No 18

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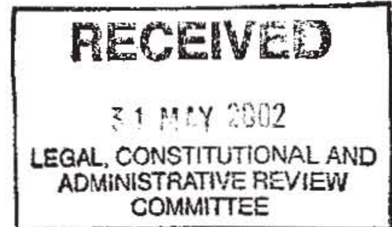
Health Rights Commission

30 May 2002



SPEC 42·1

Ms Newton
The Research Director
Legal, Constitutional and Administrative Review Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Ms Newton

Re: The Queensland Constitution: Specific Content Issues; Issues Paper April 2002; Chapter 13: Statutory Office Holders

I wish to make the following submission concerning Chapter 13 of your Issues Paper of April 2002.

Paragraph 13.1: Special Constitutional Provision

Recommendation under review

QCRC R7.1. That certain statutory office holders be identified in the Queensland Constitution as requiring special provisions.

Issues

33. Is there a need for special recognition of certain statutory office holders in the Constitution? Are existing statutory provisions sufficient and/or appropriate to make the independent status of the offices clear?

I submit that the proposal to make specific provision to guarantee the independence of certain statutory office holders should be supported for the reasons set out by the QCRC in their Issues Paper of July 1999 at para 7.33 which is quoted in your Issues Paper of April 2002 at paragraph 13.1

34. If special recognition of certain statutory office holders is to be made in the Constitution, is the QCRC's list of statutory office holders appropriate? Should other office holders be added to, or removed from, the list?

I submit that the statutory officers currently proposed for special constitutional provision should be included within the proposal for the reasons outlined.

I further submit that the office I currently occupy of Health Rights Commissioner should also be included within the proposed special constitutional provision.

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In paragraph 7.33 of their Issues Paper of July 1999 the QCRC make specific reference to the Electoral Commissioner and then state in relation to the other statutory officers proposed to receive protection:

> *[they] are in sensitive positions because they investigate, and may report adversely on, the activities of government departments and agencies with possible consequences for the political reputations and careers of Cabinet Ministers and, more rarely, other members of Parliament...*

That passage exactly describes the position of the office of Health Rights Commissioner.

It may be that because the functions of this office are not explicitly expressed as being directed to investigating and reporting on the activities of government the position of this office was not sufficiently understood by the QCRC.

For your convenience I set out below the functions of this office as provided for by section 10 of the *Health Rights Commission Act 1991.*

> ***Commissioner's functions***
>
> ***10.*** *The functions of the commissioner are —*
>
> *(a) to identify and review issues arising out of health service complaints; and*
>
> *(b) to suggest ways of improving health services and of preserving and increasing health rights; and*
>
> *(c) to provide information, education and advice in relation to —*
>
> > *(i) health rights and responsibilities; and*
> > *(ii) procedures for resolving health service complaints; and*
>
> *(d) to receive, assess and resolve health service complaints; and*
>
> *(e) to encourage and assist users to resolve health service complaints directly with providers; and*
>
> *(f) to assist providers to develop procedures to effectively resolve health service complaints; and*
>
> *(g) to conciliate or investigate health service complaints; and*
>
> *(h) to inquire into any matter relating to health services at the Minister's request; and*
>
> *(i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and*
>
> *(j) to provide advice to the council; and*

(k) to provide information, advice and reports to registration boards; and

(l) to perform functions and exercise powers conferred on the commissioner under any Act.

I ask the committee to note in particular the responsibility which this office has for receiving and examining health service complaints and for identifying and reviewing issues which arise out of health service complaints.

By far the largest single provider of health services is the Department of Health. Approximately one third of the complaints which this Commission receives relate to activities of Queensland Health and its various agencies.

The Health Rights Commission is required, among other things, to examine and report upon systemic issues which arise in relation to the management, resourcing, protocols or procedures of Queensland Health institutions including public hospitals.

For the Committee's information, I **enclose** a copy of the 9th Annual Report of the Health Rights Commission for the financial year 2000 to 2001. The report contains a number of de-identified narratives of complaints received and processed by the Commission. It can be seen that many of them relate to public hospitals and that aspects of the management of those hospitals was examined by the Commission. Examples include Narratives 8, 9, 13, 15, 16,17, 21 and 23.

Health is an issue which is of major importance to the community of Queensland. I submit that it is important that the body responsible for examining complaints about the government department primarily responsible for providing health care should not only be, but be manifestly seen to be, independent and impartial.

It is apparent from the Issues Paper that your Committee is already aware of the provisions made in the *Health Rights Commission Act 1991* for the appointment, removal and suspension of the Health Rights Commissioner. The Committee will appreciate there is no parliamentary involvement in these matters nor in developing or approving the budget for the Commission.

Under Section 33 of the *Health Rights Commission Act 1991*, the Minister for Health decides the Commission's budget for the financial year and the Health Rights Commissioner must authorise spending only under the budget decided by the Minister unless the Minister otherwise directs. The Minister for Health also bears Ministerial responsibility for the Department of Health. In practice the Health Rights Commission is funded by way of an annual grant through the Department of Health.

