the way early in 1985 in which Labor retained office, several steps were taken to initiate action on


\textsuperscript{144} Parliament of Victoria, Social Development Committee, \textit{Interim Report on Complaints Procedures against Health Services}, Government Printer, Melbourne, 1983; and \textit{Final Report on Complaints Procedures against Health Services}.


\textsuperscript{146} The intention behind the district health councils (DHCs) was to provide a mechanism to enable greater consumer representation and participation in health service planning. Although never reaching the full potential originally envisaged for them, the DHCs did succeed in providing a mechanism for increasing consumer participation in health service planning. However, the DHCs did not escape the cuts and restructuring of the Victorian Liberal government in the early 1990s and were defunded. A new organisation Consumer Health Voice Inc, established in May 1993, took over some of their functions.
the recommendations of the Social Development Committee Report by the newly appointed Minister for Health, Mr David White: a Health Commission officer was appointed to draft the government’s response to the recommendations, another officer was given the task of developing complaints procedures within the Commission, all health units were instructed to identify a ‘Complaints Liaison Officer’ within their organisation and the review of the registration of health practitioners was set up. The Minister’s proposal for a revamped health complaints system in Victoria, released several months later, outlined the plan to establish an independent health complaints office and legislation to support this, a health complaints information service and a complaints advisory committee to monitor the new system. The Minister seems to have responded favourably to lobbying from the new consumer advocacy Health Issues Centre (HIC) on the issue of health complaint mechanisms, as representatives from HIC were included on the Health Complaints Implementation Task Force, established in late 1985, to oversee the implementation of the proposal. Apart from the HIC representatives, this Task Force was comprised of predominantly Health Department Victoria officials, although an advisory committee, with broader government and professional representation, was also formed to “act as a sounding board” for the Task Force.

Meanwhile funding had been approved for HIC to establish Health CALL, a telephone advisory line to provide advice and referral information for health consumers wanting to make a complaint. This service, established early in 1986, continued until the Health Services Commissioner’s office became operational in 1988. Health CALL received 1,585 calls in the first six months, 1,176 of which were categorised as complaints.

149. The positive dialogue that had developed between the Minister and the HIC was also indicated by the Minister of Health officially launching the HIC in September 1985. “Health Launch”, Health Action, September/October 1985, pp3-4.
150. This group included representatives from the Medical and Dental Boards, the hospitals, other Ministries such as Consumer Affairs, and the Victorian Law Reform Commission. G. Ednie, “Complaints Procedures Moving”, Health Action, November/December 1985, pp22-23. The Health Commission Victoria was restructured into the Health Department Victoria in August 1985.
In a similar pattern to the NSW experience, almost 60% of the complaints involved doctors or hospitals, although there were a greater number of complaints about the private health care system, particularly in regard to fees.\(^{152}\) While the role of Health CALL was to inform and advise consumers of their rights and how to complain, existing complaints procedures were criticised and recommendations for improvements made. Interactions with service providers, however, were not necessarily as positive as they were with consumers and, even three years after Health CALL had ceased operation, the name still held negative connotations for some service providers.\(^{153}\)

In early 1986, a discussion paper and draft legislation were released, with the legislation scheduled for tabling in the Victorian Parliament in the Autumn session. The Bill made provision for the establishment of a Health Services Complaints Office, and outlined the powers that would be accorded to the Office to conciliate and investigate complaints. Extensive opposition from the Australian Medical Association (Victorian Branch) and the Liberal Opposition, holding the balance of power in the Legislative Council and who demanded a fuller consultative process be conducted, prevented the tabling of the Bill in Parliament for a further six months. The AMA conducted an intense campaign to discredit the legislation, stating their opposition to the Bill through media reports, their own publications and direct mailing to doctors generally. The Health Services Complaints Office was described by AMA publicity as "health policing machinery" and it was claimed that sufficient need for such a service had not been demonstrated.\(^{154}\) In response, HIC and other community groups also conducted a campaign to rally public support for the Bill and over three hundred submissions were received. During this time the draft Bill, developed by the Task Force, was considerably

\(^{152}\) Health: Complaints Advisory Link Line Newsletter, Health: C.A.L.L. 3rd Floor 148 Lonsdale st Melbourne, December 1986. For further discussion of HealthCall see ch5.2.


\(^{154}\) P. Lynch, "Health Service Complaints Legislation", President of the Doctors Reform Society (Victoria) reported in Health Issues, May/June 1986, pp4-6; Murphy p182.
altered and a new Steering Committee set up to finalise the redrafting; the differences in the final draft from the original draft revealed the extent of concessions made to the service provider lobby. Gone were mention of the word ‘complaint’ from the title of the legislation and the title of the Commissioner, now the rather innocuous Health Services Commissioner, guiding principles replaced users’ reasonable expectations, the relationship between the health practitioner registration boards and the Commissioner was ill defined and the continuation of the legislation was contingent on a three year review (“the sunset clause”). Finally tabled in December 1986, the Parliamentary debate on the Bill was deferred until the Autumn session in 1987 when it was passed. The Office of the Health Services Commissioner commenced in March 1988.

Consumer issues and consumer rights in the health area had been highlighted in other legislation before the Victorian Parliament around this time adding to the momentum to finally legislate in the area of health complaints. For example, mental health legislation, passed in 1985, had included reference to consumer rights and the Health Services Bill introduced in 1987, allowed for the appointment of community residential services visitors who could inquire into the living conditions and well being of residents in hospitals or services. Another inquiry of the Social Development Committee, the Inquiry into Alternative Medicine and the Health Food Industry, had reported in 1986 and recommended that complaints against practitioners of alternative medicine also be covered by the proposed Health Services Complaints Office. As well, the interim report of the Review of Registration for Health Practitioners in Victoria, released in November 1987, made a number of recommendations to alter the system, such as the reconceptualisation of registration of health practitioners to reflect the advantage to the public interest rather than

professional interests, for greater community representation on the registration boards, and the need to improve complaints handling procedures by the registration boards.\textsuperscript{158}

The Health Services (Conciliation and Review) Act 1987 was a significant step in the handling of health complaints in Australia, despite the dilution of the originally strong consumer orientation. The Act covered all health care services in Victoria, public or private. The stated purpose of the Act is

\begin{quote}
(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 and
(c) to set out the functions and powers of the Health Services Commissioner".\textsuperscript{159}
\end{quote}

The preamble to the Act outlines a set of guiding principles that includes such terms as “respect for privacy and dignity”, “provision of adequate information” and “participation in decision making affecting individual care”. Although not a statement of consumer rights, the principles do convey a sense of the need for greater consideration of consumers by health service providers and gives the Health Services Commissioner a legitimate role in pursing these issues. The idea of enhancing quality of health service provision is compatible with the newer managerial and professional notions of quality and quality assurance already discussed. The stated emphasis on resolution of complaints at the local level as the first step, and the inclusion of formal conciliation processes, made for a picture of a more conciliatory model of complaints handling than that used by the Complaints Unit in NSW at the time. The Commissioner, though, is not able to be the complainant for cases before registration boards, or able to initiate investigations without a complaint. As well, the Commissioner can not accept the complaint if the matter is already before a court, tribunal or registration board. In a similar way to the Ombudsman, the Commissioner has


\textsuperscript{159} Parliament of Victoria, Health Services (Conciliation and Review) Act 1987, reprint with amendments 1993, s1. p2.

Page 378
powers to compel attendance and apply for warrants to enter premises and view records, but also has no real powers to adjudicate on a complaint or enforce recommendations made as an outcome of an investigation. As the first legislation of its kind in Australia, the Victorian *Health Services (Conciliation and Review) Act 1987* provided a model that other states/territories have been able to build on in drafting their respective health complaints legislation. Many of the essential components of the combined consumer model for health complaints mechanisms can be identified in the Victorian model.

The first Commissioner, Dr Ian Siggins, played a crucial role in the establishment of, and gaining support for, the new Office of the Health Service Commissioner.\(^{160}\) Described as taking a “responsible and sensitive approach”, Siggins gained a profile for the Office through participation in regular radio interviews and numerous meetings and forums.\(^{161}\) Despite the initial strong opposition from service providers, a survey conducted during the evaluation of the Act in 1990, revealed a high level of support and acceptance for the work of the Office by consumers and service providers who had contact with the Office.\(^{162}\) In fact, service providers expressed greater satisfaction with the outcomes achieved than did the service users who had made complaints. Consumer groups, while supportive overall of the Act, continued to raise concerns about the limitations of the Act from a consumer perspective; for example the limited role of the Commissioner in complaints proceedings of the registration boards and the sunset clause; and the missing essential components of the combined consumer model, such as the lack of provision for consumer advocates.\(^{163}\) The report of the evaluation concluded that the implementation of the Act had “proved both effective and popular”, recommended the repeal of the sunset

---

160. Dr Siggins left the position in 1992 to set up the new Health Rights Commission in Queensland under legislation that extended the Victorian approach.


162. Keys Young, pp54-55.

clause and several other amendments, most specifically in regard to clarification of the relationship between the Commissioner and the registration boards.164 The Act was amended accordingly. However, the work of the Office had not proceeded without difficulty; the Commissioner’s budget line was still within the Health Department Victoria and the Commissioner experienced similar constraints, through insufficient resourcing and staffing issues, to those reported by the Ombudsmen.165 (See ch6.3.1.) From 1989, the Office had also taken over the handling of complaints about residential care and accommodation, previously managed by another section of Health Department Victoria, adding to the workload.

In the first two years of operation, the Office of the Health Services Commissioner dealt with 6,324 inquiries and complaints of which 43% (2,739) were classified as complaints.166 In line with the provisions of the Act, the Office had, as a first step, referred the complainant back to the point of service for resolution and over 45% of complaints had been finalised in this way, and a further 19% resolved during the initial assessment process in the first twenty four months of operation. The number of registered complaints rose to a peak of 2,063 in 1991 (with 6,881 calls received) before falling to 1,391 (with 6,186 calls received) in 1993. The Health Services Commissioner attributed this decline in calls leading to registered complaints to a more rigorous definition of complaints, and to “less serious complaints being more easily resolved by providers directly, as they improve their accessibility to consumers”, but she goes on to note that there had been “an increase in the complexity and seriousness of registered complaints”.167 The Office developed a five point scale of seriousness of complaints ranging from trivial through minor, routine, and substantial to serious. In 1993, over 600 complaints were rated as routine, a further 400 as substantial and just under 200 as serious on this scale.168 In the same year, just under two
thirds of the registered complaints were resolved through referral back to the point of service or during the assessment phase. Of the six main categories used by the Office, in 1993, 48% of complaints were categorised as relating to treatment issues, 15% to communication issues, 13% to rights issues, 11% to access issues, 10% to cost of treatment and 3% to administrative issues. Complaints relating to treatment issues have consistently been the highest proportion of all registered complaints made to the Office, a similar picture to the experience of the Complaints Unit in NSW. Medical practitioners (41% in 1993/94) and public hospitals (36% in 1993/94) were also the most complained about health service providers and services.169

One of the features of the Victorian legislation was the establishment of a conciliation process in which proceedings were confidential and privileged, that is evidence presented could not be used in another court of law or reported elsewhere. Requiring the voluntary agreement of the complainant and the person/organisation named in the complaint, the aim of the conciliation process is to reach an agreement that it seen to resolve the complaint. Although both parties are not represented, the complexity of some issues has required the involvement of third parties in the conciliation process, such as insurers and the advice of relevant ‘experts’. The conciliator provides a confidential report to the Commissioner, the complainant and provider on any agreement reached, or alternatively advises that the dispute cannot be resolved through the conciliation process and may recommend that the Commissioner should or should not investigate the complaint. About half the conciliation agreements in recent years have included compensation payments to the complainant.170 On average over the years, only about 8% of the total number of complaints have been referred for conciliation, despite the emphasis placed on the use of conciliation in the Act. The high percentage of complaints resolved during assessment, the need for both parties to voluntarily agree to the process and the

unsuitability of the conciliation process to resolution of some complaints have all mitigated against the more extensive use of conciliation. From a consumer perspective, there are some significant limitations to the use of conciliation. Lulled into a false sense of informality about the process, the complainant may be at a serious disadvantage, without the benefit of advice from a lawyer or advocate, and in a weaker bargaining position compared to the service provider, in a similar way to that described in relation to administrative appeals tribunals. (See ch6.3.2.) In 1990, the Keys Young review had found that, although complainants supported the conciliation process, over 40% did not think that their problem had been cleared up and, not surprisingly, a similar percentage were fairly or very dissatisfied with the outcome. The conciliation process does not allow for the broader issues arising from conciliated complaints to be pursued or revealed for greater public or professional scrutiny and action.

Another feature of the Victorian legislation was the specific link to reviewing and improving the quality of health service provision. In line with this provision, the Health Services Commissioner was assigned the task of chairing the review of the Medical Practitioners Act. Concluded in 1991, the review made recommendations for revised legislation to include “better definitions, enhanced investigative and hearing structures, and more flexible sanctions”. Earlier amendments to the Act had resulted in a broadening of the Medical Board membership to include a community representative and a lawyer. Ongoing dialogue between the Office of the Commissioner and the registration boards helped to ensure that complaints involving issues of professional misconduct did not become entrapped between the different bodies, and, although the Commissioner could not be the complainant, the Commissioner could (and did) attend registration board proceedings as an impartial observer in some instances. The Commissioner has used the

annual report as a means to highlight instances where individual complaints have led to broader systems policy and/or procedural changes. However, perhaps because of the pressure of dealing with new complaints, the Commissioner does not report taking an active role in ensuring that changes made are sustained over the longer term. Data on complaints received and complaints handling at the local level, collected by the Complaints Liaison Officers in the hospitals and health services, have been provided to the Office, but a lack of uniformity in coding and ambiguity in interpretation of the reporting form supplied by the Office, limited the use of the data for informing systemic change.¹⁷⁶

The Health Services (Conciliation and Review) Act 1987 made provision for the appointment of a Health Services Review Council with a three fold task: to advise the Minister of Health on the complaints system and the operations of the Commissioner; to advise the Minister and the Commissioner on issues referred to it by the Commissioner; and with the Minister’s approval, refer matters relating to health services complaints to the Commissioner for inquiry. The Act specifically states that the nine ministerially appointed members must be drawn from three groups: those reflecting the interests of service providers; those reflecting the interests of consumers; and an independent group with neither service provider nor user affiliations. Although the role stated for the Council is primarily advisory, it does provide another mechanism through which the work of the Office of the Commissioner can be both scrutinised and publicised. For example, the incoming President, in 1994, indicated that the Council was involved in developing a strategy to promote the role of the Health Services Commissioner emphasising “the Commissioner’s ability to act as a partner in solving problems”.¹⁷⁷ At the time the Act was proclaimed, even the existence of such a Council went further than was traditionally the

¹⁷⁶ Health Issues Centre, The Role of Complaints in the Improvement of the Health Services, researched and written by Jackie Kearney, HIC, Level 11, 300 Flinders St, Melbourne, 1994, pp20-24. This report makes detailed recommendations about how these problems might be overcome.
situation with complaints handling bodies, where the idea of advisory committees had been shunned in case impartiality was seen to be compromised.

The Victorian solution to the problem of handling health complaints at the central level put forward by the Social Development Committee took time to implement with the passing of the Health Services (Conciliation and Review) Act 1987 three years later and then with considerable concessions to service provider interests. Sections of the Act required later amendment to increase and clarify the powers of the Commissioner and to strengthen her/his ability to perform the role envisaged. The volume of work arising from complaints made, and the limited resources available, forced the Office of the Health Services Commissioner to give priority to the pressing immediate need of handling individual complaints above other areas, such as broader quality service issues and community education. Several years after the establishment of the Office there was still considerable ignorance amongst workers in a variety of community agencies and the public about the functions of the Office. But the novelty of the concept of an independent health complaints body must not be overlooked. Noting the increased acceptance of “the model of the industry ‘complaints ombudsman’”, the Health Services Commissioner recently pointed out that

“it [the Health Services Commissioner] was the first authority of its kind in Australia, in the health industry or indeed in any industry. It focussed on defining its role and establishing its credibility to both consumers and providers, in an environment where few people knew what was needed, or what the function of the Office should be”.179

The Victorian legislation established a precedent that advocates of health complaints legislative reform in other states/territories could hold up as a viable working model. The establishment of the Health Service Commissioner was only one part of the original multifaceted approach recommended by the Social Development Committee, but it was the most

important in terms of the influence on central health complaints mechanisms across Australia. While the work of the central complaints body has been complemented by the development of role of Complaints Liaison Officers in local health services and hospitals in Victoria, the focus of reform had been primarily on the development of the Office of the Health Services Commissioner. The differing ideas about self regulation and the smaller role for government services promoted by the new Liberal Coalition government of the early 1990s, again brought the spotlight back to complaints handling at the local level.\textsuperscript{180} The Health Services Commissioner pointed to a strategic change in direction for her organisation over the 1993/4 period, with greater priority being given to training health service providers to manage complaints better at the local level, thus allowing the Office to concentrate on the more serious complaints. The Health Services Commissioner might be changing direction, but the legacy left by the introduction of legislation and the establishment of such an Office significantly altered concepts about government involvement in health complaints mechanisms around Australia.

