SUBMISSION SOURCE

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ADAVB's MAIN AREAS OF INTEREST

- Unregistered providers
- Role of Health Services Commissioner
- Relationship between HSC and health registration boards
- Referral of complaints

KEY ISSUES OF CONCERN

We support

- Extension of the HSC's powers to deal with non-registered persons, including dental technicians and owners and/or CEOs of dental practices and laboratories, who are not registered persons.

We do not support

- Legislated supervision of complaints handling mechanisms conducted by professional associations. We already have a registration Board dealing with dental care providers and paid for by registration fees. The ADAVB is happy to cooperate with the HSC as at present, but not as a Branch office of the HSC.
- Extension of the 'naming powers' of the HSC, since this presumes there could never be errors.

We argue that

- The health and safety of the public should be protected by adequate regulation. We consider the health practitioner registration provisions fail to adequately protect the community from the actions of unregistered persons who offer health services, or who employ registered persons to do so. The HSC may be in a position to remedy some of the problems permitted by the lack of any power on behalf of registration boards to regulate the behaviour of non-registered health service providers.

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- Since all registered dental care providers who intend to provide care require indemnity, but need not be members of professional associations, it may be preferable for the HSC to form a dialogue with all indemnifiers.
- Often, the worst problems arise in connection with practitioners who choose not to belong to the Association. The public benefit would be better served considering means by which to address their participation.
- Data about complaints currently published by the HSC fails to identify the number of practitioners involved in multiple complaints, and so gives the impression that the number of complaints is indicative of the number of practitioners generating them. This problem would be exacerbated under splitting provisions, unless the HSC ensured that reporting on complaints highlighted the total number of practitioners responsible for the complaints associated with each area of health service. The HSC might also refer to the relevant registration board, instances where the one practitioner was responsible for say three or more serious complaints (from separate patients) in any one year.

We note that

- The Branch liaises closely with the HSC on dental complaints lodged against members, and has often been able to assist in resolution of such matters.
- The Discussion Paper incorrectly refers to dental technicians as registered persons (Section 5.2, p. 25). Dental prosthetists, previously known as 'advanced dental technicians' are registered dental care providers, but the legislation review process did not consider that dental technicians should be registered, since they should only be dealing with dentists and have no direct dealings with patients. This may not happen in practice, and measures are required by which to address inappropriate relationships between dental technicians and the public.

NOTE REGARDING PRO FORMA GUIDELINES

The ADAVB objects to the restrictive guidelines attached to the Submission Pro Forma, especially given the explicit invitation within the body of the Discussion Paper to comment on no less than 37 (!) separate questions.

According to notes within the guidelines, they were "provided to assist individuals and organisations in the preparation of submissions. Submissions, which should be limited to three pages, are due by close of business on 10 November 2000…" (emphasis added). Simply transcribing the questions would occupy more than three pages alone. Remembering that many audiences for our submission will not have the Discussion Paper at their elbow when they read it, we believe it is entirely appropriate that a longer format has been used. Imposing an arbitrary guideline like this potentially exposes the process to the risk of superficiality and to missing out on significant points.

This submission therefore adopts the pro forma guidelines to the extent they are relevant, and deliberately ignores them otherwise.

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1. INTRODUCTION

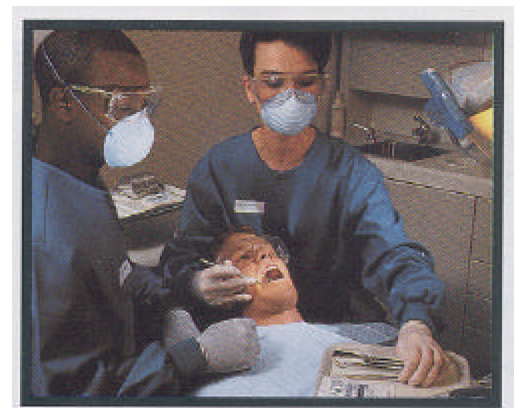
Dental services are defined under section 3 of the Health Services (Conciliation and Review) Act 1987 (the Act), as one of the health services subject to the jurisdiction of the Health Services Commissioner.

The Australian Dental Association Victorian Branch Inc. (ADAVB) is the professional association of dentists in Victoria, representing around 94% of active private practitioners and around 60% of public sector dentists within its membership of over 2000 dentists. Whilst there are around 2,400 registered dentists, many of these are interstate, overseas, academics, not practicing, or otherwise outside the system.