In the 9th Annual Report of the Health Rights Commission for the year 2000/2001 I said:

> *"It is not possible for the Commission to provide all the services articulated in the* Health Rights Commission Act 1991 *to all the people of Queensland with the resources available. Whilst every endeavour has been made to streamline the activities of the Commission using best practice techniques and maximising the use of technology, it would appear that there is no alternative other than to limit the Commission's functions to deal only with complaints of a serious nature"* (page 8).

It is pertinent to mention that some additional funding for the Commission has been granted by the Minister for Health in the last twelve months. Further, a major review of this Commission has recently been completed by independent consultants at the direction of the Premier. I understand the recommendations from the review are presently being considered by the Minister for Health. I anticipate further support for the Commission will result.

The Issues Paper makes reference to sections 11 and 31 as being "Other Relevant Provisions".

Section 11 of the *Health Rights Commission Act 1991* provides:

> ***Commissioner s independence***
>
> *11. In performing functions of office mentioned in section 10(a) to (k), the commissioner is to act independently, impartially and in the public interest.*

I submit that there is the potential for this statutory independence to be perceived as undermined, or actually undermined, under existing arrangements which ought to lead to the inclusion of this office among those for whom special provision is to be made.

I further submit that there are other provisions in the Act which are relevant to the Committee's decision whether to include the office of Health Rights Commissioner among those statutory positions receiving special protection.

I have already referred to the funding provisions under section 33. Those funding provisions have been a matter of concern to me for some time. I consider that it is reasonable for members of the public to perceive the Commission as not properly independent, despite section 11, because of those provisions. I also consider that the potential exists for the Commission's independence to be undermined in fact.

There is an argument that the reporting arrangements in sections 34 and 35 of the *Health Rights Commission Act 1991* provides appropriate safeguards for the Commission to function independently, impartially and in the public interest. I would not agree.

Under section 34 the Commissioner is required to report in the annual report any direction given by the Minister. The Commissioner is also empowered to include in the annual report information, opinion and recommendations about health service complaints, inquiry matters and offences against the Act. The annual report must be tabled in the Legislative Assembly by the Minister.

Section 35 of the *Health Rights Commission Act 1991* provides:

> ***Special Report***
>
> *35.(1) The Commissioner may, at any time, give to the Minister a report providing information in relation to the activities of the commission.*
>
> *(2) Subject to section 36, the commissioner may include in the report information, opinion and recommendations disclosing details of-*
>
> *(a) health service complaints, inquiry matters or contraventions of this Act; or*
>
> *(b) results of investigations into health service complaints, inquiry matters or contraventions of this Act.*

> *(3) The Minister is to lay a copy of the report before the Legislative Assembly within 10 sitting days of receiving the report.*

At present, this is interpreted to be only special reports such as reports on major issues. I believe that all reports of the Commissioner to the Minister should be required to be tabled in Parliament. This would ensure the public interest is served and the Parliament is kept informed of the activities of the Commission.

I do not consider that the current process addresses the concerns raised by the QCRC. The QCRC is concerned to protect statutory office holders whose responsibilities are likely to bring them into conflict with the executive and the majority in parliament who are linked to the executive. Section 34 does not provide for any such protection. On the contrary, a report submitted under it may potentially be one means by which this office comes into conflict with the executive and the majority in parliament.

Difficulties of this nature could be avoided if the office of Health Rights Commissioner were to be included among those receiving special protection along the lines proposed by the QCRC.

I have for sometime, held the view that because this Commission investigates and reports upon the activities of government in delivering health services it is not appropriate that its functions be within the portfolio of the Minister for Health or that the existing reporting and funding arrangements should remain in place. I am of the opinion that public confidence would be considerably enhanced if this Commission were made subject to special provision guaranteeing its independence in the discharge of its functions and avoiding any public perception that it was vulnerable to indirect pressure through funding decisions and reporting arrangements.

The office of Health Rights Commissioner is effectively an ombudsman for the health services. I submit that it is anomalous that the arrangements made to ensure that the Ombudsman's statutory independence is not vulnerable to being undermined have not been extended to protect the statutory independence of the office of Health Rights Commissioner.

I therefore submit that the office of Health Rights Commissioner ought to be included within the statutory office holders for whom special provision is proposed.

35. If special recognition of certain statutory office holders is to be made in the Constitution, is clause 58 of the QCRC's Constitution appropriate? If not, how should the clause be amended?

In my submission clause 58 (1) creates an element of uncertainty and, if it is interpreted in a particular way, may have undesirable consequences.

I submit that the use of the term "independent" without qualification is both uncertain and unnecessary.