7.5.3 South Australia: the Ombudsman Option?

At the same time as the Social Development Committee in Victoria was conducting its inquiry into health complaints handling, a major enquiry into hospital services was being conducted in South Australia. Part of the brief of this wide ranging Enquiry, commissioned by the Minister of Health and given six months to complete the task, was to review and report on “the need, if any, for consumer protection legislation” for those using public and private hospital services.\textsuperscript{181} The Enquiry Committee approached this issue by asking a question that was to set the direction of future discussions within South Australia about health consumer issues for the rest of the decade: “What are the conditions that the


\textsuperscript{181} Enquiry into Hospital Services in South Australia, Report of the Enquiry into Hospital Services in South Australia, Dr S Sax Chair, South Australian Health Commission, Adelaide, September 1983, pxvii. “The Sax Report”.

Page 385
consumer should be able to expect will prevail in the provision of health care?". At the time, this focus on patients’ rights was more radical and far sighted, with greater potential for systemic change in health service provision, than a narrower focus on complaints mechanisms allowed. It represented an attempt to find ways to make service providers more accountable to consumers for their actions, through identification of a set of expectations that consumers could reasonably hold; a preventive approach aimed at overcoming the more common causes of consumers’ complaints. These expectations included technical competence of individual professionals, reasonable care, informed choice and well coordinated programs of care where several providers were involved.

A “review of consumers’ grievances” was undertaken to help identify specific problem areas for consumers as part of the Enquiry process. A total of 529 patient complaints were examined, collected from four different sources and covering different time spans: ministerial correspondence (169 complaints), the Australian Medical Association SA Branch (52), the Medical Defence Association (234) and the Professional Negligence Action Group (74). While this study did not represent a systematic collection of consumer health complaints and largely reflected the nature of the organisation (for example allegations of practitioner negligence predominated in the Medical Defence Association sample) it did provide an overview of the problems encountered by consumers in their interactions with health service providers at a time when little Australian information about health complaints existed. The fact that the study was able to collect information about complaints was an indication that consumers were willing to, and did, complain but the study did not go so far as to include details of how the complaints were handled or the resolution outcomes. The final report of the Enquiry noted

182. Report of the Enquiry into Hospital Services in South Australia, pp92-93.
184. The Professional Negligence Action Group (PRONAG) was “a small volunteer based telephone advice service aimed particularly at helping aggrieved clients of doctors, dentists and lawyers”. Report of the Enquiry into Hospital Services in South Australia, p336. By the time research began on this thesis a decade later, this organisation had disappeared without trace. Several other consumer groups had formed in the meantime and the Social Health and Welfare Councils also provided advice.
the inadequacies of available complaints mechanisms while outlining the components of an effective grievance mechanism: access, referral, information, expertise, style, conciliation, correction and compensation. The need for a system of financial compensation for those consumers who had suffered injury through medical misadventure or adverse outcomes was stressed.

The Enquiry did not recommend that specific consumer protection legislation in the health area be pursued. Instead, the Enquiry made recommendations, underscored by the proposed set of patient’s rights and expectations, about “four directions for change”: community accountability; a patient telephone advice service; a patient advice office; and no fault medical misadventure compensation. It was proposed that a “statutory Patient Advice Officer: who would serve as a kind of medical, hospitals, health care ombudsman” be created. This position was linked to the proposal for a no fault medical misadventure compensation scheme; the Patient Advice Officer was to investigate, and, if the complaint was substantiated, would provide a report to a Medical Misadventure Tribunal, who would then determine payments to be awarded to the complainant. It was envisaged that the jurisdiction of the Patient Advice Officer would cover private health service provision, but be limited to matters relating to individual care rather than broader public health policy and administrative actions. While the discussion of the ideas for the four directions was quite detailed, the wording of the specific recommendations in the final report of the Enquiry lacked force; for example “public discussion of the concepts of a Patient Advice Office and a No Fault Medical Misadventure Compensation Scheme as described be encouraged”.

The political climate at the time was such that it could have been anticipated that action taken would have gone further than the recommendations made by the Enquiry. The successive Labor governments in office in South Australia in the 1970s and 1980s have been noted for promoting ‘social reform’ at the state level through innovations in

186. Report of the Enquiry into Hospital Services in South Australia, p110.
legislation and public sector activities.\(^{187}\) The Minister of Health throughout the period 1982-88, Dr John Cornwall, strongly supported the notions of the social view of health, and greater community participation in health service planning and decision making. Perhaps it was the sheer number and scope of recommendations made by the Enquiry, listed over sixteen pages in the final report, or maybe the financial implications of a no fault medical misadventure scheme, but the recommendation that broader public discussion about the directions for consumer protection advocated by the Enquiry were not pursued. It took another quite different event, several years later, to prompt wider debate and further consideration of the need for an independent statutory based health complaints authority in South Australia.

A small Patient Information and Advisory Service (PIAS) was established within the central office of the South Australian Health Commission (SAHC) the following year, August 1984. PIAS was described as providing “a centrally located, comprehensive information and patient advocacy function to assist and protect consumers of health services, both patients and relatives, throughout South Australia”.\(^{188}\) However, no special powers or authority were accorded to PIAS to assist the process of investigating complaints, and consumers with complaints about health practitioners in private practice were advised to try the registration boards. In the first year of operation 463 complaints were recorded. By the end of the second year, PIAS’s patient advocacy function was more clearly defined as undertaking “investigation of complaints about Government-funded health services” and referring other health complaints to the relevant authorities.\(^{189}\) Complaints made had risen to 627, and over 3,000 enquiries were answered. With only

---

three staff members, the existence of PIAS was not well publicised and there were major limitations to the extent to which complaints could be investigated.

Patients' rights came to the fore again with publicity surrounding the presentation of a paper, *The Crisis of Accident*, by Ms Judith Cross, Director of Counselling Services, Adelaide Central Mission, to the first national crisis intervention conference held in Adelaide in 1986.190 The interest in this paper and national exposure to the issues raised led to the Adelaide Central Mission, a large and influential non-government service organisation in South Australia, holding a “Patient Care Phone-In”, the results of which were summarised, along with a series of recommendations, in a submission to the Minister of Health. The Minister’s response was to immediately set up a Task Force on Patients’ Rights, with terms of reference that included examination of mechanisms for the handling of consumer complaints by the major public hospitals and the scrutiny of the role and function of PIAS.191 The Task Force reported in November 1987, following extensive consultations with a range of organisations within South Australia and interstate. By this time, the Complaints Unit had been operating for several years in New South Wales and the Health Services (Conciliation and Review) Act 1987 had just been passed in Victoria.

A detailed framework for “treating patients properly in hospital” was outlined in the report of the Task Force and recommended for implementation within public hospitals. This framework reinforced and developed the focus on patients’ rights discussed in the final report of the Enquiry, four years earlier. A series of recommendations for developing and improving complaints handling by hospitals (that is at the local level) were also proposed, including the piloting of a patient representative scheme. The Task Force did

190. Ms Cross, a well known and respected professional in the health and welfare field, vividly described her own experiences of the hospital system to illustrate the issues she raised in her paper. Her paper “The Crisis of Accident” was included as Appendix 2 to the Task Force on Patients’ Rights, *Report of the Task Force on Patients’ Rights*, I. Bidmeade Chair, South Australian Health Commission, Adelaide, November 1987.

191. The Taskforce consisted of Cross, two senior nurses, the president of the AMA (SA Branch), administrators from two of the major public hospitals, chaired by a lawyer, Mr Ian Bidmeade, previously Chairman of the inaugural Guardianship Board, and an executive officer appointed from SAHC staff.
not, however, "favour the creation of a separate, independent, legislative based complaints body". The expansion of role possible by the South Australian Ombudsman in relation to health complaints handling was seen as one factor mitigating against the creation of a separate independent health complaints unit, particularly as amendments to the Ombudsman Act had increased his jurisdiction to include a wider range of incorporated hospitals and health services. As well, it was suggested that the smaller population of South Australia did not necessarily warrant another small statutory complaints mechanism, drawing on increasingly restricted government funding. On the issue of independence it was argued that, as the SAHC was legally a separate entity from the health services incorporated under the SAHC Act, a complaints unit based in the SAHC should be able to take an independent and critical stance in relation to the activities of health services. The Task Force did recommend that PIAS be substantially upgraded, renamed the Health Complaints Office and give priority to complaints handling rather than general advice giving. The Task Force recommended the SAHC Commissioners take "an active role in monitoring and supporting the activities of the Complaints Office and related patient care issues" to demonstrate genuine commitment to the promotion of patients' rights and complaints handling. The Task Force also recommended review of the Complaints Office in four years time "to see whether our preference is still appropriate, or whether at that stage, a separate complaints body should be created, or the Ombudsman further empowered or resourced in the health area". The third option, that of extending the powers of the Ombudsman, presented a different direction again to the NSW and Victorian models.

PIAS was renamed the Health Advice and Complaints Office (HACO) and moved to a shop front location over the next couple of years. But basically HACO's operation remained unchanged, its ability to handle complaints compromised by limited resources and perceived by health service providers and consumers alike as part of the central office

bureaucracy. In the 1990/91 period HACO recorded 780 complaints and the number of general health enquiries had increased to over 8,000, despite the Task Force recommendation that this function be reduced.\textsuperscript{194} The highest percentage of complaints (15\%) were categorised as relating to complaints about "costs/fees and charges", perhaps reflecting perceptions of the administrative nature of HACO, and as these complaints mainly involved private practitioner billing practices there would have been little that HACO could do. Inadequate or wrong treatment was the next largest category reported. Few other details about complaints lodged and outcomes of HACO's intervention were made publicly available.

The Task Force on Patients' Rights re-convened in 1991, with slightly different membership, to review action taken as a result of the first report and to consider the Consumers' Health Forum report \textit{Legal Recognition and Protection of the Rights of Health Consumers} that had been distributed through the Australian Health Ministers' Advisory Council. 60\% of the publicly funded hospitals in South Australia responded to the Task Force's request for information on the process of implementation of the earlier recommendations of the Task Force, in their organisation.\textsuperscript{195} Recommendations that fitted with management or professional practices, such as establishing quality assurance or patient care committees, or that were relative easy to carry out, such as making available an information booklet about the service, were the recommendations most likely to have been implemented. A number of gaps were found; for example information about patients' rights was limited and rarely available in multiple languages. While a number of hospitals reported the availability of information about internal complaints procedures, few included information about HACO. There was no attempt to assess the effectiveness of the internal complaints procedures overall and there was no central collection of complaints data from

\begin{footnotesize}
\begin{enumerate}
\end{enumerate}
\end{footnotesize}
the various health services. The Task Force was critical of a number of aspects of HACO’s operation, despite attempts to improve accessibility, and stated “HACO has not been able to establish an appropriate profile or independence as part of the Commission, and the time has come for serious consideration of this issue”.\footnote{South Australian Task Force on Patients’ Rights - 1991, p10.}

The Consumers’ Health Forum report provided the impetus for the Task Force to consolidate its position on a number of matters to do with patients’ rights and a series of recommendations were made for strengthening patients’ rights within the public health system. However, the Task Force did not recommend the immediate establishment of an independent, statutory based complaints body, as was proceeding in other states, but set itself the task of advising the SAHC on this issue after considering “in detail the concept of an Independent Complaints Body”.\footnote{South Australian Task Force on Patients’ Rights - 1991, p10.} As later events unfolded this further delay proved crucial to the final outcome in South Australia, although at the time this could not have been foreseen. Meanwhile, the manager of HACO had retired and the position, although eventually advertised was not filled, placing HACO in an even more precarious position at a time of major SAHC restructuring and staff cuts. The strong leadership that could have been provided by an incumbent in the manager’s position, desperately needed to pursue the issue of an independent complaints unit with the SAHC Executive, was not there. In June 1992, a short internal discussion paper of the Task Force finally recommended the establishment of “an independent statutorily [sic] based health complaints office with universal coverage along the Victorian and Queensland lines”.\footnote{Task Force on Patients’ Rights, An Independent Health Complaints Unit for South Australia?, unpublished paper South Australian Health Commission, Adelaide, June 1992, p13.} This paper was not widely distributed, or indeed contained enough detail to be generally circulated as a discussion paper. No immediate action was taken and early in 1993 the Task Force was disbanded. By this time the Labor government was trying to minimise budgetary problems...
with an election due later in the year; establishing a health complaints body was not top priority for the SAHC Executive or anyone in government.

Persistent lobbying of the Minister for Health and the SAHC Executive by the President of the fledgling Medical Consumers' Association (SA), and the conditions of the Medicare agreement (see following section) meant that the issue did not completely fall from sight and, in June 1993, the Planning and Executive Services Division, SAHC, called a meeting of interested groups to again discuss the proposal. At this meeting of representatives from public and private health service provider groups, government officials, consumer groups and academics, there was agreement that a comprehensive discussion paper be written, outlining the framework for a South Australian independent health complaints body.\textsuperscript{199} This paper was to be circulated widely for comment as soon as possible. It took a further four months for the paper to be drafted; the task was allocated to one officer unfamiliar with the area and issues, on top of an already heavy workload. The interested groups met again to finalise the discussion paper in November 1993. However, shortly after, in December 1993, a Liberal Coalition government was elected with a landslide victory and the new Minister for Health, a doctor, did not support the idea of an independent, statutory based health complaints body. If anything was to be done, he favoured the third option put forward by the Task Force back in 1987, that of extending the powers of the Ombudsman. The discussion paper was never released, and throughout 1994 consumer groups were unable to obtain any movement on the issue. Restructuring of the SAHC, a proposal for a new Health Services Bill and the first privatisation of a major public hospital dominated political, SAHC and consumer groups agendas. The release of the first draft of the document \textit{Citizens Charter for the South Australian Health System}, produced by the Public Information Unit, SAHC, in August 1994, had not inspired the confidence of consumer groups in the new government's understanding of, or commitment

\textsuperscript{199} The author was a member of this group.
to, health consumer rights. In November 1994, in answer to a question in Parliament put by the Opposition Spokesperson for Health, the Minister for Health stated that the government was considering the option of expanding the Ombudsman’s role in dealing with health complaints and this would serve to meet the requirements of the Medicare agreement. Various consumer groups and supporters held a series of meetings throughout 1995 to develop and maintain a concerted consumer voice agitating for an independent health complaints body, auspiced by appropriate legislation, and for the discussion paper to be released for public comment but without success. Despite the amendments to the Ombudsman Act extending the definition of ‘authority’ some years earlier, the Ombudsman’s involvement in health complaints handling had not increased significantly; only 62 complaints related to health units of the total 2,309 complaints made to the Ombudsman in 1993/94 and, of the 62 complaints, 20 received advice and another 9 were declined, terminated or withdrawn. Although a new manager had been appointed to HACO, who supported the idea of an independent body, and actively advocated for this within the health bureaucracy, still no action was taken. Finally the Minister stated, again in Parliament, in April 1995 that “we would be resourcing the Office of the Ombudsman to take over that role of the independent complaints office”. No details of the proposal were released for public discussion. It was unclear what legislative changes, if any, would be made, potentially excluding complaints about private sector health services and practitioners under the current jurisdiction of the Ombudsman. The important monitoring

202. The author participated in these meetings.
204. Parliament of South Australia, House of Assembly, Parliamentary Debates, 49th Parliament, No.19, 2nd Session,11 & 12 April, Government Printer, Adelaide, 1995 pp2303. This statement was made by the Minister for Health in the context of lengthy debate of proposed amendments to the Health Services Bill 1995.
role that the Ombudsman had played in relation to the early years of the health complaints units interstate would be lost. The concerns raised by the coalition of consumer groups, particularly in the light of plans for further privatisation of public health services, were ignored. The increment approach to examining the issue adopted by the Task Force, regardless of the favourable political climate, proved too slow, and unlike Queensland, where the establishment of an independent statutory based health complaints mechanism was described as “an idea whose time had come”, in South Australia it was an idea whose time had passed.205

The focus on patients’ rights during the second half of the 1980s had overshadowed the issue of an independent central health complaints handling mechanism, leaving consumers in South Australia without a viable health complaints system. By the time a firm proposal for the establishment of such a mechanism was agreed amongst service providers and consumers, the political climate was such that a different model was put forward, much less comprehensive than proposed or in place in any other state. By mid 1995, South Australia did not have a central health complaints unit, administratively or in any other way, independent from the SAHC. The small unit (HACO) that did operate was unable to deal with complaints about organisations or service providers outside the SAHC’s ambit and did not have a high profile or reputation for investigating complaints, demonstrating few of the essential components of the combined consumer model for health complaints mechanisms. Health complaints legislation for South Australia had not been drafted at any stage and even the requirements of the Medicare agreement held little compulsion for action. South Australian health consumers could be forgiven for thinking that little had changed with health complaints handling.206


7.5.4 The Commonwealth *Medicare Agreements Act 1992*

By 1992 independent health complaints mechanisms were on the national agenda. Reviews of the two established state health complaints bodies had been completed and were generally positive. The *Health Rights Commission Act 1991* had been passed in Queensland, extending the Victorian model by including a specific focus on patients' rights. Draft legislation and a discussion paper had been circulated for public comment in Western Australia in 1991 (an earlier draft had been withdrawn in 1989 due to AMA opposition). A discussion paper for public comment had also been circulated in Tasmania early in 1991. The South Australian Task Force was giving the issue “serious consideration”, and the Australian Capital Territory Labor party, which was to win office later in 1992, had made a pre-election promise to set up an independent complaints mechanism. The attention of the Australian Health Ministers' Advisory Council had already been drawn to issues of the rights of health consumers. For example, in 1990 the Western Australian Minister for Health had tabled the Consumers' Health Forum report *Legal Recognition and Protection of the Rights of Health Consumers* at the Australian Health Ministers' Advisory Council for consideration and action by the states/territories.207 The health rights listed in this report included the right to comment and complain and discussion about the need for independent, specialist, statutory based complaints mechanisms. The Health Ministers had endorsed the detailed *Mental Health Statement of Rights and Responsibilities*, in March 1991, which also stressed the right to mechanisms of complaint and redress.208 The National Health Strategy had examined and reported on an extensive range of issues relating to health service provision including consumer issues. As well, the Consumers' Health Forum had been lobbying the Ministers for Health across

the nation, about the need for statements of consumers' rights and independent statutory based complaints mechanisms.\textsuperscript{209}

Two other factors helped consolidate the movement for change. The first was the revelations of the \textit{Report of the Royal Commission into Deep Sleep Therapy} in NSW and the \textit{Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of the Townsville General Hospital} in Queensland.\textsuperscript{210} Both reports were released in 1991 and attracted considerable media attention. The extensive mistreatment consumers had suffered while trying to obtain treatment for mental illness had been further compounded by the unwillingness or inability to investigate or take action when complaints were made to the bodies supposedly set up to deal with such matters, such as the medical registration boards. The reports drew attention to the shortcomings of the systems in place to deal with such complaints and the need for independent complaints units to have the necessary powers to act.\textsuperscript{211} In the vein of Freidson's comments twenty years earlier, Justice Slattery stated

"It is of critical importance that the community realises the strength of the medical lobby. The Chelmsford saga has demonstrated that the profession cannot be relied on to keep its own house in order without some investigative mechanism such as the Complaints Unit to take up matters which may involve practitioners seriously departing from proper practice... Justice requires government involvement in the complaint investigation process in order to maintain a balance between the rights of doctors and the rights of patients".\textsuperscript{212}

By the time the reports were released, the two states involved had already taken steps to improved their health complaints systems, but the reports served as timely reminders of the possible consequences of complacency in this area. The \textit{National Inquiry into the Human

\begin{footnotesize}
\begin{enumerate}
\item S. Elliott, "Legal Health Rights - Setting the Cat Amongst the Pigeons", \textit{Health Forum}, no.20, December 1991, pp16-17.
\item G. Hawker, "Inquiries into Policy Communities: Townsville and Chelmsford", in Davis, \textit{Royal Commissions and Public Policy}, pp93-106.
\item \textit{Report of the Royal Commission into Deep Sleep Therapy}, p312.
\end{enumerate}
\end{footnotesize}
Rights of People with Mental Illness had already commenced public hearings by mid 1991, and there were strong indications that the issues raised by the earlier inquiries were widespread. The findings could not be dismissed as merely the problems of a few specific health services or aberrant health service providers.