2. ABOUT DENTISTRY

There are four categories of registered dental care providers under the Dental Practice Act 1999 (the DPA), namely dentists, dental therapists, dental hygienists and dental prosthetists. Dentists are further subdivided into general practice and 11 specialties in the fields of

Orthodontics
Periodontics
Endodontics
Prosthodontics
Paedodontics
Oral Surgery
Oral and Maxillofacial Surgery
Dentofacial Radiology
Public Health Dentistry (Community Dentistry)
Oral Medicine and
Oral Pathology



According to the most recently available registration numbers, the following populations of each group currently exist in Victoria:

Dentists	2500
Dental Therapists	230
Dental Hygienists	100
Dental Prosthetists	305

Following the competition law reform review of the Dentists Act 1972 and the Dental Technicians Act 1972, the new DPA now permits non-registered persons to own and operate dental practices and dental laboratories. Dental technicians, who were previously licensed to operate, are no longer required to be registered, because it is assumed that they do not deal directly with the public.

The ADAVB has endorsed professional indemnity schemes on behalf of its members since its inception in 1928. At various times these schemes have involved use of discretionary mutual medical defence organisations or insurance companies. Currently, the Branch's defence scheme is conducted in the form of a claims made insurance cover underwritten by Guild Insurance Limited (GIL). GIL is owned by the Pharmacy Guild of Australia, and also indemnifies pharmacists, veterinarians, and various other professional groups. Most, but not all ADAVB members, choose to participate in the ADAVB Dentists Liabilities Insurance Policy.

3. PROFESSIONAL INDEMNITY INSURANCE

Another key change brought about by the DPA was the requirement that all registered dental care providers must have professional indemnity insurance [section 4(3)(a)]. This means that whilst an association cannot compel all practitioners to become members of its defence scheme, since this would constitute a third line forcing breach of the Trade Practices Act, all providers are covered by an indemnifier of one kind or another.

In the dental field, the main indemnifiers are ADAVB in conjunction with Guild Insurance Limited, Aon Risk Services (for the public sector agencies and their staff), and Dental Protection Limited (DPL), a subsidiary of the Medical Protection Society (MPS), a London based discretionary mutual. For approximately 30 years until 1 July 1999, the ADAVB defence scheme had been conducted in conjunction with DPL. One of the reasons for a change to a claims-made insurance cover was recognition by the ADAVB, that members of the community wanted more surety in professional indemnity arrangements, and that the purely discretionary form of cover was under scrutiny as to its adequacy.

Other indemnifiers operate on the fringe of the Victorian market, including United Medical Protection and St Paul Insurance.

4. DENTAL COMPLAINT RESOLUTION

The ADAVB conducts a Community Relations Function, which provides a conciliation service to patients concerned at some aspect of the treatment or relationship with member dentists. It does not seek to offer such services in relation to non-member dentists or other dental operatives. Around 80% of matters raised with the Branch are resolved to the satisfaction of the patient without recourse to the Health Services Commissioner or the courts.

The Branch liaises closely with the HSC on dental complaints lodged against members, and has often been able to assist in resolution of such matters.

We note that the Discussion Paper makes reference to the possible role to be played by the HSC in providing "advice, support and monitoring" for complaints handling mechanisms conducted by professional associations. We do not see any need to legislate for such a role, since we already have a good working relationship and frequent dialogue with the HSC, including a recognised protocol for dealing with matters of mutual concern. (Refer chart attached)

It is also important to recognise that often, the worst problems arise in connection with practitioners who choose not to belong to the Association. The public benefit would be better served were the current review to consider means by which to address the participation of these practitioners.

The requirement that all registered dental care providers be indemnified may mean that a more comprehensive approach would be achieved by means of the HSC forming a dialogue with all indemnifiers. While professional associations exist for each of the dental hygienists, dental therapists and dental prosthetists, they do not have the wherewithal to conduct complaints handling processes, and to our knowledge, they have no wish to establish such resource intensive functions. The indemnifiers may be able to work with the HSC to establish better lines of communication in the event of a complaint affecting these operatives.

5. NON-REGISTERED PROVIDERS

The ADAVB supports the extension of the HSC's functions to address complaints relating to non-registered providers. In the dental field we suggest that this might include dental technicians (even though they would normally be engaged by dentists to perform sub-contracted laboratory work), and non-registered owners of dental practices and laboratories. We would emphasise that in the dental area, illegal practice may not be readily recognised by patients.