The important objective is that such statutory officer holders be "independent" in the discharge of their functions not that they be independent in all things. Statutory Bodies are still Government agencies implementing the policies of the Government enshrined in legislation. The use of the term "independent" without specifying what that independence consists of may be interpreted as requiring forms of administrative independence which in my submission are unnecessary and which would hamper the efficient operation of the statutory office. For example, I find it efficient to rely upon the negotiations conducted by Queensland Health with

their employees for the purposes of negotiating terms and conditions of employment of Commission staff. I consider it is desirable for staff of the Health Rights Commission to be public servants. I do not consider it desirable for a general statutory declaration that statutory offices are required to be "independent" to have the effect that statutory office holders could no longer confidently make such administrative arrangements.

I submit that the desired objective is better served by making specific provision to address those areas in which independence in the discharge of functions may potentially be undermined. My comments in the remainder of this submission address those areas.

I suggest that clause 58 would more effectively achieve its purpose if subclauses (1) and (2) were combined as follows and subclause (3) renumbered as subclause (2):

> *It is declared that the statutory office holders mentioned in subsection (2) are subject only to the law and must exercise their powers and perform their functions impartially and without fear, favour or prejudice.*

Paragraph 13.2: Removal

Recommendation under Review

That [the statutory office holders] be removed by a procedure comparable to that provided for the removal of judges.

Issues

36. Is there a need for the Constitution to include a removal procedure for certain statutory office holders such as the QCRC proposes? Are existing provisions regarding the removal of the identified statutory office holders sufficient or might they be sufficient with certain amendments?

It is my submission that the proposal that the removal procedure for statutory office holders be assimilated to that of judges is unnecessary.

I submit that the provision made for the suspension and removal of the Ombudsman under the *Ombudsman Act 2001* and the Information Commissioner under the *Freedom of Information Act 1992* are adequate to protect the independence of those officers and should be extended to apply to all the statutory office holders proposed to be made subject to special provision.

37. If special provision is to be made in the Constitution for removal of the identified statutory office holders along the lines recommended by the QCRC, does the process contained in clause 59 of the QCRC's Constitution of Queensland 2000 require amendment in any way?

It is my view that clause 59 does not need amendment if the proposal of the QCRC is to be adopted.

38. If special provision is to be made in the Constitution for removal of the identified statutory office holders along the lines recommended by the QCRC, should special provision also be made for their appointment?

I submit that the public perception of impartiality would be enhanced if special provision were to be made for the appointment of statutory office holders to provide for transparency in the appointment process and to ensure some measure of bipartisan support for the appointment.

I suggest that the following process should be adopted in relation to all statutory office holders:

- The Governor in Council should consult with relevant statutory committee as to the process for selection and the appointment of the statutory office holder.
- The appointment should be by the Governor in Council subject to the person appointed enjoying majority support in the statutory committee other than a majority consisting wholly of members of the governing party.

39. If special provision is to be made in the Constitution for removal of the identified statutory office holders along the lines recommended by the QCRC, is there a need for complementary provisions providing for life tenure, or terms beyond which tenure cannot be extended?

I submit that providing for life tenure of statutory office holders is unnecessary and undesirable. It may be appropriate for judges but they are not subject to the same managerial responsibilities as statutory office holders. Providing for life tenure may deny statutory offices the opportunity of receiving fresh ideas and perspectives which the periodic replacement of the statutory office holder will provide for.

It is my submission that public perception of impartiality would be enhanced if appointments were for fixed periods beyond which current office holders could not be re-appointed. This would avoid any public perception that a statutory office holder may discharge his or her functions with the desire for re-appointment in mind.

Paragraph 13.3: Resources

Recommendation under Review

That appropriate statutory committees be required to ensure that [the statutory office holders] be given sufficient resources to discharge their responsibilities adequately.

Issues

40. Is there a need for parliamentary committee involvement in the budget of the identified statutory office holders beyond that which already exists?

I submit that committee involvement in the budget of identified statutory office holders would do much to enhance public confidence.

I suggest that the arrangements which currently apply to the Ombudsman (*Ombudsman Act 2001* sections 88(3) and 89 ought to be extended to all statutory office holders receiving special protection.

I am of the opinion that this will help to ensure that parliament, through the statutory committee, will acquire a level of expertise about the activities of statutory office holders which will enable it to engage in meaningful consultation about the level of resources to be allocated to them.

41. If the QCRC's R7.3 is to be adopted, do the terms of clauses 86(1)(e), 97(c) and 114 of the QCRC's Parliament of Queensland Bill 2000 achieve the objective of the QCRC's recommendation? If not, how might they be improved?

I make no comment concerning clauses 97(c) or 114.

I submit clause 86(1)(e) ought to be amended to include reference to the Health Rights Commissioner.

42. To what extent can the above parliamentary committees make a meaningful determination of whether the office holders allocated to them have been given sufficient resources? What other implications might be the result of expanding the jurisdiction of certain parliamentary committees in this regard?

I submit that members of parliamentary committees will acquire increasing ability to make meaningful determinations with experience particularly if they are also given a monitoring and review function.