From quite a different direction, the second factor raising the issue of health complaints mechanisms was increasing concern about the ramifications of adverse outcomes from medical treatment. The Harvard Medical Practice Study had revealed that the incidence of adverse outcomes was more common than had previously been realised. The overseas trend towards greater litigation in the health field (particularly in the USA) called into question the current indemnity arrangements for health professionals in Australia. On the other hand, few consumers had been successful in gaining compensation payments for damages resulting from adverse outcomes through the court systems. The Review of Professional Indemnity Arrangements for Health Care Professionals (PIR) had commenced in 1991 to comprehensively review the issues nationally. The first discussion paper, which included the idea of a no fault compensation scheme, was circulated in February 1992, followed by consultations conducted around Australia. Later work of the PIR focussed more specifically on health complaints systems. (See ch2.5.)

Definite indication of the Commonwealth government’s support for the notion of independent health complaints mechanisms came in the 1992/93 Commonwealth budget papers. The Federal Minister for Health, Mr Brian Howe, outlining a series of reforms that would be incorporated into the new Medicare Agreements as part of the quintennial negotiations with the states/territories, described the reforms as

“a comprehensive package which builds on the foundations of Medicare to make the system more flexible and responsive, to put the consumer squarely as the focus, and to sustain the Australian health care system into the next century”. 213

Improving access to services was seen to be "the key" to the 1992/93 reforms, and as part of this "the right to have complaints resolved by an independent complaints unit". The Medicare Agreements Act 1992 was passed by the Commonwealth Parliament at the end of 1992, and new agreements, to run for a further five years, were then to be signed with the states/territories for commencement on the 1st July 1993. The Medicare Agreements Act 1992, reflecting the managerial language of outcomes, set out several principles and commitments that the Commonwealth and the states/territories agreed upon in the provision of public hospital services. The states/territories were required to demonstrate their agreement to the principles and commitments by developing and distributing a Public Patients’ Hospital Charter, which included information about how complaints could be lodged and heard by an independent complaints body. Further clauses in Section 26 of the Act, specified

"(4) The complaints body, which does not have to be created solely for this purpose, is to be independent of the State’s hospitals and the State’s Department of Health.

(5) The complaints body is to be given powers that would enable it to investigate, conciliate and adjudicate upon complaints received by it.

(6) The complaints body is to be given a role in recommending improvements in the delivery of hospital services in respect of which the Commonwealth provides financial assistance".

The establishment of independent health complaints mechanisms across Australia seemed assured. The inclusion of reference to the power of adjudication, that is the ability to make legally enforceable determinations, went further than the powers held by existing health complaints mechanisms, although the power of adjudication was qualified in the Act by the proviso that this power could not interfere with, or override, the operation of registration boards or other disciplinary bodies or the common law rights of the individual. However, the Agreements reference to complaints about public hospital services only, and not having to create a new complaints body, worked in the favour of those state/territory governments reluctant to make changes. A discussion paper, produced by Commonwealth Department

of Health, Housing and Community Services, and distributed to the states/territories health authorities and some consumer groups in mid 1993, outlined the Commonwealth’s position on the charters and complaints bodies.\(^{216}\) Several points discussed in relation to complaints mechanisms challenged current practices: consumers were to be allowed the support of an advocate or representative during conciliation proceedings; the health complaints units were to be able to adjudicate, or refer to another body with adjudication powers; and have the capacity to order corrective action and/or compensation. While the lack of reference to specific health complaints legislation and the limitation to the public health system only were incompatible with the combined consumer model for health complaints handling mechanisms, the other points were consistent.

The Commonwealth discussion paper also focussed on the potential role of the complaints bodies to enhance health service quality through the analysis of complaints information; providing public reports and policy advice to governments; making recommendations to boards and committees working on quality and service improvement issues; and pursuing matters of concern to the public interest. It was noted, thought, that none of the existing state/territory complaints bodies were able to enforce the implementation of recommendations where the complaint or the service provider did not fall within the jurisdiction of a registration board. As well, the central complaints bodies had limited ability to demand the provision of complaints data about complaints dealt with locally by health service providers, even by the major public hospitals.\(^{217}\) In the 1993/94 Commonwealth Budget, $1.3 million was allocated for the production and distribution of the public patients’ charters nationally, although no extra financial incentive was given for the development of the independent complaints mechanisms.\(^{218}\)

---


218. A model charter, *Medicare Public Patients’ Hospital Charter*, was circulated by the Commonwealth Department of Human Services and Health in 1993.
Even before the Medicare Agreements were signed by the states/territories the momentum to establish independent, statutory based health complaints bodies had begun to slip away. By mid 1993 there had been a significant shift in the political climate with new Liberal Coalition parties in government in some states/territories and the narrow return of the Labor party to government at the Federal level, but without a majority in the Senate. The Western Australian and Tasmanian proposals for independent, statutory based health complaints units were again on hold. In South Australia and the Northern Territory discussion papers were still to be produced and circulated. Only in the Australian Capital Territory was new legislation introduced and passed establishing an independent complaints unit.\(^{215}\) In Victoria, the appointment of a new Health Services Commissioner was delayed while the review and massive restructuring and privatisation of government services proceeded. In New South Wales, the Health Care Complaints Bill (1992) was being renegotiated. One bright spot was the release of the discussion paper on *Principles and References for A Code of Health Rights and Responsibilities* by the Health Rights Commission in Queensland.\(^{220}\)

Two years later, early 1995, there had been few developments that had not been planned prior to the signing of the *Medicare Agreements Act 1992*. The Federal Minister for Health, Dr Carmen Lawrence, was supportive of the idea of independent health complaints units and health consumers’ charters, but it was unclear what sanctions, if any, the Commonwealth could apply if the conditions of the Medicare Agreements were not met. Plans were underway for the release of different versions of the patients’ charters by several states/territories later in 1995. Four states/territories still did not have specific health complaints legislation in place, although in Western Australia and Tasmania, health complaints legislation was set to be tabled in parliament. But, as this account of the

\(^{219}\) *The Health Complaints Act 1993*, passed by the Australian Capital Territory, is perhaps the most progressive of all the health complaints legislation.

establishment of central statutory based complaints units in Australia has demonstrated, such plans are easily thwarted and delayed, particularly if political support is no longer forthcoming.

The greater role for governments in relation to health complaints handling created through the establishment of the independent statutory based complaints mechanisms was only reluctantly being take on. The intervention of the Commonwealth government, through the Medicare Agreements, had not succeeded in accelerating the establishment of these mechanisms across Australia as many consumers had hoped. Nor had it resulted in greater consistency of approach to health complaints handling or health consumer rights. The promotion of policies advocating adoption of uniform standards and regulations, prominent in other areas of government, had not been applied to health complaints mechanisms. To add to the plethora, in an attempt to stem the flow of contributors away from private health insurance, in mid-1995 the Commonwealth government announced that it intended to draw up a Private Patients’ Hospital Charter, for those using private health cover and to establish a Commissioner of Complaints for this area, similar to the industry ombudsman created elsewhere. This was despite the fact that in all, but South Australia and the Northern Territory, the health complaints bodies (established or planned) provided universal coverage, that is they could accept complaints relating to public and private sector health services, although dealing with complaints relating to fees was more limited. The original emphasis on simplifying complaints pathways, through the establishment of central health complaints mechanisms to deal with all manner of health complaints, as put forward by the Commonwealth in the 1992 Medicare Agreements, appears to have become lost in the maze of Commonwealth and state/territory governments’ responsibilities for health.
As pressure from without and within the system became too strong to ignore, the health system has been forced to address the need for complaints mechanisms that, from a consumer perspective, were more accessible, sympathetic to the hearing of complaints and able to demonstrate fairness and impartiality in the investigation and resolution of complaints. But change has been slow and piecemeal, often thwarted or only pursued when the proposed reforms were seen to advance other political, managerial or professional agendas. The individualisation of complaints and little use of complaints data to inform systemic change found in other areas of public sector services are also prevalent in the health sector and compounded by health professional control of complaints mechanisms. Consumers still have much to be concerned about the complaints handling processes used in the health area.

The influence of the health professions, particularly the medical profession, has dominated the complaints handling reforms, shaping the responses. The lodging of a complaint by a consumer strikes at the core of professional culture; questioning and asking for justification of professional knowledge, skills, and decision making. The changes to health complaints handling mechanisms, to date, have not challenged the notion that only those who are similarly qualified can ultimately judge the actions of a fellow professional, a notion deeply ingrained in a society where obtaining the status of a professional is associated with social prestige, financial reward and autonomy over one's work. Adjudication of complaints remains the province of the professionally controlled registration boards and disciplinary tribunals, using professionally determined standards. 221 It is the registration boards and disciplinary tribunals, judging the professional's action

221. There have been instances recently where it has been suggested that the courts through their determinations, have taken a more active in setting standards for example the Rogers vs Whitaker case, but making a determination contrary to 'expert witness', that is professional, advice would seem to be the exception rather than the rule. For discussion of the Rogers vs Whitaker case see Review of Professional Indemnity Arrangements for Health Care Professionals, Compensation and Professional Indemnity in Health Care. An Interim Report, pp151-153.
against, often, ill defined and professionally determined standards, who ultimately decide what disciplinary action will be taken. The complainant has no control and, frequently, little input into this process once the complaint has been lodged. The impartiality of the professionally dominated mechanisms has been compromised, in consumer's eyes, by the dual role of responsibility for registration of members and handling of complaints about members. It has been in the interests of health professionals to improve complaints handling by these mechanisms, or otherwise risk greater outside intervention if the situation reached untenable levels for increasingly articulate and vocal consumers. Challenging the continuing retention of the power of adjudication, in effect, by the professional groups through the registration boards, is a possible area for future reform, although it is unlikely that the professions will willingly concede this. Any reforms proposed need to be carefully scrutinised to ensure they do not just transfer power to another expert group, for example lawyers or managers, again by-passing consumers.

The complaints handling policies and procedures of health services, used in the local resolution of complaints, have been revised under the impetus of accreditation and managerial change. The powerful and unique position held by many health professionals in their relationships with consumers, based on trust that health professionals would always act in the consumers' best interests, has always made it particularly difficult for consumers to seek resolution of their complaints by confronting the offending service provider/s direct. Statements of patients' rights help to define not only what is fair and reasonable to expect from the service and health professional, but also legitimise the lodging of a complaint. The Complaints Liaison Officer can reduce the uneasiness often felt by consumers in making a complaint direct, by acting as a 'go between' for the consumer and the health service/service provider. But the Complaints Liaison Officer, employed by the health service, cannot suffice for a consumer advocate able to support and present the consumers' perspective.
Some health service providers have been keen to revise complaints handling policies and procedures for their organisation as 'customer feedback' proved useful to furthering their own managerial or professional agendas. Health professionals soon realised the implications of allowing consumer information, such as that provided by complaints, interpreted by managers into health service debates. Established practices, such as quality assurance programs, were revamped to reflect the new quality paradigm enabling health professionals to maintain their own sources of data. The ongoing struggle between health professionals and managers for control of the decision making process in an increasingly data driven environment, meant that information about each others' area of work, from whatever source, may offer an advantage.

Other health service providers made changes to their complaints handling policies and practices to comply with accreditation requirements and expand risk management strategies. Still others have been unwilling or disinterested in making any changes at all. A few health service providers have been genuinely interested in improving complaints handling processes for consumers, to hear what they have to say, and to use complaints data for health service planning. Overall, implementing complaints handling reforms at the local health service provider level have tended to be gradual and incomplete, and the mechanisms in place have yet to gain credibility amongst consumers.

The model of central complaints handling developed in Victoria had evolved from quite a different process to the NSW Complaints Unit. However, both had occurred in an environment of political reform and bureaucratic change challenging traditional policies, structures and processes, demanding greater accountability and greater action. The issue of complaints handling had become part of the struggle for gaining greater political control over the health system dominated by the powerful interest groups of health service providers. The support of the Ministers for Health, and strong leadership of the health complaints units during establishment, had been crucial to the ongoing credibility and long term viability of the mechanisms. The priority given to the handling of individual
complaints by these central mechanisms was demonstrated and reinforced by their annual reports detailing individual case vignettes, representative of the work undertaken. In many individual cases the central mechanisms were instrumental in gaining a satisfactory resolution for the consumer. While the mandates of the central units have often included contribution to health service improvement, the ability to become involved in broader systemic changes have been thwarted by insufficient resources and authority, an experience common to other central complaints handling mechanisms across government.

The large number of complaints made to the central complaints mechanisms support the notion that consumers are willing to make complaints given access to a system in which they feel they may have a chance of being heard and treated fairly. The essential components of the combined consumer model for health complaint mechanisms, are now better reflected in the newer statutory based health complaints bodies, but there are still limitations. The central health complaints bodies generally do not impose penalties or deregister professionals, but refer the complaint to the registration boards for final adjudication. The role of the central bodies to impartially and independently investigate the circumstances of the complaints precludes them from formally advocating for the individual consumer's position, although they have advocated for the right for complaints to be heard and to be dealt with fairly. The introduction of conciliation procedures has brought mixed benefits for complainants, in a similar way to the informal mechanisms used by review and appeals tribunals, discussed in chapter six. The implementation of recommendations made by the central complaints bodies for changes to policies and practices are still largely dependent on the goodwill of health service providers. Feeding timely information from health complaints into health service planning and decision making forums may still be difficult. For some consumer groups, the central, statutory based health complaints bodies currently in place are still not seen to offer consumers
“solution[s] to health care complaints that cannot be, or are not being, dealt with by the legal system”.222

The central mechanisms have highlighted the breadth, extent and seriousness of consumers’ health complaints. As new central independent health complaints mechanisms are established across Australia, the ability of these mechanisms to meet consumer needs and expectations will only be fully revealed in the second half of the 1990s. The experiences of the existing central mechanisms in New South Wales and Victoria provide important information about the issues that are likely to be crucial to the operation of the newer mechanisms:

- access to sufficient resources;
- the extent of the jurisdiction and terms of the legislative base;
- adequate powers to be accorded to the Commissioner;
- the goodwill of registration boards, professional associations and health organisations;
- the need for ministerial support and strong leadership, at least initially; and
- the need for clearly established consumers’ rights as the basis for action.

As the Victorian Health Services Commissioner recently noted, at the time of the establishment of the Victorian Health Services Commission, industry based independent complaints mechanisms, supported by legislation, were rare, and it has only been through the experience of the early mechanisms that knowledge about complaints handling by central mechanisms, in the Australian situation, has been acquired and advanced. There is benefit in the central mechanisms developing consistency in methods of approach and standards common to all, as long as the most limited model is not adopted as the minimum standard, putting hard won gains in some areas at risk. It would indeed be unfortunate, from a consumer perspective, if the proposed South Australian model was set as the minimum standard.

There have been changes to health complaints handling within the health system over the past decade. But even with the establishment of the central bodies, the health

service providers, both managers and the health professions, have retained considerable control over the development of complaints handling processes throughout the health sector. The view that complaints are an affront to professional and organisational integrity persists, prompting defensive and evasive responses. Only rarely are complaints seen to be anything more that the individual problem of the consumer, to be addressed by an individual solution. In a way analogous to the experience in other sectors, continued individualisation of complaints and their resolution, in the health sector, pose little threat to the dominant interests of health service providers and health bureaucracies, hampering ‘consumer agenda’ reforms to complaints processes.