6. COMPETITION ISSUES

In weighing up the public benefit test of whether alternative approaches to the legislation might be more effective, the ADAVB maintains its longstanding view that competition principles have little application to health services.

The health and safety of the public should be protected by adequate regulation. We consider the health practitioner registration provisions fail to adequately protect the community from the actions of unregistered persons who offer health services, or who employ registered persons to do so. The HSC may be in a position to remedy some of the problems permitted by the lack of any power on behalf of registration boards to regulate the behaviour of non-registered health service providers and owners.

7. RESPONSES TO DISCUSSION PAPER QUESTIONS

The questions raised in the Discussion Paper have been reproduced in tabular format below, along with our responses, where these have been deemed appropriate.

4.1.1 Should the definition of service provider expressly include those persons who hold themselves out as providing a health service?

Yes. We have recently witnessed a case where the non-registered owner of a health practice providing medical services, was actually a registered dentist. In these circumstances he was not accountable to the Medical Practice Board, because he was not a registered medical practitioner, yet he was also outside the jurisdiction of the Dental Practice Board since the matters did not concern the operation of a dental practice. The HSC might have had power to deal with this case, because the person involved was a registered person, although there could have been an argument that the particular situation was also outside the HSC's jurisdiction.

Non-professionals may now own practices, and they should be vicariously liable for the services they offer, to afford increased public protection. We believe the protection offered in these circumstances should be greater than previously applied when only registered dentists could own a dental practice, since the practice owner's ignorance of clinical issues could lead to higher public risk.

One possible concern with this however, is that unregistered practitioners might acquire a form of (dubious) legitimacy by being defined as, health "service providers".

This should be reviewed in relation to other pieces of State and Federal legislation. If such persons are not covered by other regulations, then the net should be closed to enable prosecution, where necessary, of anyone purporting to provide a health service.

4.1.2 Should the definition of the health service be expanded to expressly include any of the services outlined above?

Non registered owners should be included if they provide laundry services, cleaning, catering, or other support to hospitals, etc. as the adequacy of these ancillary services could have a bearing on the outcome of treatment.

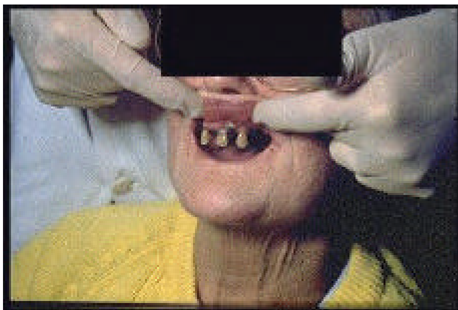
As mentioned on page 4 above, dental laboratories are no longer operated by registered persons. Whilst they should normally only provide services to a dentist and have no dealings directly with the public, any laboratory that did would not be accountable to the Dental Practice Board, since they only have the right to deal with registered persons.

The ADAVB understands that the HSC does not have the function of validating complaints and imposing sanctions, but rather seeks only to conciliate disputes between parties involved in a health service transaction. We believe that there may be circumstances where such conciliation would be required between a consumer and a dental laboratory, and that the HSC should have the power to respond if such a situation does arise.

Our concerns regarding the lack of adequate controls over the behaviour of non-registered owners of practices and other businesses involved in the provision of dental services, is that the Dental Practice Board and the HSC currently have no jurisdiction to protect the public from inappropriate behaviour. There is a provision in the Dental Practice Act (Section 65) prohibiting a person from requiring a dental care provider to do anything which "is or could be detrimental to the welfare of the patient". This is read to mean primarily that they may not direct the use of sub-standard materials, or the provision of an inappropriate service. It would not be likely to deal with inappropriate advertising or fees. A breach of this section would require police action!

In summary, the ADAVB supports inclusion of any allied services that bear a direct relationship to an area of health care – with the proviso that they should be subject to some form of State regulation/accreditation also.

4.1.3 Should the definition of user be extended to expressly include those persons who seek health services and those who are refused a health service?



Some elderly or chronically ill patients with medically compromised conditions require special facilities for their dental treatment.

"User" should include a person who wants to access services and who cannot, or has been refused services. However, the Law must not regard access to any particular practice's services, as an inalienable right. There may be circumstances in which it is reasonable for a health practitioner to refuse to treat a patient, such as where they do not require emergency relief of pain or trauma, and / or

- the practice does not have the required medical backup for some medically compromised patients
- their consent cannot be acquired due to substance abuse
- where they have breached good faith in their previous relationship with the practice.