I believe that the implications of expanding the jurisdiction of the committees will be beneficial in that funding decisions will become more transparent which may lead to greater press attention and more public interest.

43. Instead of a number of committees having responsibilities regarding the resourcing of statutory office holders, would it be preferable for a designated committee- for example, a statutory office holders committee-to be conferred this role?

I submit that a designated committee would be preferable.

I am of the opinion that such a Committee would enable the common interests of all statutory office holders responsible for investigating the activities of government to be addressed in a consistent fashion and enable the members of the committee to acquire greater expertise and understanding of the activities and requirements of the statutory office holders.

Conclusion

In conclusion I would point out that the term of my appointment as Health Rights Commissioner expires on 25 August 2002. I have not sought re-appointment. I welcome the opportunity afforded by the review being conducted by your committee to generally support the proposals under consideration. I consider that taking proactive steps to protect statutory office holders from any undue pressure will do much to enhance public confidence in the integrity of their operations when they are investigating the activities of government agencies.

As discussed with an officer of your Secretariat, I would like to forward a copy of this submission to the Minister for Health for her information. I would be grateful if you would advise me when the Committee authorises the release of this submission so that I may do so.

Should your Committee wish to discuss any aspects of this submission with me, please do not hesitate to contact me.

Yours sincerely

Ian Staib
Commissioner

Encl.

9th ANNUAL REPORT

Health Rights Commission **2000/2001**

Health Rights Commission

30 September 2001

The Honourable Wendy Edmond MP
Minister for Health
Level 19
Queensland Health Building
147 - 163 Charlotte Street
BRISBANE QLD 4000

Dear Minister

I am pleased to present the ninth Annual Report and Financial Statements of the Health Rights Commission for the year ended 30 June 2001.

In preparing the Report, attention has been given to the requirements of section 34 of the *Health Rights Commission Act 1991*, section 46J of the *Financial Administration and Audit Act 1977* and section 95 of the *Financial Management Standard 1997*.

The Report documents the work of the Commission in the receipt and resolution of health service complaints, the maintenance and improvement of health services and the promotion of health matters.

Comment has been made on the development of collaborative working relationships with the health practitioner registration bodies, as required by the amendments to the *Health Rights Commission Act 1991*, effective from 7 February 2000.

Yours sincerely

Ian Staib
Commissioner

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COMMISSIONER'S REVIEW

The thirtieth of June 2001 saw the completion of the implementation period of the Commission's Strategic Plan, which commenced on 1 July 1998. I am pleased to be able to report that the plan was implemented in full. Many Queenslanders benefited from the enhanced services provided by the Commission as a result of the implementation of the Strategic Plan.

The Strategic Plan placed emphasis on encouraging direct resolution of complaints between consumers and providers and streamlining the Commission's formal procedures for handling the more serious complaints.

Approximately 62 percent of complaints closed during 2000/2001 were resolved informally between the parties concerned. In many of these cases the Commission was able to facilitate dialogue which resulted in an explanation from the provider to the consumer that resolved the matter. Many providers appreciated the opportunity to respond to complaints in the early stages of the Commission's processes. In several of these cases the provider was not aware of the complainant's concern and was only too willing to supply further details to the complainant about the procedure or the service. There were a number of instances where a simple misunderstanding had occurred and an apology from the provider to the complainant resolved the matter.

In some of the cases resolved directly between the parties, the Commission was able to confirm, with the assistance of independent opinions, that the treatment or procedure received was appropriate for the symptoms displayed. There is little doubt that it is far preferable to resolve complaints in such a manner with minimal formal intervention. There is every likelihood that as a result of the direct resolution of complaints facilitated by the Commission, the relationship between the consumer and the provider, that may have taken years to develop, can be maintained.

During the year, 63 formal investigations were completed by the Commission. Many of these investigations resulted in systemic and procedural changes being made in Aged Care facilities and public and private hospitals to prevent a recurrence of the event that was the cause of the complaint.

The Commission's conciliation process again proved its effectiveness with 163 complaints being closed during the year following conciliation. Approximately 13 percent of these complaints involved financial settlements. Many complaints were closed in conciliation following receipt of an independent opinion which enabled a more detailed explanation of the procedure and outcome to be given to the complainant.

Commissioner Ian Staib

Mission Statement

The Health Rights Commission provides an independent, impartial and collaborative health complaints system designed to improve health care services and promote health rights and responsibilities in Queensland.

Seventy four (74) providers were referred to registration bodies as a result of complaints that related to the professional standards, practice and/or conduct of registered providers. Action taken by the registration bodies, as a result of the Commission’s referrals, included de-registration, suspension, the imposition of restrictions on a provider’s right to practice and referral to the Boards’ "Impairment Program" for counselling and advice.

Some 2,520 new complaints were opened and 1,714 complaints were closed during 2000/2001. As at 30 June 2001, there were 1,359 open complaints. There was a substantial increase in the number of new enquiries and complaints received particularly since 1 January 2001. This placed an additional burden on the Enquiry Officers, the Complaints Co-ordinator and the Review Officers.