While the central health complaints handling mechanisms have always encouraged the local resolution of complaints where possible, there has been a more pronounced shift to enforcing this as the first option for consumers wanting to lodge health complaints. The priorities of the central health complaints mechanisms, now focussed on the investigation and resolution of complaints considered to be the most serious and complex, have been influenced by revised government policies, aimed at reducing intervention by central bodies and requiring cost savings, in a similar way noticeable for central complaints mechanisms in other areas of government as discussed in chapter six. However, evidence presented in the next chapter indicates that attention to reform of the local handling and resolution of complaints is required if this is truly to be a viable option for consumers.
CHAPTER EIGHT

LOCAL HANDLING OF HEALTH COMPLAINTS

8.1 INTRODUCTION

If central mechanisms are not able to provide ‘consumer friendly’ complaints processes incorporating all the components of the consumer agenda, perhaps the local handling of complaints will. Certainly resolution of complaints at the local level, between consumers and health service providers, usually organisations, has been encouraged as the first step regardless of the availability of central health complaints bodies and a significant percentage of health complaints are handled in this way. In Australia, there has been little research about the processes used and effectiveness of resolution at the local level. The discussions of the preceding chapters suggest that perspectives of consumers and health service providers about the complaints handling process and successful resolution of complaints at the local level may differ because of the underlying assumptions and expectations of the different groups. To gain a better understanding of current complaints handling practices at the local level, seen through the eyes of consumers and service providers, I conducted a field study in the state of South Australia. Key informants from health service organisations, consumer groups and other individuals/groups with a particular interest in or knowledge of complaints systems were interviewed about various aspects of complaints handling at the local level.

The findings of this study provide information about the subject matter of complaints; the procedures that have been developed by health service providers to handle complaints and the common processes used; consumers’ experiences of making a complaint; and the different perceptions of the resolution of complaints. Informants also identified a number of ways in which complaints handling at the local level could be improved. The findings of the South Australian study were compatible with other studies
of health complaints handling at the local level conducted around the same time and reported during the research period of this thesis, one other in Australia and three in Britain. It is perhaps indicative of the move back to greater emphasis on local handling of health complaints, noted in chapters six and seven, that five studies were conducted in the early 1990s, whereas little other research in this area had been reported in the academic or professional literature over the previous two decades.

The findings of the South Australia study, the other studies of local health complaints handling and the combined consumer model for health complaints mechanisms, outlined in chapter five, provide the basis for the identification of sixteen elements necessary in a consumer model for health complaints handling at the local level. However, the incorporation of these elements into current complaints handling practices of health service organisations is restricted by the 'individualisation' of complaints. In this chapter, therefore, I propose the notion of collective individuals as a way of thinking that increases the acceptability of the sixteen elements of a consumer model for health complaints handling at the local level.

8.2 PERSPECTIVES ON THE HANDLING OF HEALTH COMPLAINTS AT THE LOCAL LEVEL IN SOUTH AUSTRALIA

The field study was designed to obtain an insight into the health complaints processes that operate in selected health care settings in South Australia, with particular emphasis on the perception of the resolution of complaints at the 'local' level (ie. between service provider/organisation and consumer) and complaints that were not likely to lead to litigation. Key informants were used to obtain this insight from the perspectives of both consumers and service providers.

---

1 The other Australian study was the Health Issues Centre study of complaints handling in Victorian hospitals discussed in ch5.2; the British research were the studies by Longley, Lloyd-Bostock & Mulcahy and Nettleton & Harding discussed in ch2.3.
The timing of the study, mid 1993, and location, South Australia, are important in the light of events relating to complaints mechanism reform around Australia, discussed in the previous chapter. There had been no history of an independent, statutory based, central complaints body in South Australia, and the only central mechanism for handling health complaints, other than the registration boards and in certain instances the Ombudsman, was a small unit, the Health Advice and Complaints Office, within the health department. (See ch7.5.3.) The profile of the central complaints unit amongst consumers and health service providers was low, although some changes had been made to increase the visibility and accessibility of this unit, for example moving to a shop front location. The limited resources and few staff meant that the unit was unable to conduct anything other than minor investigations, and it only had a mandate to follow up complaints about public sector services. Occasionally, the Ombudsman investigated a complaint relating to the public sector health services. The limitations in using the registration boards for anything other than the most serious complaints (according to professional definition), outlined in the previous chapter, applied to the South Australian situation.

Complaints handling for the majority of complaints, if it occurred at all, was most likely to occur at the local level, where it did appear that there had been a number of changes since the mid-1980s, in contrast to the limited changes that had been made centrally. The South Australian Task Force on Patients' Rights, in 1987, had made a series of recommendations for reforms to complaints handling by public sector health services and a review by the Task Force, in 1991, found that a number of the recommendations had been implemented. By mid 1993, patient adviser positions had been established in two of the large teaching hospitals; the mental health services had nominated several officers to specifically deal with complaints and introduced a toll free telephone line; a specialist teaching hospital had completed a project aimed at increasing consumer feedback and involvement in service planning; and a newly established public hospital had designated a specific officer to set up their complaints procedures. As well, the Community Health
Accreditation and Standards Project had released revised draft guidelines that included reference to improving complaints procedures for smaller community based health centres. It was anticipated that there would be enough interest in complaints handling among South Australian local health units to generate informed comment about the issues. Apart from the internal annual reports of the patient advisers and Health Advice and Complaints Unit (largely statistical), no local South Australian research about complaints and complaints handling could be identified since the Patient Care Phone In and the Enquiry into Hospital Services in South Australia in the mid-1980s. (For details of both these events see ch7.5.3.)

8.2.1 The Study

The broad objectives of the study were to:

1. identify the processes used to address complaints within a variety of health care settings in SA;
2. examine the experience of health consumers in making complaints direct to the service provider (either individual or organisation);
3. ascertain the perception of the effectiveness of these processes in resolving complaints by both service providers and consumers.

As well, particular attention would be given to the identification of changed and new practices in complaints handling at the local level. The selection of health service provider organisations was specific rather than random. Ample evidence already existed about poor complaints handling practices, as outlined throughout this thesis. Useful information seemed likely to come by primarily targeting organisations that were the most likely to offer new insights about complaints handling at the local level. Using the SA Task Force on Patients' Rights 1991 reporting of the implementation of the Task Forces' 1987 recommendations and verbal accounts from service providers and consumers as a guide, eleven organisations, providing a range of public sector health services in South Australia and where there were indications that complaints mechanisms were in place, were selected. Ten consumer groups were selected to reflect the range of different groups but with a particular focus on self help groups, using the South Australian Community Services...
Directory as a guide. In addition, seven relevant individuals and central advocacy or peak bodies with an interest in or knowledge of complaints processes in South Australia were approached to obtain their perspectives. Letters were sent to the Chief Executive Officer (or the equivalent position) of the selected service provider organisations inviting them, or other senior members of staff familiar with complaints handling in their organisation, to participate in the study. Similarly, letters were sent to the President (or equivalent position) of the consumer groups selected inviting members to participate, and to the peak group informants.

All but one of the 28 organisations/individuals initially approached readily agreed to participate in the study and two other peak organisations/individuals were included on the recommendation of other participants.2 The group of ten service provider organisations comprised four generalist health services (primarily hospitals), three specialist health services, two specialist community health services and one generalist community health service. The group of ten consumer groups comprised six consumer groups with a specialist focus (such as a self help group for a particular illness) and four groups with a more general focus. The group of nine peak informants could be divided into those with a consumer focus (five) and those with a service provider focus (four). See Table Four.

A total of 33 interviews were held, involving 41 individuals across the 29 organisations. See Table Four. The interviews were shaped by three semi structured interview schedules (service provider organisation, consumer group and peak organisation), which informants had received prior to the interview. (Appendix Two) All interviews were conducted by the author, face to face, except for one which took place over the telephone. Usually the interview was held at the informant’s organisation and lasted approximately forty five minutes. All informants were given the choice to be interviewed alone or with others from their organisation or group. Individual and group responses were

---

2. The non participation of this one organisation was not through outright refusal to participate but difficulties in making direct contact with the Director of the organisation to arrange an interview time during the period of the study.
collated according to the organisation with which the individual or group was associated for the purposes of analysing the results.

**TABLE FOUR**

Organisation Type by Number of Organisations and Number of Informants Interviewed

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>Number of Organisations</th>
<th>Number of Informants Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service - general</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Health Service - specialist</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Community Health Service - general</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community Health Service - specialist</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health Consumer Group - general</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Health Consumer Group - specialist</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Peak - consumer focus</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Peak - service provider focus</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>29</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>

Of the forty one individuals who participated in the interviews, thirteen participants were classified as belonging to the service provider group, eighteen to the consumer group and ten to the peak group. The health service provider informants held a number of different staff positions, such as CEO or Director of the Service, Director of Medical Services, Nursing or Social Work and the Patient Advisers. See Table Five.

**TABLE FIVE**

Health Service Provider Informants by Organisation Type and Position Held

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>CEO/Admin 1</th>
<th>DMS 2</th>
<th>DON 3</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service - general</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Health Service - specialist</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Community Health Service - general</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Community Health Service - specialist</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>8</strong></td>
<td><strong>2</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

1. Chief Executive Officer, Administration Officer or Patient Adviser
2. Director of Medical services or Director of Clinical Services
3. Director of Nursing or Nurse Manager
Consumer group informants and peak group informants were either consumers and/or paid staff members employed by the organisation (in some instances also a consumer). See Table Six.

**TABLE SIX**

Consumer and Peak Informants by Position Held

<table>
<thead>
<tr>
<th></th>
<th>President/Member/Volunteer</th>
<th>Executive/Project Officer</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Groups</td>
<td>14</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Peak Informants</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
</tbody>
</table>

8.2.2 Complaints and Complainants

Service provider informants (SPI), consumer group informants (CGI) and peak organisation informants (POI) identified a diverse range of issues about which complaints were made. All three groups identified a major area of complaints related to issues of access to and availability of services. Waiting lists, waiting times, implementation of administrative policies and procedures; limited resources and restricted or insufficient services were all likely to be sources of consumers’ complaints. Both a SPI and a CGI suggested that the expectations of consumers about the availability and provision of health services in the public sector may be unrealistically high in the current environment of cutbacks, leading to higher rates of complaints.

Another major area of complaints related to the interactions between service providers and consumers. CGIs noted the behaviour and attitude of some service providers towards consumers, such as the way people were treated or spoken to and the lack of respect for the rights of individual consumers, led to complaints being lodged by consumers. SPIs identified interpersonal communication issues as sometimes being a
problem, particularly when staff felt under pressure due to resource restrictions. Complaints involving charges of unprofessional behaviour and conduct, including sexual and physical harassment and abuse of authority, were also mentioned by some CGIs and POIs.

SPIs attributed complaints relating to standards and quality of care to consumer misconceptions about what to expect and to consumers’ ignorance of the health system. CPIs gave a different explanation; they suggested that being given inaccurate or insufficient information to make informed choices, or being given no choice about treatment options, contributed to complaints about the intervention/treatment received. Several SPIs said that complaints about the quality of care provided by their organisation were rare, and others commented they heard more complaints about other services than they did about their own organisation.

Complainants were generally thought to be consumers or their relatives, although SPIs often did not have detailed information about this or other characteristics of those who complained, such as age and gender, to be able to ascertain a trend. CGIs and POIs concurred with the SPIs that complainants were most likely to be the consumer concerned or a close relative. One POI thought that “if a person with a disability makes a complaint it is often treated less seriously than if a partner or carer makes the complaint”. Occasionally, another service provider would make a complaint, either about the treatment/intervention received by a client, or on behalf of a consumer or their relatives, or the complaint came via a politician’s office.

Several CGIs commented that some complainants had probably acted with consultation and support from a consumer, advocacy or self help organisation. Similarly, some SPIs suggested that services still receive complaints only from articulate consumers. Both SPIs and CGIs thought consumers and their relatives were more likely to make a complaint if they were suffering from a long term condition that meant repeated contact with the health service in the future; one SPI noted “the parents of children with chronic
conditions have a different set of things to complain about”. Informants from the three groups suggested that the fear of future victimisation prevented many complaints from being lodged. One POI commented that s/he thought “basically people’s expectations to have rights are low” and therefore not many people complained.

8.2.3 Processes and Procedures

The processes used for handling complaints followed a typical pattern: the complaint was received; an acknowledgment of receipt of the complaint sent or, less commonly, contact made with the complainant for further clarification; the individual service provider or service head was contacted for a response to the complaint; a resolution to the complaint was developed by the service provider; and the outcome communicated to the complainant by telephone or letter. However, the detail in following this process, according to SPIs, varied from organisation to organisation. A different view of the processes was also reported by CGIs, discussed in the next section.

Almost all SPIs said they thought all staff in their organisation had some responsibility for handling complaints. In some organisations the staff member receiving the complaint was encouraged to follow the complaint through to resolution, if possible. While in all the organisations a particular staff member or members (usually in senior positions) were identified as handling complaints for the organisation, this was often an extra task added to the staff members’ regular duties, thus limiting the time spent on, and the priority given to, responding to complaints. Some of the larger organisations had designated a particular staff position, patient adviser, with duties focussed on addressing complaints. However, not all complaints made to the organisation were attended to by the designated staff member for handling complaints.

In some organisations, complaints were actively investigated by the designated staff member, whereas in other organisations the response of the service provider or service head concerned was taken to be sufficient. In some instances, clear timelines for
responding to complaints had been set. Some organisations would only follow through on written complaints, whereas others were willing to act on complaints made verbally, usually by telephone. Putting the complaint in writing was also seen to have other advantages, as one SPI commented “often I suggest to put it in writing as it formalises the complaint and I am able to take [the complaint] more seriously”. The telephone was seen by SPIs as an efficient means of providing information and responding to initial complaints on the spot.

Of the ten service provider organisations, eight had a written policy and/or procedure for complaints handling within the organisation. SPIs for the two organisations without such documentation said that a policy/procedure was either being prepared or would be in the near future. Of the eight organisations with written policies/procedures half were still in draft form, one had just been reviewed and another two were being revised. Accreditation requirements were mentioned as a major impetus for drafting and/or reviewing policies/procedures relating to complaints handling. The documented policy and procedures were generally part of the organisations’ policy manual but sometimes they were issued as an administrative instruction or a memo from the CEO to all staff. While most organisations referred to complaints handling in the title of the policy/procedure, in one organisation it was included in their “rights and responsibilities” policy.

All the organisations had statements outlining patient/consumers’ rights and responsibilities when using their service that included at least brief information about making complaints. These were available to consumers as part of the patient/consumer information booklet or as separate pamphlets. SPIs thought that these booklets and pamphlets were readily available throughout their organisations, and some organisations ensured that consumers received the pamphlet/booklet by staff handing or posting these to consumers on, or prior, to the first visit/appointment. Several organisations kept suggestion forms, suggestion boxes or books for consumers’ comments. Some
organisations had used the media to raise awareness amongst consumers that they had complaints handling policies and procedures in place.

SPIs generally thought that assistance and support were available to people wishing to complain about their services and that all staff in their organisation were prepared to provide assistance and/or support. More specifically, those in positions identified as dealing with complaints, such as the patient adviser, saw that an important part of their role was to provide assistance and support to consumers wanting to make a complaint. This took the form of listening and clarifying the complaint, providing information, helping with letter writing, providing a confidential space for the person to talk, accompanying complainants to meetings with other staff, making sure consumers knew their rights, providing advice about action that could be taken, and providing assistance throughout the duration of the complaints resolution process. Several SPIs noted that it was sometimes difficult to provide support to the complainant if they were also the staff member investigating the complaint, although only one SPI added that, in such instances, another staff member would be asked to provide support to the complainant. Some SPIs had referred the complainant to another organisation, such as a self help group, to obtain support.

Staff awareness of the organisations' policies/procedures on complaints handling was considered adequate by most SPIs and primarily achieved through staff orientation and inservice training programs. Policy/procedures manuals were drawn to the attention of, and accessible to, all staff. As well, staff were made aware of the information provided to consumers, such as the pamphlets on patients/consumers rights and responsibilities. Staff/organisation newsletters also had been used to increase staff awareness of new or changed procedures. In some instances, staff had been actively consulted and/or involved in the development of the policy/procedures. The effectiveness of the strategies to inform staff about complaints handling policies and procedures had not been evaluated to any of the SPIs knowledge.
SPIs were asked specifically to identify any distinctions that were made in the way complaints were handled by their organisation according to who make the complaint or the subject of the complaint. Some said that the same process was always used. Others thought that distinctions were made. One SPI noted that in her/his organisation a complaint would not be dealt with using the normal complaints procedures if the complainant had already sought legal advice or wanted financial compensation. Several SPIs commented that they used a different process when the complaint came through a local Member of Parliament or the Health Minister and, in some instances, they may not actually contact the consumer concerned in drafting a response. Some SPIs suggested that complaints coming via these sources received faster and greater attention, although other SPIs disagreed.