By joining a waiting list, making an appointment or presenting for consultation, a person becomes a "user" and is covered by section 16 of the Health Services (Conciliation and Review) Act. Caution will be required when considering admission of disreputable, unproven, or suspect treatment as grounds for complaint, since this could be inappropriate in terms of precedents set, HSC workload, adverse publicity, etc.

Question 4.1.3 raises other issues, such as

- What are acceptable grounds for refusal?
- Where are these enshrined?
- Are professional or personal reasons acceptable?
- Are physical access issues acceptable?
- Are there any issues of refusal that couldn't go before Equal Opportunity?
- Which piece of legislation takes precedence?

4.2.1 Should the functions of the Council be amended as outlined above?	Victoria already has a Dental Practice Board and a Dental Practice Act of 1999 to set Codes of Practice via a wide consultative process including all dental stakeholders. The ADAVB believes that the preparation of such Codes should involve consultation with the HSC, but that regulation of the behaviour of registered dental care providers, and for that matter practice owners, should reside in the Board. (See also 4.1.1 above). There appears to be potential for crossing of boundaries in the proposal for the HSC to develop voluntary standards and codes. In section 4.6 of the Discussion Paper, the role of the HSC in relation to voluntary guidelines and codes of practice appears to be limited to assisting providers, while section 4.2 refers to the Council advising the Commissioner on "the development of voluntary standards and codes of conduct". These separate references do not appear to be exactly the same, thus leaving open the question as to whether the HSC would do more than simply assist providers. For whom and about what are voluntary standards and codes of conduct being written?
4.2.2 Should the Act be amended to provide for the removal of members for non-attendance and other specific grounds as referred to above?	It should be stated as to why the Council member has been removed. A person must know the rules by which they are playing. Reasons such as those cited in the Discussion Paper (p.19) seem reasonable. However, whilst the last three grounds are based on matters of fact, the first is not and should be capable of being appealed. Other issues raised by this question include: 1. Why should a "physical incapacity" prevent a member from contributing? If this were caused by disability, then exclusion would be discriminatory. 2. Who decides on the "nature of misbehavior" or degree of mental incapacity? This needs further definition and clarification.
4.3.1 Should section 19 (2) be amended to clarify that if an issue raised in a complaint has already been determined by the Coroner, the Commissioner must reject the complaint to the extent to which it relates to that issue, unless in the Commissioner's opinion it relates to matters which were not raised before the Coroner?	Once a complaint is with the Coroner, Board, VCAT, or any other Statutory body with its own legal processes, the Commissioner should stay out of the action. The law has the processes in place. An extra party may confuse issues, and add time and cost to the process. The discretionary provision for the Commissioner to proceed with some part of the matter anyway may be an excess of power, and interfere unduly in other processes.

4.3.2 Should section 20 (6) be amended to provide that progress reports be provided in the conciliation process, where requested by the Commissioner?	This recommendation appears to be aimed at eliminating some, at times, unnecessary 'red tape', viz. mandatory progress reports to the Commissioner by HSC conciliators. If this is all it seeks to do then the ADAVB has no objection.
4.3.3 Should the Act be amended to provide for 'splitting of complaints, in terms similar to the Northern Territory provisions?	There should be splitting of complaints however, as most complaints are interrelated, there should be a limit to the amount of splitting. The "splitting" concept should extend beyond registration boards to other persons, organizations or agencies as already referenced in Section 19 (7). Data about complaints currently published by the HSC fails to identify the number of practitioners involved in multiple complaints, and so gives the impression that the number of complaints is indicative of the number of practitioners generating them. This problem would be exacerbated under splitting provisions, unless the HSC ensured that reporting on complaints highlighted the total number of practitioners responsible for the complaints associated with each area of health service. The HSC might also refer to the relevant registration board, instances where the one practitioner was responsible for say three or more serious complaints (from separate patients) in any one year.
4.3.4 Should the Act be amended to clarify the kind of material which may be forwarded by the Commissioner to registration boards when referring a complaint?	Yes. As described, the material could (without breach of confidentiality) still be broad enough to permit effective investigation.
Should the Act be amended to clarify the kind of material which may be forwarded by the Commissioner to persons, agencies or organisations when referring a complaint?	All information that the Commissioner has on a case must be passed to the Board, a person, organisation or agency, so there is every opportunity to resolve the case properly. The person making the complaint does not have to repeat him or herself.
4.3.5 Should 'appropriate person, organisation or agency' be defined for the purposes of section 19 (7)?	An expanded type of definition would be helpful as long as it did not establish an exclusive list.