Staff movements during the year inhibited the Commission’s work. Recruitment procedures were completed to fill 15 positions. This represents over half of the entire staff complement of the Commission. Full details of these movements are contained in the Executive Services section of this Report. There is no doubt that the turnover of staff has had a major impact on the operations of the Commission. This is due to the loss of expertise and skills of staff, the constant cycle of training and development of new staff and the time that elapses during the recruitment process.

Working in a complaints agency can be a stressful experience due, in the main, to the nature of the complaints. In addition, the small size of the Commission limits promotional and career development opportunities for staff. Some of the initiatives introduced in an endeavour to minimise stress experienced by staff are proving to be effective. Arrangements were introduced during the previous financial year for the intake work of the Enquiry Officers to be performed on a part-time basis. This has resulted in a pool of well-qualified and competent Enquiry Officers being established with an improved service being provided to the Commission’s clients.

The staffing situation had stabilised as at 30 June 2001 with all positions in the Commission being occupied at that time. The Commission now has an extremely well qualified and dedicated team of staff that is committed to achieving the objectives of the legislation. I take this opportunity to express my personal appreciation to all staff of the Commission for their dedication, commitment and loyalty to the organisation during the year.

As I reported last year, following the invitation of quotations from relevant firms in accordance with Government tendering arrangements, a firm of public relations consultants was engaged to develop a Community Outreach Strategy for the Commission. For some time I have held the view that the Commission’s existence is not widely known in the community. The purpose of the strategy is to achieve the education, information and promotional requirements of the legislation. Further, it was considered necessary to prioritise the Commission’s energies in the area of community outreach and education within the Commission’s limited resources.

Media Link Communication Group presented the strategy in September 2000. Following some modification, work commenced on the implementation of the Community Outreach Strategy. The appointment of the Communications Officer in April 2001 will facilitate the implementation of the Strategy.

As noted above, the Commission’s Strategic Plan expired on 30 June 2001. All staff of the Commission met in March 2001 to undertake the preliminary stage of the planning process for the development of the 2001/2006 Strategic Plan. A consultant was engaged to facilitate the planning process and provide guidance for the direction of the first draft of the Strategic Plan. A strategic planning focus group then managed the finer details of the plan which was completed by 30 June 2001. In accordance with the requirements of the *Financial Administration and Audit Act 1977*, the plan was provided to the Minister for Health for endorsement in July 2001.

During the year, the Commission completed a review of the draft Code of Health Rights and Responsibilities that had not been accepted by various governments previously. A detailed background paper on the preparation of the Code was prepared and submitted to the Health Rights Advisory Council for its consideration and advice. Formal consultation on the preparation of a further draft of the Code took place with the Council on two separate occasions.

Ms Colleen Cartwright, a consumer representative on the Council and Senior Research Fellow at the Medical Faculty of the University of Queensland, was commissioned to prepare a further draft document in liaison with the Commission's Communications Officer. It is proposed to develop a document that is satisfactory to the Commission and the Health Rights Advisory Council. That document will then be submitted to the Minister for Health recommending acceptance for implementation. Experience has shown that it is essential that some formal documentation is available to both consumers and providers detailing reasonable expectations of a health service and procedures for resolution of complaints about such services.

Following the completion of the audit of the Commission's finances as at 30 June 2000, the Auditor-General raised the matter of the Commission as a "Going Concern". The Auditor-General advised that I raise the matter with the Minister for Health. After detailed examination and discussion, the Minister for Health granted approval, on 8 May 2001, for the Commission to be funded on an accrual basis. This approval, and other arrangements documented in the Executive Services section of this report, will overcome the situation where the Commission was required to show a negative balance as at 30 June 2000 due to its non cash liabilities for leave entitlements and depreciation.

Provision was made in the Commission's budget allocation for 2000/2001 for an amount of $60,000 for the creation of an additional full-time position. The Commission also received a budget allocation of $40,000 for Depreciation and Long Service Leave and $71,662 for EBA4 costs. As a result of the funding for the extra position, an additional Review Officer was appointed. Nevertheless, the work of the Commission continues to be restricted by its limited resources. A formal submission will be made to the Minister for Health, in July 2001, seeking additional funding for the 2001/2002 financial year.

(L-R) Dr Susan Young, Chairperson, Queensland Nursing Council, The Honourable Wendy Edmond MP, Minister for Health, Ian Staib, Health Rights Commissioner

It is not possible for the Commission to provide all the services articulated in the *Health Rights Commission Act 1991* to all people in Queensland with the resources available. Whilst every endeavour has been made to streamline the activities of the Commission using best practice techniques and maximising the use of technology, it would appear that there is no alternative other than to limit the Commission's functions to deal only with complaints of a serious nature. A policy has already been implemented for the triaging of complaints into various categories to enable them to be prioritised for attention depending on the seriousness of the complaint and any threat/risk to the public.