Nearly all the SPIs said that their organisation collected data about complaints made. In one instance, the number of complaints made to the organisation had been too small to warrant this, but the SPI suggested that data would be collected if this situation changed. In several organisations, it was up to all staff to record information about complaints, although the designated person within the organisation for dealing with complaints or a senior management person collated the information and generated reports. How the information was recorded and the extent of the information collected varied greatly across organisations from the SPIs reports of these processes. Several organisations had set forms for recording the complaint and action taken, which was then forwarded to a central point. In some organisations the records relating to complaints and subsequent correspondence was kept in a separated file held centrally. However, in several organisations all correspondence relating to a complaint was filed in the individual casenotes (medical records) of the person lodging the complaint (or where a relative made the complaint, the medical records of the person on whose behalf the complaint was being made), especially if it was thought the complaint could lead to a compensation claim.
Nearly all the organisations generated collated reports of the complaints data collected; the format varied from brief statistical tables to more detailed reports including short case scenarios of each complaint with identifying information deleted. SPIs were mostly rather vague about the distribution and availability of the collated reports and how the information was used by the organisations. SPIs thought the most likely end point for the collated complaints data reports were the heads of units or the patient care/quality assurance committees. However, SPIs did not know, or were not particularly clear about, how the information from complaints data was used by these staff members or committees.

8.2.4 Consumers’ Experiences of Making a Complaint

CGIs related their own experiences of making complaints or those of other consumers whom they knew personally. These accounts were often described with significant emotion even though the events may have occurred some years previously and were said to have been resolved satisfactorily. The intense feelings generated by the perceived injustices of the experiences that led to complaints are rarely forgotten.

The complaints process for consumers does not begin with the lodging of a complaint. Several steps are taken prior to this action, according to the CGIs. First, consumers needed to gain “permission to complain”, by asking the opinions of friends and relatives (particularly if they had medical knowledge) or other consumers (through self help and advocacy groups) about the event and gauging whether others, from their experiential knowledge, also thought it was reasonable to complain. Sometimes the opinions of other service providers were also sought. Second, consumers needed to evaluate the possible negative consequences of complaining, such as getting a reputation as a ‘trouble maker’, or that they, or their relative, might be victimised (as one informant put it “receive the cold bed pan treatment”), particularly if the consumer was still dependent on the service. Third, consumers needed to assess whether they had the time and energy (particularly emotional) to complain. Fourth, consumers needed to obtain information about the complaints process of the organisation.
Finding out who to approach and how to make a complaint was seen as a problem. Half the CGIs did not know if the health service they used most frequently had a written complaints policy/procedure (although several assumed it did), and most had not seen such a document. One CGI commented that, while the organisation had a policy/procedure in place, s/he thought there was no commitment on the part of the organisation to the implementation of the policy/procedure. Several CGIs had not seen the more general patient’s/consumers’ rights statements, either, and were concerned that consumers of health services generally did not know that they could complain or what mechanisms were in place to do so. The majority of CGIs thought that it was important that the policies/procedures for handling complaints should be written and that these should be widely publicised, along with the statements of consumers’ rights.

The injustices of the event/s that led to making a complaint, some CGIs found, were compounded by further injustices through the complaints processes used. For example, one CGI felt that she had been treated as a “neurotic mother”, and her complaint had received little acknowledgment or given credibility. Others said they had felt frustrated by the complaints process, powerless even though they had made a complaint and patronised by those dealing with the complaint. Some had been actively discouraged from complaining by a staff member of the organisation. Half the CPIs said that they were not given any support by the service provider/organisation, and those that did receive support said it was very little or only from one member of staff, such as the patient adviser or a ward nurse. Family and friends, self help and advocacy groups were identified by CGIs as providing the most support and assistance to consumers wanting to make a complaint, particularly by providing information and sometimes advocacy. Once a complaint had been made, for some CGIs, it seemed that the complaint “disappear[ed] into a black hole”, action taken on the complaint was slow and sometimes there was no formal response from the organisation about the complaint. One CGI vividly described the frustration of waiting
for a telephone call or letter of response and the negative impact this had had on her/his daily life.

Several CGIs noted that if service providers seemed approachable and not likely to take the complaint as personal criticism, the process of making a complaint was much easier and not so intimidating. A few CGIs had found the complaints process in place worked in getting their complaint heard. Two CGIs discovered that, because they had sought legal advice in the first instance, other avenues of complaint were closed and they had inadvertently became locked into a system in which to not proceed with legal action would result in major financial cost to themselves.

8.2.5 The Resolution of Complaints

Satisfactory resolution of complaints at the local level from the perspectives of both consumers and service providers was not necessarily easily obtained. The service provider handling the complaint, SPIs said, generally communicated the outcome to the complainant by telephone or in writing or both. Only in some instances was a face to face meeting held. Some SPIs said, though, that they preferred to communicate the outcome of the complaint to the complainant over the telephone or in person as it was easier to check whether the complainant was satisfied with the action taken and to determine whether the complaint was resolved for the complainant.

Overall, SPIs thought that at least 90% of complaints were resolved to the satisfaction of the organisation. Some SPIs simply assumed that the complaint was resolved when no further communication on the matter was received. Several stressed there would always be “a hard core of complaints that can’t be dealt with”, particularly where the matter related to organisational policy, such as no smoking on the premises or where the organisation had little control over the matter, such as public patient waiting lists. All that could be done in these situations was to offer an explanation and this was frustrating for both consumers and service providers. Half the SPIs also estimated that complainants
found the resolution of their complaint was satisfactory at least 85% of the time, and several estimated 100% of the time. Only one SPI suggested a lower estimate of 70% to 80%. Several SPIs commented that sometimes the complaint was clearly not resolved from the complainant's perspective but the staff member handling the complaint had no other ideas or suggestions for gaining a more satisfactory resolution. In these instances, SPIs said agreement from the complainant that the complaints handling process had been satisfactory was sought, even though the complainant was not happy with the resolution. Some SPIs were unable to make an estimate of the percentage of complaints where the resolution had been satisfactory from either the organisations' or the consumers' perspectives. One SPI commented that her/his organisation “hadn’t developed a system for gauging what the consumer thinks of the complaints service”.

CGIs were not as convinced that complaints were resolved to the complainants’ satisfaction. While several CGIs thought that the resolution had been satisfactory for the individual consumers in the particular situations that they knew about, several others qualified their responses with comments about the difficulty in checking that recommendations had been acted upon or in stimulating systemic change to prevent the same situation that prompted the complaint re-occurring. Sometimes, satisfactory resolution had been achieved only after considerable effort on the part of the complainant, and for others the resolution had not been satisfactory. Consumers often felt excluded from the resolution process, being told the outcome rather than being involved in the determination of this. CGIs were able to identify a number of other outcomes they would have liked to have seen in the resolution of the complaints. They wanted the resolution to include an assurance that the instance/experience would not happen again to another consumer; to see sustained changes within the organisation, and “an opportunity to discuss the complaint face to face with an advocate or support person being there”. They wanted to know details about the action taken and the outcomes of this action, particularly any changes made. CGIs also wanted to feel that they had been treated with respect when
making a complaint; that the complaint was perceived as important and legitimate; and that the organisation acknowledged that the organisations' 'system' had erred. One CGI noted that “sometimes service providers take action but they don't actually acknowledge that this was the result of a complaint”. Just over half the CGIs indicated that they would complain again. Others said they would complain again only if they could see tangible outcomes from complaining. Several CGIs said that they would not complain again because the current complaints procedures did not provide the support needed or, if they were given outside assistance, they would complain through a different mechanism than the one they had used previously.

Commonly, service providers and consumer groups referred complainants to other agencies and complaints handling bodies, such as self-help/ advocacy groups, lawyers, police, the Ombudsman, the central complaints unit and local members of Parliament. Several SPIs said they always made sure complainants knew their 'rights' about where to go to next if unhappy with the resolution of the complaint provided by their organisation, or it was not appropriate for their organisation to deal with the complaint. One SPI commented that sometimes referral was not necessary because the “more affluent citizen was likely to know their rights and the system to complain, such as going to their local MP”. CGIs said their organisations often took on an advocacy role for people wanting to make complaints and people were often referred to them for that purpose. Some groups referred consumers on to other advocacy groups with more specific briefs for handling complaints, such as the Disability Complaints Service or the Welfare Rights Service. Several CPIs mentioned they had taken complaints to the media (outcomes had been mixed), the Minister for Health and local members of Parliament. Members of Parliament were seen to provide useful assistance, and one informant commented that, after trying to resolve the complaint at the local level for some time, s/he had finally "got more answers by having questions raised in Parliament". However, several informants suggested that this broad range of other agencies to which consumers could take their complaints could also
be a disadvantage by increasing the potential for “handballing of complaints from one [agency] to another”.

8.2.6 Ideas for Improving Complaints Handling at the Local Level

There were a number of suggestions about improving complaints handling at the local level. From the perspectives of CGIs, greater attention to the emotional needs of complainants throughout the complaint process was seen to be important for several reasons: the trauma of the experience that led to a complaint, which in some cases had resulted in long term physical damage; the anxiety in challenging service providers' actions by lodging a complaint; and the stress involved in negotiating the complaints process. This support often could not be, nor was it appropriate that it should be, provided by the person handling the complaint. Consumer support and advice available outside the service provider system was seen to be needed. Self help groups were identified as an appropriate mechanism to provide this support but it was pointed out that these groups, currently, often did not have sufficient resources to enable them to take on the task and would need to receive funds to do so. As well, CGIs suggested that health workers’ training should include greater explanation of consumers’ rights and fostering greater sensitivity to consumers’ needs.

Increasing staff awareness of consumers’ rights, particularly the right to complain, and encouraging staff to respond in a less defensive way to complaints would improve complaints handling at the local organisation level, from the perspectives of SPIs. It would also allow individual staff/service providers “at the ward level” to take greater responsibility for dealing with complaints. More specific in-service training of staff in these matters and demonstrated commitment by senior staff members to consumers’ rights would go some way to achieving this. Some SPIs thought that a process to enable staff to complain about patients would help to increase the acceptability of complaints processes amongst service providers.
The importance of written policies/procedures for the handling of complaints was stressed from the perspectives of POIs. Such documents and comprehensive collection of complaints data, POIs suggested, ensured greater accountability and consistency in the handling of complaints; increased the likelihood of the complaint being taken seriously; made explicit timelines and lines of responsibility; improved consistency in the recording and monitoring of complaints; and could be used to improve services by acting as a quality assurance tool. Several POIs commented that a written policy/procedure offered protection to both consumers and service providers. Although most of the organisations had written policies and procedures, these were often thought to be hidden away in policy manuals rather than directly visible to consumers and staff alike. Consumer involvement in staff training was suggested by some POIs as a possible effective way of increasing awareness of the issues around complaints handling amongst staff.

The accountability of the complaints handling procedures of health service provider organisations was of concern to a number of informants and considered an area in need of improvement. Written and easily accessible information about the complaints policy and procedures of the organisation, already mentioned, were seen to be part of the accountability process. Accountability could also be increased through the improved collection of data that included information about the outcome of the resolution process, follow up on action promised and consumers' satisfaction with the process and resolution. This data needed to be channelled into the appropriate planning and policy development processes of the organisation if it was to have any impact on the organisation's systems. Several CGIs thought that consumers needed to be actively involved in formulating, evaluating and monitoring the complaints handling processes devised by individual organisations for the processes to be improved. One SPI suggested that a consumer 'watchdog' body outside the control of the service provider organisations could help keep pressure on organisations to maintain good complaints processes. Several informants recommended that the complaints handling processes at the local level be well linked with
an independent central mechanism, enabling greater coordination and consistency in complaints handling.

The development of an organisational culture that was open to hearing complaints was identified as a factor that could potentially improve complaints handling at the local level by a number of informants. This would require a change in attitude towards complaints to one that was not blaming and sought to obtain the best resolution of the matter, not only for the individual consumer involved but also for the organisation and other consumers. Complaints would be viewed as valuable and positive contributions to the organisation’s service provision processes. For this to be achieved there must be: commitment to complaints handling from the most senior management of the organisation; sufficient resources dedicated to complaints handling by the organisation; clear and visible policies and procedures that are actively promoted; and encouragement of consumers to lodge complaints. As well, there needs to be greater openness in the actual handling of complaints, explaining to consumers what was done and not done and why, rather than simply saying the matter has been reviewed/ investigated. Establishing patient adviser (complaints liaison officer) positions within health organisations and allowing consumers to make complaints with the assistance of an external advocate were also seen as important by some informants. One POI suggested organisations could establish a “buddy system”, whereby consumers with experience and knowledge of the organisation befriended and assisted “new” consumers.

Informants were asked if they knew of any services that, in their opinion, handled complaints at the local level in an exemplary way. Generally, informants thought that processes for dealing with complaints at the local, health service provider level reflected a mixture of good and bad practices, making none exemplary. Several informants commented that some services were trying hard; for example, the procedures put in place by a patient adviser in one of the public hospitals. Some SPIs said that, while their complaints handling processes still needed improving, there should be greater
acknowledgment of the progress that had been made in developing better complaints mechanisms in their organisations, over recent years. The interest in improving complaints handling at the local level amongst health service providers was evident from their willing participation and thoughtful consideration of the interview questions; and the changes to complaints handling practices that a number of organisations had introduced, indicated by their recently drafted policies and procedures. This interest had not gone so far as to produce an exemplary mechanism. Complaints handling practices at the local level, by health services in South Australia, still left considerable room for improvement.

8.3 A CONSUMER MODEL FOR HANDLING HEALTH COMPLAINTS AT THE LOCAL LEVEL

The insights provided by this South Australian study, together with the findings of three recent studies in Britain, discussed in chapter two, and the combined consumer model for health complaints mechanisms outlined in chapter five (incorporating the Health Issues Centre Victorian hospitals study), provide ample indicators of the elements of a consumer model for health complaints handling at the local level.3

Not unexpectedly in a period of tight fiscal policies and major restructuring of public health services, issues arising from the accessibility and availability of public health services were a common subject of complaints made in the South Australian (SA) study. Interactions between consumers and service providers was another common area of complaints. The diversity of issues about which consumers are prepared to make complaints, reflected in the studies about health complaints handling at the local level, suggest that consumers do perceive that they have a considerable stake in the provision of

---

health services and are prepared to invest the personal time and energy necessary to lodge a complaint. This diversity also presents unique challenges to complaints handling by health services at the local level, as the complaints mechanisms must be flexible enough to be able to pursue a complaint about any issue. Complaints were most likely to be lodged by consumers or their families; Nettleton and Harding found that over half the complaints letters had been written by a relative and over two-thirds of the authors of the letters were women; Lloyd-Bostock and Mulcahy made similar findings. Further analysis by Lloyd-Bostock and Mulcahy also revealed that in many situations where relatives and friends made the complaint "they were expressing their own dissatisfaction with the way their relative or friend had been treated". The need for the definition of the term 'consumer' to encompass more than just those actually receiving the health service, as discussed in chapter three, would seem well justified. The finding that more women than men are likely to make a written complaint warrants further investigation, although a number of reasons why this might be so could be drawn from the knowledge and experience of the women's movement in health, discussed in chapter four.

The issue of who should handle complaints within an organisation is more complex than may first appear. Although all the organisations in the SA study had designated a staff member to handle complaints, only in some instances was this the primary task of the position. Control over complaints handling, as already discussed in chapters six and seven, may provide sensitive information to some service provider groups about other service provider groups that can then be used to further particular agendas, such as providing managers with information about clinical workers and clinical matters. However, there is another important issue associated with the question of who handles complaints: the use of discretion by complaints handlers in the way they chose to deal with the complaints. Service providers, in the SA study, had put forward the proposition that all staff should take responsibility for handling complaints as the first step, rather than leaving this to the

4 Lloyd-Bostock & Mulcahy, p128, original emphasis.
designated complaints person only. On the other hand, consumers reported being discouraged by some staff from making complaints more formally. Even with well defined policies and procedures in place, the individual interpretation of the complaints handler’s role led to wide variations in implementation and inconsistencies, supporting consumers’ perceptions of the lack of clearly identifiable ‘organisational’ approaches to complaints handling. The difference in approach taken by the complaints liaison officers was discussed in the HIC study, and discretion was found to be a factor contributing to the difference in complaints handling by Family Health Service Authorities, even with detailed guidelines, in the studies by Longley, and Nettleton and Harding.\textsuperscript{5} The potential for inconsistencies in approach seems to be compounded if the complaints handling function is diffused amongst all staff but the idea of a designated staff member to deal with complaints will be effective only if the person is given sufficient resources, authority and organisational support to carry out the tasks required of the position; for example as outlined in the discussion of complaints liaison officer positions in chapter seven.

Not a great deal of attention had been given by organisations, in the SA study, to the collection of information about complaints: for example determining clearly how this was done; in what form it was to be used, who by and for what purpose; and where information pertaining to complaints might be stored. Regular monitoring and use of complaints data to inform the decision making processes of the health services did not seem to have been set in place in most instances. The links between complaints handling processes and broader quality assurance committee type activities also were not well established. From a consumers’ perspective it is important that the information contained in complaints is channelled into the appropriate mechanisms with authority to make the necessary changes to policies, procedures or practices within the organisation, to prevent similar events occurring to other consumers. The altruistic intent in the expressed desire by complainants for action to be taken for the benefit of other consumers in the future, rather

\textsuperscript{5} Longley, pp11-12; Nettleton & Harding, p55.
than for themselves, has been downplayed and often dismissed by health service providers. Yet it is a common theme for consumer groups. Consumers have been equally sceptical of health service providers' promises to make systemic changes to policies and practices, and then to ensure their implementation. Without the expression of dissatisfaction, either by exit or voice according to Hirschman, it is unlikely that the organisation will make the changes of its own accord. Organisations do, however, take the credit for successful changes once made, without necessarily acknowledging the source.