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4.3.6 Should the Act be amended to provide either for an increased period for making of referral decisions, or alternatively, to provide the Commissioner with a limited discretion to extend the period currently provided where this is necessary to assess the appropriateness of a complaint for referral?	All complaints should be completed as quickly as possible. Some limited discretion should be provided, especially for best handling of complex complaints. However, it should not be a frequent event, since the colder the trail, the more difficult the resolution. Hence the second option is preferable.
4.3.7 Should the Act be amended to close complaints where the Commissioner is of the view that the complaint cannot be conciliated and that no further action is warranted?	There should be an ability to close a case if conciliation cannot be reached. The ADAVB supports this measure provided conciliation has been attempted (the question doesn't imply this) and there is an opportunity to reopen the case if circumstances change, or new information is forthcoming.
4.4.1 Is it necessary for a code of practice to be incorporated into regulation?	Yes. Codes of practice incorporated into regulations are considered necessary to keep other participants in the health care sector within acceptable bounds, since they are not subject to the jurisdiction of the registration boards. Why should the Commissioner be exempt from adopting a code, when all of the providers, and their associations it seems, are expected to adopt such codes? It is not immediately obvious how the Commissioner is impeded in "publishing information on the Commissioner's functions" by being obliged to consult all affected parties about the regulatory code.
4.4.2 Should providers, classes of providers, timelines for completion of returns and forms be prescribed by regulation?	ADAVB would not support this as it could enforce the ADAVB to provide reports that would increase the present workload, and distract us from the important work of resolving disputes. It is appropriate however, for all reports that are delivered to the HSC, to consist of the same information and be measured the same way.
4.5 Should the name of the Heath Services Commissioner be changed to Health Services Ombudsman?	Is there not currently an Ombudsman? The office of Commissioner has gained recognition and respect under the present name. A change might downgrade the office and/or confuse the community.

4.6 Should the Act explicitly recognise the role of the Commissioner, Council and staff in provision of information, education, research and training?	The provision of information, education, research and training is huge. Where does it start and end? What budget is proposed and from what source? Who is the training for? Is it CLO or is this to the general public and/or health service providers. Is this training through a recognised education body, and are they paying for this? Is the HSC to be **the** provider for training, or one of a number of such providers?
Should the Act explicitly recognise the role of the Commissioner and Council in assisting providers to develop voluntary guidelines and codes of practice for prevention and management of complaints?	No perceived contra – indication(s), provided it is recognised that the diversity of providers precludes a standard formula and any such initiatives should remain voluntary. A common template for individual provider adaptation across all health services would be helpful.
4.7 Should the Act be amended to enable the Commissioner to refer a matter from an investigation under section 21 to conciliation?	Yes, if it can clarify what is currently confusing in this section of the Act. What the Act states and what is actually happening in practice at present does not follow.
If so, should the grounds on which this is undertaken be set out in the Act?	It should be left to the Commissioner's discretion to change from investigation to conciliation.
4.8 Should the Act be amended to: • **Ensure that the Commissioner and officers are competent to give evidence but cannot be compelled to do so?**	No
• **Remove the requirement for the Commissioner to seek consent of the Minister, along the lines of the Ombudsman Act 1973?**	No
Alternatively, should the current provisions be retained, with a limited exception in criminal proceedings?	Yes, this seems a better proposition.

5.7.1 Should section 19 (7) and (8) be amended to specifically include the referral of a health services compliant to the Direction of the Officer of Fair Trading and Business Affairs?

Yes, in particular because of relevance to unregistered health service providers. There needs to be a mechanism for review of complaints for registered and non-registered health service providers. The Director of Consumer and Business Affairs Victoria seems appropriate.

We disagree that there is a "community perception" (p.29) that health complaints do not fit within fair-trading. The OFT decline to handle complaints about dentistry and refer callers to this Association. We agree that the section should be amended to include referrals, but implicit in this is the willingness of the OFT to pursue such matters and the allocation of appropriate resources to perform such duties.

5.8.2 Is frequency of complaint to the Commissioner an appropriate way to assess the nature and extent of problems associated with unregistered providers of health services?