During the year, the Commission came under scrutiny from the media, in particular The Courier Mail, in a number of articles that were critical of the Commission and the Queensland Government. This media attention highlighted the delays experienced in the Commission completing some investigations and the fact that some positions in the Commission had not been filled with the financial allocation for these positions being used to appoint temporary staff. These staff were assigned to deal with outstanding investigations and the conciliation of complaints that had been awaiting finalisation for some time. Clearly, there is a concern in the community about the Commission's ability to deal with complaints in a timely manner.

The *Health Rights Commission Act 1991* provides for the Minister for Health to prepare and table in the Legislative Assembly a report on –

(a) the performance of the commission; and

(b) the development of the Code of Health Rights and Responsibilities; and

(c) the operation of the Act generally

as soon as possible after the Act had been in operation for a period of two years.

It is understood this was done at the time. However, it is now over five years since the activities of the Commission were formally reviewed. In view of the increase in complexities of the issues raised in health care complaints and the implementation of the amendments to the legislation in 1999, I believe there is a need for a formal review of the Commission to be undertaken. I was pleased to learn from the Premier, the Honourable Peter Beattie MP in July 2001 of the Government's decision to conduct such a review.

The work of the Commission continues to be augmented by the provision of independent clinical opinion and advice. Independent opinions from experts in the relevant fields are frequently used as a basis for determining the suitability of treatment or services that are the subject of complaints. I wish to extend my appreciation to those practitioners who so readily assist the Commission in this way. I also wish to acknowledge the Australian Dental Association Queensland which arranges for a dentist to be "on roster" each week to assist the Commission with advice on matters emanating from complaints.

The Commission continues to work with consumer and advocacy groups in order to educate the community about the provision of health services and the role of the Commission. These groups provide the Commission with valuable information about trends and difficulties being experienced by health consumers. I look forward to these relationships evolving as part of the Community Outreach Strategy.

I wish to thank the Health Professional Registration Boards, the Office of the Health Practitioner Registration Boards and the Queensland Nursing Council for their co-operation and support throughout the year. Extensive consultation took place with these bodies in the development of procedures for the consultation processes required by the new legislation.

Ian Staib
Commissioner

COMPLAINTS UNIT

The year under review saw a consolidation of complaint handling processes in response to the *Health Practitioners (Professional Standards) Act 1999* and the subsequent amendments to the *Nursing Act 1992* and the *Health Rights Commission Act 1991*. These processes were refined to best meet the needs of health service consumers and providers in Queensland. The amendments made specific provisions for the handling of oral complaints. Thus the statistics provided in this section of the report show both written and oral complaints in accordance with the Act.

There was a substantial increase in the number of enquiry calls and new complaints. Delays in dealing with complaints were unavoidable, particularly in the latter part of the year. The capacity of complaints staff who worked under constant pressure was stretched to the extreme.

Officers of the Commission continued to meet on a fortnightly basis with representatives from the Health Practitioner Registration Boards and the Queensland Nursing Council to discuss new complaints received by the Commission and the registration bodies.

INTAKE

The Intake Unit is the first contact point for many complainants. These people have telephoned or written to the Commission with a complaint about a health service. Some sought information about health service policy and procedures or the availability of services.

The decision taken in the previous year to employ four permanent part-time Enquiry Officers assisted in reducing the pressures placed upon intake staff by distressed callers who were making their first contact with a complaints body. Three temporary Enquiry Officers were appointed during 2000/2001 due to the absence of officers on secondment, maternity leave and acting in higher duties.

There was an increase in both telephone calls initiating new complaints and written complaints from complainants who had no prior contact with the Commission. New telephone enquiry calls totalled 4,274, an increase of some 14 percent from the previous year. Of these new calls, 2,361 (55%) were enquiries only and 1,913 (45%) were registered as oral complaints. Three hundred and fifty seven (357) (18%) of these were subsequently confirmed in writing. One thousand and twenty six (1,026) (53%) of the oral complaints received were closed at the intake level. The most common reasons for closure were the complainant's view being recorded (485) (47%), remedial action by the service provider (102) (10%), complaint not being confirmed in writing despite follow up (96) (9%),explanation from the provider (80) (7%) and complaint out of time (51) (5%). As at 30 June 2001, 530 oral complaints remained open.

During the reporting period, 964 written complaints were received. Six hundred and seven (607) (63%) of these had no prior contact with the Commission. The Complaints Coordinator closed forty five (45) written complaints at the intake level primarily as a result of negotiation between the complainant and the provider.

Due to the increase in the number of complaints received and staffing shortages experienced during the year, a triaging system was introduced whereby substantial and serious complaints were allocated for formal assessment in advance of complaints considered to be routine or of a less serious nature. The number of complaints awaiting allocation for assessment increased significantly in the last six months of the year.