For consumers, the process of making a complaint begins well before they lodge a complaint with the organisation, as the matter is discussed with various other people, usually relatives and friends. Consumers go to considerable lengths to point out why their complaints are justified and need to be taken seriously by the organisation. The practice of keeping correspondence relating to complaints in the consumers' medical records trivialises and individualises the complaint as being part of the consumers' treatment/intervention episode, rather than an intentional questioning of, and comment on, the processes of service providers, adding to consumers' fears of the possibilities of 'victimisation' or gaining a reputation as a 'difficult' patient or troublemaker. The information contained in complaints often clearly outline the normative expectations of consumers about the actions, behaviour and attitudes of health service providers. For example, Nettleton and Harding found that complainants expected general practitioners "should be caring and supportive... technically competent;... and... readily available in times of illness".

As service providers control the complaints process at the local level, priority tends to be given to the resolution of complaints in terms of organisational and professional needs. The consumer often has little influence over the processes used to investigate and resolve complaints. Once made, the complaint falls into the domain of the 'expert' health

6 Lloyd-Bostock & Mulcahy, p143.
7 Lloyd-Bostock & Mulcahy, pp134-135; Nettleton & Harding, pp53-54.
8 Nettleton & Harding, pp53-54.
service provider, who determines what shall be done, how and why. Consumers ask for the organisation to account for the occurrence of the complainable event but do not necessarily include other specific goals about what they expect from making a complaint. Perhaps the passive role frequently expected of consumers in health care relationships, and the fact that often the harm done to the consumers cannot be 'undone', makes it difficult for consumers to initially identify specific goals. The emotional impact on a consumer of a perceived injustice can be very significant and a powerful motivator for making a complaint. For some consumers, this will result in wanting the offending person or organisation punished for the harm done. But for many others, it is more important that the same thing does not occur again to someone else. Greater involvement of consumers in the resolution process may provide the opportunity to make explicit some desired outcomes so that satisfaction with the complaints handling process from the consumers’ perspective is increased. Lloyd-Bostock and Mulcahy found that genuine expressions of apology from an organisation were likely to increase satisfaction with the complaints process and outcome. It seems particularly important that the resolution of a complaint includes some discussion and negotiation with the complainant and identification of an enduring outcome. An outcome that involves health service organisational change that is sustained and of benefit to all consumers using the service, would certainly be a satisfactory outcome from the perspectives of the consumer group informants in the SA study.

The principle elements of a consumer model for health complaints handling at the local level are easily identified (Table Seven), based on the research findings and the combined consumer model for health complaints systems outlined in chapter five. The first element is commitment from the most senior executives of the organisation to ensuring that the perspectives of consumers are reflected in the complaints handling practices of their organisation and to addressing complaints at the local level.

10. Lloyd-Bostock & Mulcahy, pp143-144.
**TABLE SEVEN**

**Principle Elements of a Consumer Model for Health Complaints Handling at the Local Level**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Commitment of organisation, through the most senior executives, to complaints handling at the local level.</td>
</tr>
<tr>
<td>2</td>
<td>Complaints handling mechanism applicable to the whole organisation: all staff and services included.</td>
</tr>
<tr>
<td>3</td>
<td>Statements of consumers' rights well developed and known and linked with complaints handling.</td>
</tr>
<tr>
<td>4</td>
<td>Written complaints handling policies and procedures for the organisation, readily available, reflecting fairness and impartiality, and including timelines for steps to be used in the complaints handling process.</td>
</tr>
<tr>
<td>5</td>
<td>Designation of staff position, such as that of complaints liaison officer, with responsibility for complaints handling throughout the organisation.</td>
</tr>
<tr>
<td>6</td>
<td>Delegation of sufficient authority to the complaints liaison officer to investigate and resolve complaints.</td>
</tr>
<tr>
<td>7</td>
<td>Dedication of sufficient resources to complaints handling by the organisation.</td>
</tr>
<tr>
<td>8</td>
<td>Complaints mechanism to be accessible, including seeking out consumers who may want to make a complaint, and with no cost to the complainant.</td>
</tr>
<tr>
<td>9</td>
<td>Complaints mechanism to be highly visible to all through publicity and promotion; and through developing a credible reputation.</td>
</tr>
<tr>
<td>10</td>
<td>Complainants offered support prior to, and during, the complaints handling process independent of the health service organisation.</td>
</tr>
<tr>
<td>11</td>
<td>Others able to advocate on complainant's behalf during any stage of the process.</td>
</tr>
<tr>
<td>12</td>
<td>Complainants to be invited to be actively involved in the resolution of the complaint and determination of the outcome.</td>
</tr>
<tr>
<td>13</td>
<td>Collection of comprehensive complaints data and commitment to using this to inform improvements to health service provision.</td>
</tr>
<tr>
<td>14</td>
<td>Ongoing evaluation and monitoring of the complaints mechanism in place, that includes consumers' participation throughout including the decision making processes.</td>
</tr>
<tr>
<td>15</td>
<td>Option to appeal the complaints handling processes used and resolution reached at the local level through an independent central health complaints mechanism.</td>
</tr>
<tr>
<td>16</td>
<td>Accountability of complaints mechanism to organisation, consumers and broader community.</td>
</tr>
</tbody>
</table>
The second element is that the complaints handling mechanism must be able to deal with a complaint about any part of the organisation, staff or services. Once some services or staff are excluded, consumers are again confronted with a confusing system and barriers to making complaints: any demonstrated commitment of the organisation to complaints handling is thus considerably compromised.

The third element is for complaints handling to be clearly link with consumers’ rights. Recognition of, and respect for, the rights of consumers is critical to the complaints handling process, as discussed in chapter five. Well defined statements of consumers’ rights, that are well known to consumers and staff, help create an environment in which complaints can be made and resolved fairly but the statements must reflect consumers’ perspectives of ‘rights’, not just the determinations of service providers. The fourth element is for complaints handling policies and procedures to be written and readily available. The policies need to reinforce the high value placed on the information contained in complaints by the organisation and how the organisation intends to use this information, as well as demonstrating a commitment to fairness and impartiality in complaints handling. The procedures need to include an outline of the steps that will be taken to investigate and resolve the complaint, including timelines, and a commitment to keeping complainants informed of progress. The involvement of consumers in the development of these documents is crucial.

The fifth element of a consumer model for complaints handling at the local level is for the designation of responsibility for complaints handling within the organisation to be centralised in one staff position, such as that of Complaints Liaison Officer (CLO). While other staff may be involved in aspects of complaints handling, it is the role of the CLO to ensure that complaints are appropriately dealt with. The sixth element is for the CLO to have sufficient delegation of authority to investigate complaints and negotiate resolutions. The seventh element is that the organisation must make available sufficient resources for complaints handling, such as administrative support and facilities for the CLO, and this
may include assistance to self help groups providing support to complainants. The eighth element of a consumer model for complaints handling at the local level is that the complaints mechanism must be accessible to consumers. The CLO must be situated in a physically accessible location and also be prepared to readily accept and act on complaints made by telephone or any other medium. The CLO must be prepared to seek out complaints from groups of consumers unrepresented amongst complainants.

The ninth element is that the complaints handling mechanism must be made highly visible. The mechanism must be publicised and promoted by the organisation so that all staff and consumers are aware that it exists and how it can be accessed. The tenth element is that support must be available to consumers, both prior to and after having made a complaint. This support might not be best provided by the organisation but the organisation has a responsibility to ensure that support is available. In some instances, where the complainant has experienced significant trauma, access to skilled counselling and rehabilitation services may also be needed. The eleventh element is that complainants must be allowed to have others advocate on their behalf when making a complaint and throughout the complaints handling process. The twelfth element is that complainants are invited to become actively involved in the resolution and determination of the outcomes from complaints if they wish. At a minimum, complainants are to be informed of the outcome and any action planned as a result of the complaint.

The thirteenth element of a consumer model for complaints handling at the local level is the collection of complaints data and commitment to using this to inform changes to the practices of service providers and the policies and procedures of the organisation. The complaints data collected needs to go beyond simple statistical totals, such as how many complaints were made, to include the substance of the complaint and the details of the resolution of the complaint. In this way, the complaints data can fulfil several functions by: providing feedback to service providers about their performance and consumers' expectations that may not be available otherwise; providing information that can be used in
service planning and review; and providing information about the complaints handling process, such as the satisfaction of consumers with the complaints resolution reached. The fourteenth element concerns the ongoing evaluation and monitoring of the actual complaints handling mechanism used to ensure the above elements are in place and working effectively. The fifteenth element is that complainants must be able to appeal the processes used and outcome reached at the local level through another health complaints handling body, such as a central, independent, statutory based health complaints mechanism or the Ombudsman. The sixteenth element is that the accountability of the complaints mechanism is not just to the organisation but to the consumers using the mechanism and more generally to the wider community.

The elements also identify a significant role for consumers in relation to complaints handing mechanisms at the local level: active participation in the various stages of the complaints handling process and particularly in forming a satisfactory resolution; involvement in providing information, advocacy and support to other consumers making a complaint; involvement in the monitoring of the effectiveness of process and procedures of the complaints handling mechanism from the perspective of consumers; participation in the broader policy development in relation to the complaints mechanisms operations; and involvement in advocating that the substance of complaints be taken seriously in health service planning and decision making. However, as discussed in chapter four, simply the act of making a complaint can be regarded as participatory activity.

This ‘complaints enhancing’ consumer model for health complaints handling at the local level incorporates the suggestions made by informants in the South Australian study for improvements to complaints handling, as well as drawing more broadly on the knowledge about consumers’ experiences of, and perceptions about, health complaints handling discussed throughout this thesis. Other models of health complaints handling at the local level that have been developed in recent years have also outlined a number of similar elements, for example the models put forward by the Health Issues Centre and the
Health Services Liaison Association. Together, these models provide ample evidence that ‘best practice’ in complaints handling at the local level, for the Australian situation at least, must include the elements outlined above. Until this occurs, consumers are unlikely to have confidence in the complaints mechanisms available to them at the local level, and the accountability of health service providers directly to consumers will remain fragile.

The willingness of health service providers to reform their complaints handling practices has often been influenced by other agendas, as discussed in chapters six and seven. In a similar way to the essential components of the combined model consumer for health complaints mechanisms, a number of the essential elements have been introduced into local complaints handling. The adoption of all sixteen elements of the consumer model for complaints handling practices at the local level is unlikely, unless the elements are seen to compatible by health service provider managers and professionals with these other more influential, but not necessarily more important, agendas.

8.4 LOCAL COMPLAINTS HANDLING: ‘COLLECTIVE INDIVIDUALS’

One of the major barriers to the adoption of the elements of the consumer model of complaints handling at the local level is the ‘individualisation’ of complaints and complaints handling. By viewing complaints as problems of individuals (consumers and service providers) rather than problems of organisations and systems, the link between complaints and organisational and/or systemic change remains tenuous. Yet one of the primary reasons that health consumers have given for taking the time and effort to make a complaint, has been to try to generate some change so that other consumers do not have to experience similar distressing events. The notion of collective individuals enables a new conceptual model of complaints handling at the local level in the health area to be proposed that formalises the nexus between complaints and organisational and/or systemic change.

The individualistic dynamics of complaints have been reinforced by the linear model of complaints handling that suggests that a complaint is the first stage in a claim for compensation. The purpose of complaints handling then becomes preventing or minimising that claim without regard for its legitimacy. The intense feelings of hurt and anger generated by some complainable situations easily lead to calls for retribution and punishment, particularly when other acceptable outcomes do not seem to be present. The idea that the health service provider may 'get away' with the incident, is an affront to commonly held notions of justice and fair play. The individualisation of complaints compounds this adversarial position between complainant and respondent. Alternatively, consumers' statements identifying altruistic motives for taking the time and effort to pursue a complaint, do not 'fit' with the linear model, as the desired outcomes include solutions that involve systems rather than individuals. Although health service providers identify altruistic aspects of their own professional behaviour, the divide between professionals and consumers seems to make it difficult for professionals to acknowledge the same altruistic attributes in others.

The notion of *collective individuals* encompasses the idea that each consumer (complainant) does not stand alone, even when the substance of the complaints appear quite disparate. The factor common to all complaints is the interactions that occur between consumers and service providers. While the individual consumer and service provider may be different for each complaint, overall, the making and resolution of complaints represent an important part of the interactions of the body of consumers, *collective individuals*, with the body of service providers, the health service organisation. It is from the results of this interaction that sustained organisational or systemic change, originating from complaints, can be achieved. In this way, the force of the complaints generated by *collective individuals* can potentially be greater that the sum of the individual complaints.

The assumptions about complaints handling underlying the notion of *collective individuals* are quite different to the assumptions underlying complaints handling viewed
as an individual activity. This is not to suggest that satisfactory resolution of individual complaints is unimportant or unnecessary; indeed it is still critical for the individual consumer. But the expected outcomes of collective individuals complaints are more than individual acts requiring individual solutions; change to some aspect of the organisation/system is the desired outcome leaving no place for apportioning blame. The development of an organisational culture that is open to 'hearing' complaints is essential; the factors necessary for this have already been discussed. In such an environment, complaints take on a positive value as legitimate contributions to the organisation's service provision processes. To move away from blaming individuals requires greater openness in dealing with complaints and acceptance that consumers may need to be financially compensated by the organisation for the harm done to them, circumventing the linear model of 'complaints to litigation'. In this way, the idea of trying to prevent complaints escalating to litigation by using complaints handling techniques, such as 'cooling out' complainants, has no status.\textsuperscript{12} Instead, there is a new focus on preventing complainable events from occurring in the first place, not only to reduce the need for compensation but also to reduce the actual harm and injustice done to consumers during their interactions with the organisation. The information available to the organisation from the substance of complaints becomes crucial if prevention strategies are to be effective. Health professionals' perceptions of areas of 'risk' for determining action by the organisation are complemented by consumers' perceptions of areas of 'risk'.

The interactions between collective individuals and organisations refer to the dynamic processes of information sharing, discussion and negotiation between 'parties' perceived as valued partners. It does not refer to the treatment/intervention relationships between individual consumers and health service providers. Improving consumer - health service provider relationships has often been proposed as the answer to preventing events

\textsuperscript{12} For discussion of the use of 'cooling out' complainants see Lloyd-Bostock & Mulcahy, pp144. The idea is not dissimilar to Hirschman's notion of companies/organisations allowing some voice to act as a safety valve. (See ch2.2.1.)
that lead to complaints. While improving treatment/intervention relationships is a laudable goal for other reasons, to focus primarily on improving interpersonal relationships, in the complaints handling context, reduces complaints to individual problems and encourages individualisation of complaints handling, reminiscent of the rotten apples and unrealistic expectations ideas noted in chapter one.

An individual complainant’s interaction with the organisation, when making complaints, takes on a different meaning when identified as part of the overall interactions between collective individuals and organisations. Lloyd-Bostock and Mulcahy suggest that making a complaint can be seen as a hostile act and therefore “potential for defensiveness and dissatisfaction... [is] endemic to the complaints process”. But as part of a broader range of expected interactions it is more difficult to perceive complaints making as hostile acts to be treated with suspicion and secretiveness. Instead, complaints making and handling become part of the normal expected functioning of organisations. Complaints are no longer seen as being individual concerns, but are representative of the concerns of the larger collective individuals. The partnership between organisations and consumers that results is not limited to ‘strategic’ partnerships or partnerships on service provider terms.

For the organisation, moving away from individualising complaints requires greater sharing of professional knowledge and decision making and a lessening of the demarcation between the roles of managers, professionals and consumers. It requires a willingness to increase transparency of processes and outcomes to those previously regarded as outside the organisational structure. It requires fostering a culture amongst staff, within the organisation, that welcomes comment and review and enables flexibility of procedures to accommodate diversity without reducing the integrity of the services provided. It is also requires a commitment to resolving each complaint, no matter how trivial the matter may

seem to the organisation, and using that information to inform change within the organisation.

The lack of an ‘exit’ option for many health consumers makes even more important the availability of a range of different mechanisms enabling a greater scope for participatory activity to occur. Consumers willingly participate if they believe that they will be taken seriously, that their contribution will be valued in the forum in which they choose to participate and that their participation will make a difference. The similarity in conditions that encourage other participatory activity (discussed in chapter four) and complaints making suggest that not only are they linked but that complaints making is a viable and acceptable participatory activity.

As a conceptual tool, the notion of collective individuals allows organisations to reconsider the value of the substance of complaints to the organisation and to move away from continued individualisation of complaints. Thus, collective individuals do not constitute a new form of consumer group, like the consumer groups described in chapters three and four, because collective individuals do not ‘exist’ in the tangible way that consumer groups do, such as holding regular meetings, elections of office bearers, and establishing a membership. By making a complaint, consumers automatically become part of the collective individuals. For consumers, this opens up a new way to participate that does not require membership of a consumer group because making a complaint is recognised as part of the participatory activity expected from consumers. If the complaints mechanisms in place are ‘complaints enhancing’, consumers are not required to give a long term commitment of time and resources to participate, often the case with other participatory mechanisms, such as consumer representation. Consumers can select which items, from their experiences with the organisation, they find most important to complain about, rather than being constrained by the brief of a consultancy or the defined parameters of a questionnaire. This increases the potential for ‘participatory’ equity amongst consumers, that is, that all consumers have the chance and choice to participate.
Acceptance of the notion of *collective individuals* allows organisations to implement the sixteen elements of the consumer model for health complaints handling at the local level because complaints handling is no longer perceived as threatening to the interests of the organisation. Instead, providing 'complaints enhancing' mechanisms are in the health organisation’s interests indicating a willingness to account to the individual for what has happened and to be accountable to the broader community for their actions and practices; individual complaints are dealt with but they are not individualised. However, some managers and professionals are likely to find it difficult to share, or give up, some of the power and control they currently hold in a health system that continues to separate individual interests and collective interests, often favouring the former over the latter.
CHAPTER NINE

CONCLUSION: CONSUMERS AND COMPLAINTS SYSTEMS IN HEALTH CARE

9.1  THE CONSUMER AGENDA FOR COMPLAINTS SYSTEMS OVERSHADOWED

The elements of consumer models for health complaints systems for application at both the local and central levels can be readily identified from the small, but growing, research on consumer complaints in the health area linked with the knowledge provided by the broader consumer movement in health. These ‘complaints enhancing’ models focus first, on the handling and resolution of individual complaints; and second, on the use of the information contained in complaints (the substance of complaints) to inform change in, and future planning of, health service provision. To be able to complain has increasingly been acknowledged as an important ‘right’ for health consumers, and fundamental to upholding the other rights of consumers when receiving health care. As well, making a complaint presents a way for consumers to participate in providing directions for better health service provision that does not necessarily require formal membership of a group or long term involvement.