No. Frequency of the complaints is not enough of a measure. The seriousness of consequences must also be reckoned. Often, those affected by unregistered providers would not know of the Commission's existence. If they did know of the complaints body they may not have the self-esteem, literacy skills, language skills etc. to lodge a complaint, or they may be dissuaded by fear or embarrassment.

What other evidence exists to indicate risk or injury caused by unregistered providers of health services?

Such evidence cannot be standardised or categorised. It can only be evaluated on a case by case basis, and must be by independent, reputable and experienced practitioners in the same health field.

Information collected by welfare agencies, registered providers, community centres, ethnic associations, ethnic newspapers etc. could be reviewed however. The Commissioner should inform such bodies of the avenues and assistance available for complaint and of the Commission's interest in establishing a database.

5.9.1 Should the Act enable the Commissioner:

- **To formally recognise complaint handling mechanisms of a professional association?**

Yes, however formal recognition should depend on demonstration of appropriate mechanisms. The ADAVB has already completed such an exercise, documenting its complaint handling mechanisms and inter-relationships with HSC. Each association of providers should register its processes with the HSC, and document its relationship with the HSC in resolving complaints received by them.

- **To monitor those mechanisms?**

Details of proposed "monitoring" are required before response.

Should the Commissioner be empowered to require professional associations of unregistered providers to produce evidence of appropriate complaints handling mechanisms?

If it resulted in regular reporting obligations regarding all complaints handled, then we would oppose such interference.

5.9.3 Should the Act be amended along the lines proposed by the NSW joint Committee to strengthen the Commissioner's 'naming' powers?	The present power is adequate. Extension of this power presumes there could never be errors.
5.9.4 Should the Act be amended to enable the Commissioner to require providers to provide further information on action taken to remedy a complaint?	Yes, although there does not appear to be any impediment to the Commissioner obtaining all necessary and relevant information.
Should the Act be amended to provide for enforcement of determinations made by the Commissioner against unregistered health care providers as proposed by the NSW Joint Committee?	Yes
If yes, should be Commissioner to able to compel unregistered providers to attend at, or participate in proceedings where such an order is being contemplated?	Yes
Should the Act provide greater sanctions for non-cooperation with investigation?	Yes
What other amendments to the Act, if any, are required to enable the Commissioner to deal effectively with complaints concerning unregistered providers of health services?	In concept the above three suggestions are worth considering, but acceptance would depend on the wording of draft amendments to the Act. Other possibilities include: • Court enforceable orders could be instituted. • Management of complaints may involve QA statutory immunity so the information cannot be given out. • Confidentiality can be part of the success of management of the complaint. • All health care providers, registered and non-registered, to have the same relative penalties if possible, however where there is non-cooperation, referral to the appropriate body, i.e. DPBV or Director of Fair Trading should occur. • Warrants to enter premises and collect evidence, with appropriate authority (if not already in existence in the Act).

5.10 How can users of health services be made aware of the complaints resolution mechanisms available to them?	Present avenues are adequate. Quality Assurance initiatives could involve practices being encouraged (but not required) to display somewhere the details of the HSC, i.e. flyer displayed, notices, etc.
Should the Act require service providers (including unregistered providers) to promote complaints resolution procedures, in particular, the role and function of the Health Services Commissioner?	Such a requirement does not belong in the Act, but should be incorporated into the information education research and training initiatives, and the voluntary guidelines envisaged under 4.6. Greater education mechanisms should be employed through • liaison with all welfare agencies • availability of multi-lingual brochures expressed in simple terms in counter stands, posters etc. • liaison with all health provider agencies and associations • regular media coverage – newspapers, current affairs programs etc

ATTACHMENT 1

COMPLAINT HANDLING MECHANISMS OF THE OFFICE OF THE HEALTH SERVICES COMMMISSIONER AND AUSTRALIAN DENTAL ASSOCIATION VICTORIAN BRANCH INC.

During discussions between the Health Services Commissioner (HSC), her officers and representatives of the Australian Dental Association Victorian Branch (ADAVB), it was decided to document the processes used by each organisation in dealing with complaints.

The following description of the complaints handling mechanisms of the HSC and the ADAVB has been developed to:

- assist both organisations appreciate the respective stages involved in complaint resolution;
- highlight the similarities and differences in the approaches; and
- indicate where communication between the organisations may occur during the processes.