At 30 June 2001, 225 complaints were awaiting allocation for assessment. Some of these were up to three months old. At that stage it was not possible to allocate any routine complaints and only the more serious complaints were being allocated for assessment. Where appropriate, complainants were advised of the delays, and encouraged to endeavour to resolve their concern directly with the provider. Action was in hand to develop a policy to further address the backlog issue and the management of accepting complaints for assessment. The intention was to address the imbalance of complaints received being greater than those able to be allocated for assessment. In light of the advice received from the Honourable The Premier in July 2001 of the Government's decision to undertake a formal review of the Commission, further consideration of this proposal was deferred.

The Commission's policy of assisting callers to resolve complaints directly with providers, where appropriate, met with considerable success at the intake level. The following narratives are examples of these complaints:

Narrative 1

A woman said her six month old son was admitted to a public hospital for a bacterial infection. She said that the intravenous line, which was placed in her son's hand, was not checked for five days and this resulted in an infection and allergic skin reaction due to fluids from the line spilling out of the needle. The woman was advised by the Commission to send a letter to the hospital and to seek a second opinion on the effects on her son's skin. The woman later contacted the Commission stating she had received a satisfactory explanation and assurances from the hospital that procedures would be reviewed. In view of this, she said she no longer wished to pursue her complaint.

Narrative 2

A woman complained that an optometrist at an optical store verbally abused her when she complained about her new spectacles. She said that when she received the new glasses she was unable to see properly but when the optometrist checked the prescription he told her that it was just the style of the lens and that she would have to get used to them. The woman said she explained to the optometrist that when she tried to read something with the spectacles, all the words blended together. The woman said the optometrist became agitated, pushed the lenses out of the frames and threw the frames and the lenses into a rubbish bin. She said she told him she would not be paying the remainder of the bill and that his behaviour was unprofessional. The Commission advised the woman to write to the store's head office expressing her dissatisfaction with the service and the optometrist's behaviour. She contacted the Commission several days later stating that she had received a genuine apology from the Manager of the optical company, together with a full refund and a voucher for a complimentary set of lenses to be fitted to her own frames. The woman was extremely pleased with the outcome and thanked the Commission for its advice.

Narrative 3

A woman, who was referred to the Commission by Queensland Health, complained that after waiting three years to have new dentures made up by a dental clinic, the top dentures fitted perfectly but the bottom dentures did not. She said that as a result she had experienced ongoing pain in her lower left jaw and, although the dental clinic had agreed the bottom denture needed to be re-made, she had been told that she would have to wait twelve months before she could be seen. The Commission advised the woman to write to the Director of the Clinic, explaining the difficulties she had and seeking an earlier appointment. She later advised the Commission that in response to her letter, the Director had met with her and made arrangements for her to be seen by a dentist who found that she required a completely new set of upper and lower dentures. An early appointment had been made to have the problem rectified and the complaint was resolved. The woman thanked the Commission for its advice, which led to a successful outcome.

Examples of the type of written complaints closed at the intake level are as follows:

Narrative 4

A woman said that she consulted a gynaecologist in relation to treatment options for endometriosis. The woman complained that the gynaecologist trivialised her concerns, was rude and unable to suggest treatment options with her. She said she felt that she had not been given the proper care and consideration she expected from a specialist and forwarded a letter to him outlining her concerns. The gynaecologist responded to the woman in writing disputing her recollection of events surrounding the consultation and offered to refer her to another specialist. As the complaint related to two differing recollections of an event and the Commission was unable to make an informed adjudication as to the accuracy of either version, the complaint was closed. The woman remained dissatisfied with the outcome of her complaint.

Narrative 5

A man said that he went into a private hospital to have a gall bladder operation. The man complained that during his stay, he was not provided with adequate pain relief and had to continually ask for urine bottles to be provided. He said that he was not given water when requested; not cared for during periods of vomiting; not bathed within 24 hours of his operation; his dressings remained unchanged for 24 hours and he was not provided with a solid meal until the evening of the second day after surgery. The hospital responded directly to the man, providing a comprehensive explanation to each issue raised, an apology and a commitment to improved procedures in the future. The man informed the Commission that he had accepted the hospital’s apology, explanation and commitment to improved services and wished to withdraw the complaint. The complaint was therefore closed.

Narrative 6

A woman said that she visited a medical centre where she had to wait for an unacceptable amount of time to be seen by a doctor without being given an explanation for the delay. The woman said that when she was finally seen, the doctor appeared disinterested and charged her for a twenty minute session in which she believed the medical attention was negligible. The doctor responded to the woman apologising for any miscommunication that had occurred. The doctor detailed the service and advice she had provided including blood tests. The Practice Manager also responded apologising for the delay in treatment and refunding the complainant’s consultation fee. The complainant was satisfied with the outcome of the Commission’s involvement and the complaint was closed.

Narrative 7

A woman complained that a doctor did not put enough padding under a plaster cast. She said she subsequently suffered extreme pain and had to take Pethedine for pain relief. The woman said the doctor had also been rude to her and when she made a written complaint to the doctor she received no response. As the complaint related to issues, which the complainant was aware of more than twelve months before the complaint was lodged, the Commission could take no action and the complaint was closed.