But complaints handling in the health area has not generally reflected the elements of the consumers’ models, despite some recognition by health service providers and governments of the need to improve complaints handling. The mechanisms for handling complaints across the public sector have undergone reform as demand increased for greater accountability of public sector services to the government of the day and the public. The reforms have reflected the bureaucratic and professional solutions for complaints handling, rather than consumer concerns, and the emphasis remains on dealing with complaints individually. The underlying motive for accepting the reforms seemed to reflect the desire to contain and control disquiet about public sector services than a genuine concern to
rectify injustices. The administrative reforms of the 1970s established new complaints mechanisms, such as the Ombudsman and the Administrative Appeals Tribunal. Although limited in powers and jurisdiction, the Offices of the Ombudsman, for example, did increase the profile of handling complaints about administrative processes and the idea of scrutiny of public sector services by an independent body. The potential for these new mechanisms to play a significant role as catalysts for broader systemic change to the processes and procedures of public sector service provision was stifled however. Administrative control of the resources needed by the mechanisms was retained by government departments; consumer participation in the development and ongoing review of the mechanisms was not proposed. While advisory committees have been established recently for some mechanisms, for other mechanisms the idea of consumer participation has been said to compromise the impartiality of the mechanism and not adopted.

The reforms to the organisation and management of public sector services, introduced from the early 1980s, brought a different emphasis to complaints handling with the increasing attention to quality improvement and customer service. It was also a time when complaints handling by the health sector, in Australia, came under specific scrutiny as governments sought to gain better control over health sector spending and service provision. The new corporate management style directly related expenditure first to outputs and then to outcomes, and required restructuring of organisations and the introduction of more comprehensive information systems. The two agendas of consumers, seeking greater accountability of health service providers, and governments, through corporate management, seeking greater control over health service provider systems, had enough in common to foster some important developments in health complaints systems in Australia, including the Complaints Unit established by the New South Wales Health Department and the Victorian legislation for an independent, statutory based health complaints body.
The second important influence during the 1980s was that the Australian Labor Party, elected on a platform of social reform, held government in most states/territories around Australia and at the Commonwealth level. The ideas of social justice and consumer participation, part of the social reforms, were reflected in a number of government policies and documents. In the health sector, the adoption of the social view of health and the development of health promotion and disease prevention strategies were encouraged through the work of the Better Health Commission and state health departments, for example, in South Australia. As well, legislative changes in the consumer protection area had focussed attention on consumer rights. Consumer groups, such as the Health Issues Centre and the Consumers’ Health Forum of Australia, received government financial support enabling a strengthening of the consumer ‘voice’ in the health area. But this tentative move towards a more ‘consumer friendly’ environment was short lived as the political rhetoric of government debt and changing ideas about the role of public sector services took hold.

The various parts of the consumer movement in health had grown in organisation and vigour during the 1980s, providing a greater ability for consumers to contribute to health services planning and decision making. The involvement of the consumer movements in health sector debates, helped broaden the scope of those debates to include issues of concern to consumers. Consumers’ knowledge and experience about health matters gained validity as the consumer groups, often through conducting their own empirical research, became more sophisticated in demonstrating and communicating their arguments. A variety of methods were put in place to encourage greater consumer participation in the different aspects of health service provision. Consumers were increasingly able to have some influence, albeit often small, on improving health service provision. However, the skills, resources and energy available to consumers have been critical determinants of the extent of consumer participation in whatever from, including
making complaints, leaving the consumer voice vulnerable to changing political sensitivities and priorities.

By the 1990s the massive restructuring of public sector services, characterised by downsizing and privatisation, was occurring at a rapid and continuous pace. Consumers emerged from these changes now identified as ‘customers’. Indeed, many of the reforms were introduced on the basis of the need for increase responsiveness to customer demands but this did not result in greater consumer participation in decision making. Rather, consumers’ interests in health service provision, as in other areas of the public sector, were increasingly interpreted by managers and public relations personnel, who used the language of ‘customer’ demands. The establishment of central complaints mechanisms lost some of its previous appeal, as governments moved to reduce intervention and services. The account of the outcome of the Commonwealth government’s move to require all states and territories across Australia to introduce independent, statutory based, health complaints mechanisms, for example, highlights the changing agenda in regard to reform to central mechanisms for the handling of health complaints.

Changes to health complaints handling practices have taken place, but primarily because it has been in the interests of health service providers, both managers and professionals to do so. For managers, the interest in complaints handling has been inspired by the popularity of quality management practices, such as total quality management. The corporate management style demanded that the accountability of staff to the management of the organisation be clearly defined. In health service organisations, health professionals had grown accustomed to having considerable control over their own activities and being accountable to their professions, presenting a considerable challenge to managers in the way the managers were able to exerted their control. One major way the managers tackled this problem was to increase statistical data collection about the various aspect of the organisations’ activities. Control of complaints handling and complaints data provided
another way for increasing scrutiny of professional practices that might not otherwise have been accessible to managers.

In the face of this challenge by managers for ultimate control over health service activities, professionals have sought to reclaim their authority by adopting many of the managerial techniques, such as increased data collection and notions of quality service, and adapting them to advance the professionals' position in health service provision. Health professionals have taken a number of steps to ensure retention of professional autonomy in decision making by: developing more sophisticated quality assurance activities; refining other traditional methods used to demonstrate accountability for their actions, such as peer review; trying to control complaints handling in the health service organisation; and making some adjustments to the professionally controlled complaints mechanisms, for example registration boards.

The interest in complaints handling for managerial reasons has prevailed in the 1990s. But health professionals have also been active to ensure that they retain a considerable stake in complaints handling. The components of the consumer model for complaints mechanisms at the central level that were included in the new and revised complaints handling processes have not posed a real threat to managerial control or professional authority in health service provision. Key components from the combined consumer model are missing in most of the central bodies as they currently exist in Australia; in particular being able to enforce outcomes, such as the implementation of recommendations for changes to professional practices or improvements to health service procedures, and ensuring sufficient support and advocacy for consumers making a complaint. Changes to health complaints handling at the local level have rarely demonstrated all the elements for complaints handling mechanisms considered essential from the perspectives of consumers. The weight given to the consumer agenda for health complaint handling in the reform of complaints mechanisms has been influenced by the mistaken belief held by many health service providers that consumers only want a personal
solution to their complaints, such as financial compensation. The fact that consumers may be motivated to complain by an altruistic desire to see health service improvements result from their actions of making complaints has all to frequently been dismissed. Managers and health professionals, through controlling the complaints handling processes, also retain control over the impact that the substance of complaints may have on prompting health service improvements or other changes, leaving consumers with little real unvetted power or influence on the outcomes of their complaints.

There have been few real incentives for health service providers to adopt all the elements of the consumer models for complaints mechanisms, at either the local or central levels, in an environment where health service providers themselves are under threat from broader government agendas. The individualisation of complaints has continued, so that consumer dissatisfaction and dissent has been directed, controlled and used to advantage the agendas of other groups. This is in contrast to the consumer focus on using complaints data for the benefit of other consumers through informing improvements to health service provision. The major restructuring and reform of government services and demand for greater professional accountability and control have overshadowed the more modest consumer agenda for health complaints mechanisms.

9.2 IMPLICATIONS FOR PUBLIC HEALTH

The provision of medically defined treatment services has been considered an important component of strategies to improve the health of the public for most of the twentieth century. Over the past two decades, as noted in chapter one, there has been a shift of focus to encompass the social view of health, building ‘healthy’ public policies, creating supportive environments, strengthening communities, developing personal skills and re-orientating health services.\(^1\) Despite some increase of emphasis on health

---

promotion and disease prevention and community based services, health service provision continues to be dominated by hospitals and large health services. Reorientating these existing services to provide an environment more responsive to consumers remains an important goal. Complaints data provides unique information about different aspects of health service provider behaviour and health service practices that can be directly used to inform change to all aspects of health service provision.

The fact that a significant number of consumer interactions with health service providers resulted in adverse outcomes for many consumers was the basis for much of the legislation and regulation covering the provision of health services introduced late last century and earlier this century. The fact that adverse outcomes continued to occur, even with legislation in place and seemingly stringent controls on health service provider training and practice through professional registration boards and licensing of health services, was less well known. The dominance of the professions, particularly the medical profession, had stifled public discussion of the issue and promoted an atmosphere where complaints were largely taken as an affront to the integrity of the profession. The release of preliminary findings of the Australian hospital care study,\textsuperscript{2} commissioned by the Review of Professional Indemnity Arrangements for Health Care Professionals, in mid-1995, confirmed that the situation in Australia in regard to adverse outcomes mirrored the findings of other studies overseas, such as the Harvard Medical Study described in chapter two. Consumers had every right to be concerned that any interaction with health service providers may result in a serious adverse outcome. The economic cost to the health system in ‘treating’ the adverse outcome, as well as the social and financial cost to the consumers involved, provided ample reasons why adverse outcomes can no longer be ignored.

Consumers, through making complaints, had been drawing attention to the inadequacies of health service provision for many years yet this information, typically, had been dismissed as the concerns of individual consumers and their health service providers, not to be taken as indicative of more extensive problems throughout the overall system of health service provision. The lack of investment in complaints handling reflected the limited interest in complaints. Regardless of the inadequate, or non-existent, complaint handling mechanisms in place and extensive barriers to making complaints, consumers persisted in making their complaints heard, even when the likelihood of a resolution satisfactory from their perspective was rare. The injustices perceived by consumers, resulting from the experience of complainable events, were deeply felt and consumers were concerned that others might experience similar distressing events. By complaining, consumers hoped to receive an account of why events occurred as they did and an undertaking that changes would be made so that similar situations would not occur to others. But health service providers had tended to ignore these requests and, instead, perceived complaints as the first step in litigation claims.

Any environment that causes harm, injury or ill health must come under public health scrutiny. While considerable attention has been focussed on the impact of the physical environment, industrial environment and the effects of poverty on the health of the population, the impact of the health service provision environment on the health of consumers has received less intensive examination in the public health literature. It should be noted that issues relating to occupational health and safety matters concerning staff employed by health services has received greater attention, partly because of staff membership of active trade unions. This thesis shows that the perspectives of consumers about their interactions with health service providers can differ quite markedly from the perspectives of health service providers but few health service providers have learned to listen to consumers' views about service provision, or to encourage the expression of these views. Learning from consumers is sometimes seen to be contrary to the construction of
professional behaviour, dependent upon professionally determined knowledge and skills. If professionals are to be able to better accept the substance of complaints as valid, the current practice of peer review needs reinterpretation. The reliance of peer review on the fundamental notion that judgement about professional behaviour and actions can only be made by those with similar knowledge and skills must be challenged and a broadening of the notion of peer review to include others’ views is needed. More detailed and clearer definition of health service provider activities, through the development of standards and protocols for various procedures and practices with consumer input, can assist this process. In this way, the accountability of health service providers directly to consumers can be strengthened; ideally it should not take the making of a complaint to receive a sufficient account of the health service providers’ actions.

Commitment to the recognition of health consumers’ rights and encouragement of consumer participation will also influence the interaction between consumers and health service providers. Both these factors are important indicators of the health service providers willingness to hear and act upon complaints yet attention to upholding consumers’ rights, including the rights to participate and complain, have often been seen by health service providers as peripheral to health service provision. However, unless participatory actions by consumers, such as making complaints, are valued and encouraged by health service providers, an acceptable partnership between consumers and health service providers cannot be said to exist and the current inequitable relationship will continue. Better health outcomes are more likely to occur when the interactions of consumers and health service providers reflect a greater equality between the two parties.

These are not easy issues to address as consumers have been systematically excluded from involvement in health service provision as professional control has become more entrenched in the health system during this century, only really challenged by the relatively recent managerial reforms. The almost total reliance on professional decision making about health care matters has dominated health policy development and
encouraged a system more sensitive to the needs of providers than the needs of consumers. Reform to the very structure of the current organisation of health care services must be proposed if consumers are to really gain a greater say in health service planning and provision. In the meantime, complaints offer a window into the different aspects of health service provision, and the impact on consumers, that would otherwise remain hidden within the individual health care relationship.

Expecting consumers to be able to resolve their complaints with health service providers at the local level, without offering a mechanism that incorporates the sixteen elements identified in the consumer model for complaints handling, is to ignore the considerable barriers consumers face when they want to lodge a complaint. It also ignores the outcome desired by consumers that the information raised in a complaint will be used to inform change. The continued individualisation of complaints is neither ‘complaints enhancing’ for consumers nor constructive for individual service providers, who may be just as much victims of structural constraints. Health service providers need to perceive individual complaints as part of the broader participatory activity of consumers and reflective of the spectrum of complaints made not by one individual, but collective individuals, representative of all consumers of the service. The challenge to health service providers is to be able to value the substance of complaints for what they have to offer, rather than retreating behind a defensive barricade of professional expertise.

The study of complaints handling in the health sector has much to offer complaints handling in human service provision more generally. The professionalisation of welfare services, for example, mirrors many of the practices that have developed in the health system whereby consumers have been excluded from the planning and decision making processes of service provision. The professionals see themselves as acting in the best interests of their ‘clients’ and have often been impervious to consumer criticism of their actions. Often working as agents for the broader community in upholding certain community values (for example, making judgements about the ability of some women to be
competent mothers) it has been easy to overlook the real impact of the services offered on vulnerable and disadvantaged people in the Australian community. Although there have been greater attempts, recently, to be a little more accommodating of individual wishes, human services generally have not fostered an environment that has encouraged consumer complaints. The need for improved complaints handling practices in human service delivery has already been recognised by some organisations, such as the Home and Community Care Program discussed in chapter six. As well, the idea of a central, independent, statutory base complaints mechanism, similar to existing health complaints mechanisms has gained some support and the first such body was set up in New South Wales in 1994. Mechanisms generated by human service providers are likely to reflect limitations similar to the mechanisms generated by health service providers discussed in this thesis. Commitment to consumers rights and participation by consumers is fundamental to gaining improvements in complaints handling. The need to reconceptualise complaints as part of the participatory activities of consumers, and to refrain from individualising complaints is just as relevant to the human services area as the health area. Using the elements of the consumer models for health complaints mechanisms as a starting point, ‘complaints enhancing’ mechanisms for the human service sector, from the perspectives of consumers, could be developed.

9.3 HEALTH COMPLAINTS SYSTEMS IN THE FUTURE

It is likely that complaints handling in the health sector will continue to reflect the changing agendas of consumers, governments and health service providers. The improvements to complaints handling in the health area, over the past decade, have occurred during a period of extensive restructuring of health services and a redefining of professional and managerial roles. These changes have presented some opportunities for reforms to health complaints systems but the reforms have also been the result of an accumulation of factors that began years earlier with the highlighting of the barriers
experienced by consumers when trying to lodge complaints about various aspects of the health system; the greater acceptance of consumers' rights; a more conducive political atmosphere to consumer participation in health service planning and decision making; and the strengthening of consumers' voices through increased consumer group activity.

Improvements to complaints handling in the health area seem to have reached a plateau, where some changes have been made, particularly to the handling of individual complaints, but the major and important step, from the perspectives of consumers, has not been taken: that of systematically seeking out and using complaints information to inform change to organisational practices, procedures and future planning. This requires a relinquishing of some of the power and control that health service providers have become accustomed to and, it would seem, do not want to give up willingly. In line with the changes already made, it could be confidently predicted that further elements of the consumer models will only be taken up if they coincide with the agendas of health service providers and/or governments.

The move to encourage greater resolution of complaints at the local level, so that the central health complaints bodies can deal with the most 'serious' complaints, risks the development of a multi-tiered complaints system, where some complaints are afforded less value than others. As already noted, the determination of the seriousness of complaints is often made from the perspectives of health service providers. Unless all complaints are seen as valuable, the motivation for both consumers and health service providers to invest time and resources into complaints will be reduced, resulting in fewer complaints and inadequate mechanisms. The use of alternative dispute resolution by some central complaints handling mechanisms, such as mediation and conciliation, may not always be to the advantage of consumers. The further adoption of alternative dispute resolution methods must be systematically and specifically evaluated from the perspectives of consumers, if they are to be offered as a valid and just alternative to consumers.
The elements of the consumer models for health complaints systems for implementation by central bodies and by local health service organisations have been well defined in this thesis. However, the incorporation of these elements into the complaints handling practices of central bodies and health service providers has been outside consumer control in the past and is likely to remain so in the future. Notions of consumer participation are increasingly being replaced by notions of individual responsibility that will continue to encourage the individualisation of health complaints and complaints handling. In this environment consumers, unless reconceptualised as the larger force of collective individuals, will find that health complaints handling, at the local or central level, will offer little real resolution of their health complaints.
APPENDIX ONE

Consumers' Health Forum of Australia Statement on Consumer Health Rights and Responsibilities

as reproduced in Consumers' Health Forum of Australia. 1990, Legal Recognition and Protection of the Rights of Health Consumers, prepared by M. Hogan (Public Interest Advocacy Centre), Consumers’ Health Forum, PO Box 278, Curtin ACT, November, p12-113.