HSC ®®®	ADAVB	CONTACT	HSC	¬ ¬ ¬ ADAVB
1. Initial enquiry re: complaint				1. Initial enquiry re: complaint
2. An Enquiry officer decides whether HSC may be able to assist, and forwards a complaint pro-forma if the caller wishes to proceed.				2. ADAVB membership is checked. 2a. If a member, ADAVB and HSC complaint resolution procedures are outlined. The caller is asked to write to a CRO, or if not convinced of ADAVB impartiality, referred to HSC, with the offer of a brochure. 2b. If the provider is not a member, the patient is referred to HSC. HSC brochure is offered.
3. Complaint received. A Team leader (Investigator) accepts/rejects/refers the complaint. If accepted, a file is made up and passed to the Registrar for allocation to an Enquiry officer. The Enquiry officer forwards the complaint to the provider(s).				3. Complaint received. The correspondence is acknowledged, accompanied by an ADAVB brochure.
4. The Provider responds directly to the patient, with/without contacting ADAVB, or the provider responds to HSC, with/without contacting ADAVB.	As required	Yes/No	As required	4. An initial assessment is made as to whether the complaint is founded and accepted. Practitioners are contacted for reports and records of the case.

HSC ® ® ®	ADAVB	CONTACT	HSC	¬ ¬ ¬ ADAVB
5. If the patient is dissatisfied with the provider response and requests further investigation by HSC, the Enquiry officer may pass the file to an Investigator.				5. If necessary, a second opinion is requested.
6. HSC may seek ADAVB input. This may be straightforward clinical advice, or enactment of ADAVB steps 4-9. Parties must consent to involvement of ADAVB.		Yes		6. Negotiations take place with the dentist concerned.
7. The Investigator determines if the file is suitable for HSC Conciliation. It is referred to Conciliation if the user, provider and defence organisation agree to this process. A Conciliator contacts ADAVB, or Phillips Fox if solicitors are involved.		Yes		7. Recommendations are sent to the patient and the dentist.
				8. If applicable, a signed release is received.
				9. If applicable, a cheque is received and forwarded to the patient.
		Yes/No		10. If the patient is dissatisfied with outcome, offer HSC or DBV (if appropriate) as alternatives. If the patient is dissatisfied with ADAVB process, the patient is asked to write to the President for a review of the case.

ATTACHMENT 2

A BRIEF REVIEW OF ORGANISATIONS INVOLVED IN HANDLING DENTAL COMPLAINTS

An overview of the following seven organisations' complaints procedures is provided in this report.

1. Australian Dental Association Victorian Branch (ADAVB)
2. The Dental Practice Board of Victoria (DPBV)
3. Health Services Commissioner (HSC)
4. Dental Health Services Victoria (DHSV)
5. Equal Opportunity Commission
6. Office of Fair Trading
7. Private Health Insurance Complaints Commissioner

1. Australian Dental Association Victorian Branch

The ADAVB offers a dental health conciliation service in the interests of ensuring that patient concerns are addressed in a professional manner, and reinforced by expert clinical knowledge. Community Relations Officers (qualified and experienced dentists) operate as conciliators for patients of members in dispute resolution. The function has no arbitration or directive powers.

Upon receipt of a formal complaint the dentist is contacted for information on the problem. Advice may also be sought from subsequent treating practitioners, or an independent expert opinion may be obtained with the agreement of the complainant.

The complainant is advised in writing of the outcome of the conciliation process. If the complaint is supportable, recommendations are made and satisfactory resolution by conciliation is sought. If such recommendations are rejected by the dentist, the complainant is so notified and referral to the Health Services Commissioner may be appropriate (see attachment 1)

Where a claim is lodged on behalf of a complainant, the matter is referred to the Branch's Defence Committee and legal advisors.

The Branch has established a Quality Assurance Committee, which has been granted statutory immunity under Section 139 of the Health Services Act. Members are encouraged to discuss confidential matters of concern with officers of the Committee.

2. The Dental Practice Board of Victoria (as at October 2000)

The Dental Practice Board of Victoria receives written complaints regarding alleged contraventions of the Dental Practice Act (e.g. unhygienic conditions, professional misconduct). In addition the Health Services (Conciliation and Review) Act 1987 requires all complaints to be reported to the Health Services Commissioner. The Registrar of the Board meets regularly with the Registrar of the HSC to discuss complaints received and determine which authority will carry out the investigation.