Appendix A. Forum's Statement on Consumer Health Rights and Responsibilities

Consumer Health Rights

The Consumers' Health Forum of Australia promotes the following set of principles, rights and responsibilities to enhance the health rights of consumers individually and collectively within Australia.

Principles

A. We are entitled to a healthy and safe environment in which to live and work. That is:
   • our basic needs are met;
   • the physical environment enhances our quality of life;
   • we are protected from health hazards.

B. We are entitled to adequate, accurate information and education enabling us to make informed decisions which promote health and prevent ill health and disability.

C. We are entitled to participate in the development, monitoring and implementation of social and economic policies and programs.

D. We are entitled to equal access to health services which:
   • promote health;
   • prevent and alleviate ill health and disability; and
   • provide health care.

E. We are entitled to determine whether or not to seek assistance from health workers.

Rights

The Consumers' Health Forum of Australia supports the rights outlined below for all consumers. These rights are not all currently enforceable by law in Australia. The Forum recognises that, in exceptional circumstances, individuals may be unable to exercise their rights. In some cases a person independent of the care given and institution may be required to act on an individual’s behalf.
Legal Recognition and Protection of the Rights of Health Consumers

1. I have a right to appropriate, quality health care, when I need it.

2. I have the right to determine what happens to me, including:
   - to choose to leave my condition untreated;
   - to give my explicit consent before any procedure can be carried out;
   - to withdraw my consent to a procedure;
   - to refuse to allow a procedure to be carried out;
   - to refuse health care from a particular health worker (including medical practitioners, allied health professionals and alternative health practitioners);
   - to refuse health care from students;
   - to refuse to participate in research and experiments.

3. I have the right to an adequate explanation, in terms and language I can understand, of:
   - the nature of my ill health and the likelihood of my return to good health;
   - the details of any proposed procedures and therapies (e.g. consultations, tests, examinations, treatment) as well as possible alternatives including
     - expected outcome,
     - adverse and after affects,
     - chances of success,
     - risks,
     - costs and availability,
     - whether the procedure is experimental or to be used in research;
   - the results of any procedures which have been carried out and the implication of those results;
   - the possible consequences of not taking the advice of the health worker;
   - the name, position, qualifications and experience of health workers who are carrying out the procedures.

4. I have the right to receive health care in privacy and to be treated with respect and dignity.

5. I have the right to decide who will be present when I receive health care.
   - I can require the presence of other people, including a friend, family member, advocate, interpreter, etc.
   - I can refuse the presence of:
     - health workers not directly involved in my care,
     - students,
     - researchers, and
     - others including family members.

6. I have the right to seek information and advice from other sources.

7. I have the right to seek treatment from other health workers of my choice.
Legal Recognition and Protection of the Rights of Health Consumers

8. I have the right to have all identifying personal information kept confidential. Thus no identifying information about me, my condition or treatment will be made available to anyone else without my consent.

9. I have the right to access, and to seek amendment or additions, to all information relating to my health care and condition, either personally or through another person I nominate.

10. I have the right to comment on, or complain about, my health care.

11. I have the right to receive compensation for injuries or illness caused, or aggravated by, health care or health care advice provided by a health care worker.

12. I have the right to refuse admission to, and to leave, a health care facility regardless of my physical condition or against medical advice, and regardless of whether I have paid the bill.

Responsibilities

Exercising responsibilities in the health system can be as important as exercising rights.

However, there are many areas of life in which people find it difficult to exert control. In many instances consumers find it difficult to make an informed choice.

Nevertheless, it is in our best interests to assume as much responsibility for our health as possible.

After all, it is our health at stake!

In order to promote partnership between the consumer and health workers, the Consumers' Health Forum of Australia recommends that consumers:

• provide information that enables the health care worker to provide adequate advice and care;
• actively seek health care information;
• treat seriously any agreement to action chosen in partnership with a health worker;
• acknowledge responsibility for the consequences of their decision to accept or reject advice;
• recognise that choices concerning their lifestyle affect their health;
• advise the appropriate authority of any complaint they may have concerning their health care so that corrective action can be taken.
APPENDIX TWO

Interview Schedules for the study *Perspectives on the Handling of Health Complaints at the Local Level in South Australia*

**INTERVIEW SCHEDULE : SERVICE PROVIDERS**

- How are complaints about your organisation’s services addressed and by whom?

- What are the most common types of complaints made and who makes them?

- Is any distinction made about the type of complaint received, or who is making the complaint in the way it is addressed? If so in what way?

- Is this policy/procedure for addressing complaints written? (request copy if available) If so where and in what format? How are staff and consumers made aware of this?

- What assistance/support is given to people who want to make complaints and who gives this?

- How do you know when the complaint is resolved? How is the outcome communicated to the person who made the complaint? In your opinion what percentage of complaints are resolved to the satisfaction of the organisation? the consumer?

- Are complaints referred elsewhere? If so where?

- Is data about complaints collected, by whom and how is it used?

- Do you think complaints could be addressed differently in your organisation? If so in what way?

- Do you have any other comments you would like to make?
INTERVIEW SCHEDULE: CONSUMER GROUPS

- Do you know if the health service you use most frequently has a complaints procedure/policy? If so what is it? (also type of health service)

- Have you ever tried to use it? If so what was your experience?

- When using the complaints procedure or making a complaint did you receive any assistance/support with making the complaint? (what and from whom)

- What encouraged you to make the complaint? (also type of complaint)

- How was the resolution of the complaint communicated to you? In your opinion was the resolution satisfactory? (why/why not) Where there any other outcomes you would have liked to have seen? Would you complain again?

- How could the complaint have been handled differently?

- Have you used any other avenue to raise your concern/complaint? What was the outcome?

- What might encourage other consumers to complain?

- Do you have any other comments you would like to make?
INTERVIEW SCHEDULE - CENTRAL BODIES/INDIVIDUALS

From your experience in working with service providers and/or consumers what do you think are the most common kinds of complaints made and who makes them?

In your position what role do you have/take in relation to addressing complaints? What complaints mechanisms are in place currently that you use or refer consumers to? How does the type of complaint or who is making the complaint influence the action you would take/advise?

Do you know if there is any distinction made about the type of complaint received, or who is making the complaint in the way it is addressed by service providers? If so in what way?

What do you know about complaints resolution at the 'local' level? (that is between service provider and consumer) In your opinion what percentage of complaints addressed at the local level would you say are resolved to the satisfaction of the organisation? the consumer? How is the outcome communicated to the person who made the complaint?

How important is it for service providers to have a written procedure for addressing complaints and why? How should staff and consumers be made aware of this?

What assistance/support is currently given to people who want to make complaints and by whom? What assistance/support do you think should be available?

Do you know if data about complaints is collected, by whom and how is it used? How else could it be used?

Do you think complaints could be addressed differently at the 'local' level? If so in what way? Are there service providers who you see as addressing complaints at the local level in an exemplary way? What makes them exemplary?

Do you have any other comments you would like to make?
BIBLIOGRAPHY

The bibliography includes sources referred to in the body of the thesis only. It is sorted into two parts: primary sources and secondary sources.

**Primary Sources** are sorted as:
- Australian Commonwealth and States/Territories governments documents;
- Australian Commonwealth and State/Territory legislation;
- Other documents.

**Secondary Sources** are sorted as:
- Books, book chapters and reports;
- Articles from journals and newsletters;
- Presentations, conference papers and other documents;
- Theses.

**PRIMARY SOURCES**

**Australian Commonwealth and States/Territories government documents**


Home and Community Care Program. 1992, *Complaints Policy*, HACC, Department of Health, Housing and Community Services, Canberra.


National Health Strategy. 1993b, Healthy Participation. Achieving Greater Public Participation and Accountability in the Australian Health Care System, Background Paper No.12, National Health Strategy Secretariat, Department of Health, Housing and Community Services, GPO Box 9848 Canberra, March.

New South Wales, Complaints Unit. 1994, Annual Report 1993/94. In the Public Interest, Health Complaints Commission, Level 4, 28-36 Foveaux St, Surrey Hills NSW.


New South Wales, Department of Community Services. 1993, Appeals and Complaints Mechanisms for Community Services in NSW, Information Kit, Department of Community Services, Sydney.

New South Wales, Department of Health, The Complaints Unit. 1990, Annual Report 1990. In the Public Interest, The Complaints Unit, Level 5, 28-36 Foveaux St, Surrey Hills NSW.

New South Wales, Department of Health, The Complaints Unit. 1991a, Information Sheet for Health Professionals, The Complaints Unit, Level 5, 28-36 Foveaux St, Surrey Hills NSW, July.

New South Wales, Department of Health, The Complaints Unit. 1991b, Witness Information Sheet, The Complaints Unit, Level 5, 28-36 Foveaux St, Surrey Hills NSW.

New South Wales, Department of Health, The Complaints Unit. 1991c, What Happens When a Complaint is Made Against You, The Complaints Unit, Level 5, 28-36 Foveaux St, Surrey Hills NSW.


Pennington Inquiry. See Committee of Inquiry into Rights of Private Practice in Public Hospitals.


Sax Report. See Enquiry into Hospital Services in South Australia.


Ward 10B, Townsville General Hospital, see Justice WJ Carter, *Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of the Townsville General Hospital*.

**Australian Commonwealth and States/Territories legislation**

*Administrative Appeals Tribunal Act 1975* (Commonwealth)

*Administrative Decisions (Judicial Review) Act 1977*, (Commonwealth)


*Freedom of Information Act 1982*, (Commonwealth)

*Health Care Complaints Act 1993*, (New South Wales)

Health Care Complaints Bill. 1992, (first print), (New South Wales)

*Health Complaints Act 1993*, (Australian Capital Territory)


*Health Services (Conciliation and Review) Act 1987*. (Victoria) 1993, reprint with amends..
Health Services (Conciliation and Review) Bill 1992, (Western Australia)

*Health Services Act 1988*, (Victoria)

Health Services Bill 1995, (South Australia).

*Human Rights and Equal Opportunity Commission Act, 1986* (Commonwealth)

*Medical Practitioners Act 1987* (New South Wales)


*Ombudsman Act 1976*, (Commonwealth)

Privacy Act (Commonwealth)

*Trade Practices Act 1974*, (Commonwealth)

**Other primary sources**

Australian Association of Social Workers Ltd. 1994, *Code of Ethics, By-Laws on Ethics*, Australian Association of Social Workers Ltd, PO Box 84 Hawker ACT.


Australian Federation of Consumer Organisations. 1990, *Annual Report 1989*, Australian Federation of Consumer Organisations, Level 1, 40 Mort, St Braddon ACT.


*Choice*. 1993, inside front cover, September.


Health Forum. 1994, no.31 October, inside front and back cover.


Public Interest Advocacy Centre. 1993, PIAC and Access to Justice and Human Rights, Update, leaflet, PIAC, Sydney, April.


Second Story Community Youth Health Service. 1993, Know Your Health Rights, Second Story Community Youth Health Service, Peel St, Adelaide.

Solomon, S. 1984, Proposal to Establish a Health Issues Centre, 290 Wellington St, Collingswood Victoria, May.


**SECONDARY SOURCES**

**Books, book chapters and reports**


Consumers’ Health Forum of Australia. 1988, A Survey of Health Consumer Groups, Consumers’ Health Forum, PO Box 278, Curtin ACT.

Consumers’ Health Forum of Australia. 1989, Making Health Rights a Reality, Consumers’ Health Forum, PO Box 278, Curtin ACT.

Consumers’ Health Forum of Australia. 1990, Legal Recognition and Protection of the Rights of Health Consumers, prepared by M. Hogan (Public Interest Advocacy Centre), Consumers’ Health Forum, PO Box 278, Curtin ACT, November.

Consumers’ Health Forum of Australia. 1992, A Consumer Perspective on Health Complaints Mechanisms in Australia, prepared by G. Ednie, Consumers’ Health Forum, PO Box 52 Lyons ACT.


Draper, M. 1993, Casemix. Quality and Consumers, Health Issues Centre, 1st Floor, 257 Collins St, Melbourne.


Halpin, D. 1984, Consumers’ Choice: 25 Years of the Australian Consumers’ Association, ACA, 57 Carrington Rd, Marrickville NSW.


Health Issues Centre. 1988, *Getting Off the Sickness-Go-Round. Are We on the Right Track?*, Health Issues Centre, 3rd Floor, 148 Lonsdale St, Melbourne.

Health Issues Centre. 1989b, *Consumer Protection in Health - How Far Have We Come?*, Submission to the Minister for Health, Hon. Caroline Hogg, prepared by G. Ednie in consultation with the Consumer Rights Standing Committee, Health Issues Centre, 1st Floor, 257 Collins St, Melbourne, April.


Health Issues Centre. 1991b, *Complaints Handling in Victoria's Hospitals - Towards a Consumer Focus*, Health Issues Centre, 1st Floor, 257 Collins St, Melbourne, November.


Jaggard, R. 1992, "What have You Got to be Depressed About? You've Got Him, the Kids, the Dog, the Goldfish, the Car, a Sunbeam Steam Iron, a Whirpool Washing Machine, a Hoover, a Part-time Job ... So Take a Pill or Something!" in Smith, A. ed. *Women's Health in Australia, 2nd Edition*, University of New England, Armidale NSW.


Longley, D. 1992a, *Health Service Complaints Procedures*. Report funded by the Economic and Social Research Council and the British Academy, Centre for Socio-Legal Studies, Department of Law, University of Sheffield, Sheffield.


Articles from journals and newsletters


Caples, J. 1990a, “Consumer Protection in Health - Do We Know Enough about the System?”, Health Issues, no.24, September, pp14-16.


Hall, J. & Dornan, M. 1988b, “What Patients Like about their Medical Care and How Often They are Asked: a Meta-analysis of the Satisfaction Literature”, *Social Science and Medicine*, vol.27, no.9, pp935-939.


**Presentations, conference papers and other documents**


Cameron, C. 1975, *A Fair Deal for Consumers in Australia*, Speech delivered by the Australian Minister for Science and Consumer Affairs at a Meeting with Consumer Representatives, Sydney, 1 August.


**Theses**


### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAT</td>
<td>Administrative Appeals Tribunal (Commonwealth)</td>
</tr>
<tr>
<td>ACC</td>
<td>Australian Consumers’ Council (previously National Consumer Affairs Advisory Council)</td>
</tr>
<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
</tr>
<tr>
<td>ADR</td>
<td>Alternative dispute resolution</td>
</tr>
<tr>
<td>AFCO</td>
<td>Australian Federation of Consumer Organisations (from late 1995, Consumers’ Federation of Australia)</td>
</tr>
<tr>
<td>AGPS</td>
<td>Australian Government Publishing Service</td>
</tr>
<tr>
<td>AHA</td>
<td>Australian Hospitals Association</td>
</tr>
<tr>
<td>ALRC</td>
<td>Administrative Law Reform Commission</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>ARC</td>
<td>Administrative Review Council</td>
</tr>
<tr>
<td>CGI</td>
<td>Consumer group informants</td>
</tr>
<tr>
<td>CHASP</td>
<td>Community Health Accreditation and Standards Project</td>
</tr>
<tr>
<td>CHF</td>
<td>Consumers’ Health Forum of Australia Inc.</td>
</tr>
<tr>
<td>CHP</td>
<td>The Community Health Program (Commonwealth funded)</td>
</tr>
<tr>
<td>CLO</td>
<td>Complaints Liaison Officer</td>
</tr>
<tr>
<td>CU</td>
<td>New South Wales Health Department, Complaints Unit</td>
</tr>
<tr>
<td>DHSH</td>
<td>Commonwealth Department for Human Services and Health, previously the Department of Health, Housing, Local Government and Community Services; Department of Health, Housing and Community Services; and Department of Health and Community Services. In 1996 another name change to Commonwealth Department for Family Services and Health.</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
</tr>
<tr>
<td>FOI</td>
<td>Freedom of Information</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care Program (Joint Commonwealth/State program)</td>
</tr>
<tr>
<td>HACO</td>
<td>Health Advice and Complaints Office, South Australian Health Commission</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Issues Centre Inc.</td>
</tr>
<tr>
<td>HMPS</td>
<td>Harvard Medical Practice Study</td>
</tr>
<tr>
<td>IOCU</td>
<td>International Organisations of Consumer Unions</td>
</tr>
<tr>
<td>NCAAC</td>
<td>National Consumer Affair Advisory Council</td>
</tr>
<tr>
<td>PIAS</td>
<td>Patient Information and Advisory Service, South Australian Health Commission (later became HACO)</td>
</tr>
<tr>
<td>PIR</td>
<td>Review of Professional Indemnity Arrangements for Health Care Professionals</td>
</tr>
<tr>
<td>POI</td>
<td>Peak organisation informants</td>
</tr>
<tr>
<td>RIPAA</td>
<td>Royal Institute for Public Administration Australia (from 1996 Institute for Public Administration Australia</td>
</tr>
<tr>
<td>SAHC</td>
<td>South Australian Health Commission</td>
</tr>
<tr>
<td>SOCAP</td>
<td>Society of Consumer Affairs Professionals Australia</td>
</tr>
<tr>
<td>SPI</td>
<td>Service provider informants</td>
</tr>
<tr>
<td>TPA</td>
<td>Trade Practices Act 1974 (Commonwealth)</td>
</tr>
</tbody>
</table>