Dental Practice Board staff do not give advice on treatment patients have received. However, the Registrar may elect to give general dental advice. Complaints regarding fees and/or quality of work are usually dealt with by the Health Services Commissioner alone, or in consultation with the ADAVB.

3. Health Services Commissioner

The Health Services Commissioner is a statutory authority appointed by the Governor-in-Council, reports to the Victorian Parliament, and is independent of government departments. The Commissioner's powers are specified under the health Services (Conciliation and Review) Act 1987.

The Commissioner functions as an ombudsman for the health system. In the first instance the complainant is assisted in approaching the health services provider to see if the issue can be resolved directly. If this approach does not succeed the Commissioner may assess the complaint to see if it needs conciliation, investigation or referral to another authority.

Independent opinions may be obtained if they will help resolve the dispute. If compensation is claimed, conciliation may be used as an alternative to court action.

Where conciliation is not appropriate, the Commissioner may refer a complaint to the Ombudsman, a professional registration board or other avenues of review.

4. Dental Health Services Victoria

Dental Health Services Victoria provides dental treatment programs through the Royal Dental Hospital Melbourne (RDHM) and Community Health Centres. It is understood there are protocols for complaint resolution for patients attending the RDHM.

Public patients of Victorian Emergency and General Dental Schemes and the Victorian Denture Scheme (VDS) in Community Health Centres are requested to initially discuss any complaint with the treating dentist. If unable to be resolved in this manner, contact with the appropriate DHSV Regional Manager is recommended.

5. Equal Opportunity Commission

The Commission receives complaints made under both the Victorian Equal Opportunity Act 1995 and three Federal anti-discrimination Acts, namely the Racial Discrimination Act, the Sex Discrimination Act and the Disability Discrimination Act.

Once lodged, a complaint is assigned to an investigator to investigate the legal and factual issues surrounding the alleged acts of discrimination or sexual harassment. A letter is sent to the respondent (the person, company or organisation against whom the complaint is being made) notifying him/her of the details of the complaint. The respondent also receives a list of questions to help prepare a response to the matter. A copy of this response is forwarded to the complainant.

If the complaint is not declined, a conciliator is assigned to proceed with conference arrangements, bringing the parties together with proposals as to how the dispute may be resolved.

Where a party is uncooperative, the Chief Conciliator has the power to call a compulsory conference.

If attempts at conciliation fail, the Commissioner will refer the complaint to the Human Rights and Equal Opportunity Commission (HREOC) for a public hearing.

6. Consumer and Business Affairs Victoria

Consumer and Business Affairs Victoria (previously the Office of Fair Trading) has established a computer program for reference by staff receiving telephone enquiries. When a dental complaint is received, the screen advises the operator to refer the caller to different organisations, depending on the complaint. i.e. The Dental Practice Board of Victoria (for complaints regarding administration of the Act, sexual harassment or professional misconduct) and the ADAVB regarding services provided by dental professionals. ("The ADA takes and acts on complaints against dental professionals.")

7. Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman assists with enquiries or complaints about any aspect of a private health insurance arrangement. The service is available to all fund contributors, hospitals or day procedure centres, medical and dental practitioners, health funds or a person acting on behalf of any of the above, including a family member, lawyer or friend.

The suggestion is to contact the health fund in the first instance, as most funds have a means of dealing with complaints from their members. If a complaint cannot be resolved, the complainant can request the Private Health Insurance Ombudsman to conciliate the problem.

The Ombudsman may refer the complaint to other avenues for resolution, e.g. the Australian Competition and Consumer Commission (ACCC), or the state based Health Services Commissioners.

According to the Ombudsman's website "The Ombudsman cannot look into complaints about Medicare. They are handled by the Commonwealth Ombudsman. Complaints about public hospital services are handled by your State or Territory health complaints body".

SUMMARY OF ORGANISATIONS

Organisation	Govt. Dept.	Advice Free of Charge	Currently Refers to ADAVB	Conciliator appointed
ADAVB		✓		✓
DPBV	✓	✓	✓	
Dental Health Services Victoria				
- Royal Dental Hospital Melbourne	✓	✓		
- Community Health Centres	✓	✓		
Equal Opportunity Commission	✓	✓		✓
Health Services Commissioner	✓	✓	✓	✓
Consumer and Business Affairs Victoria	✓	✓	✓	
Private Health Insurance Ombudsman	✓	✓		✓