ASSESSMENT

The Commission's Review Officers are responsible for assessing complaints which have not been able to be resolved at the intake level. Lack of resolution at that level can be the result of consumers being dissatisfied with the outcomes of direct resolution or with information given to them by the provider.

Complainants frequently have unrealistic expectations about the outcome they hope to achieve when making a complaint. Providers may decline to participate in direct resolution or refuse to meet a complainant's desired outcome, for example, a request for a refund. There are instances where direct resolution is not appropriate. These include allegations of sexual misconduct and/or inappropriate physical behaviour and medical negligence where there is a serious adverse outcome for the consumer.

The legislation requires that assessment of complaints is achieved within 60 days, with an additional 30 days extension being available in prescribed circumstances. Where it is considered direct resolution is appropriate and where consumers have not attempted to resolve the issue with the provider themselves, they are further encouraged to do so during assessment.

One of the factors which impacts on the assessment process is the difficulty in receiving responses from providers within the specified timeframe, thus allowing the Review Officer to complete the assessment within the prescribed time. Following a response by the provider, the Review Officer typically discusses this response with the complainant and seeks expert independent opinion to assist in deciding the most effective recommendation at the completion of the assessment. Third party advice from other treating practitioners involved with the consumer's care is often sought.

In order to facilitate more timely responses from providers, in circumstances where a response is not received by the given due date, the officers attempt to contact providers by telephone. Reminder correspondence is sent routinely. The Commission is happy to accommodate provider requests for additional time where there are particular difficulties in meeting the request. However, this has the consequence of creating further problems for officers in meeting their statutory deadlines.

The full complement of four Review Officers was achieved in January 2001. All reached their maximum caseloads and the demand for complaints to be assessed far exceeded the capacity of the Commission on current staffing levels in terms of the triaging policy introduced in October 2000. In the main, Review Officers assessed complaints prioritised as serious, followed by those of a substantial nature.

During the year, 202 complaints were closed in assessment, with a further 158 closed in assessment extension; a total of 360. Of this number, 172 (47%) were closed as the result of an explanation being given by the provider and 71 (19%) complaints were unsubstantiated.

The following are examples of complaints resolved in the assessment phase:

Narrative 8

A woman said she visited a public hospital for a gynaecological examination. She stated that the doctor opened the plastic packaging on the speculum with his teeth and then proceeded to examine her without using gloves. She said that after the examination the doctor left the room with 'outstretched hands', making her feel violated and dirty. She said that it appeared the doctor had little respect for his female patients and she wanted an apology. The District Manager of the relevant health service district provided a response, indicating that the doctor had been made aware of the complaint, reminded of the District's infection control policy and procedures and informed of the need to use gloves on every occasion when performing examinations. The doctor had agreed that his manner of opening the speculum packaging could have been seen as inappropriate and he undertook not to do this again. The doctor was asked by the District Manager to contact the woman directly with an apology. It was the Commission's view that the District had taken reasonable action to deal with the complaint and the complaint was subsequently closed.

Narrative 9

A daughter complained on behalf of her mother, who was taken to the Accident and Emergency section of a public hospital after falling at a respite care centre. She said her mother was lying on her back when the person caring for her handed her a plastic cup of boiling water and sachets of tea, coffee and sugar. She said the person did not sit her mother up, provide a bedside table or offer any assistance. She stated that the person left the room and then her mother spilt the contents of the cup over herself when she tried to sit up. The daughter said a nurse came to her mother when she screamed with pain and poured what her mother thought was water over the burns. The daughter said her mother was left lying on the wet sheets until she arrived some time later and found her shivering and in pain. She said her mother suffered burns to her chest. The daughter complained to the staff at the time but felt she was not given a satisfactory explanation as to what had occurred or an apology. The daughter wanted hospital staff to be made more aware of the needs of elderly patients and hospital policy reviewed. In assessment the daughter was provided with an apology from the person involved, the Director of Nursing and the Medical Superintendent. It was explained that a memorandum had been sent to nursing and catering staff reminding them of the need for caution when providing hot drinks for elderly patients. The hospital also offered to conciliate the complaint to resolve any outstanding issues. The daughter declined conciliation and the Commission closed the complaint after recommending other procedural changes in order to prevent such an accident occurring in the future.

Narrative 10

A man said that he was in cardiac arrest and was taken by ambulance to a private hospital where he was refused access by staff. He said that as a Department of Veteran Affairs (DVA) gold card cardholder he believed that the private hospital was the preferred hospital for gold card cardholders. In assessment the hospital said that they do not operate an Accident and Emergency Department. However, it does have a Tier 1 Partnering Agreement with the Department of Veteran Affairs but this does not include Accident and Emergency. A 'credentialed' Visiting Medical Officer may only make admissions to the hospital. The hospital added that the Nurse Manager had not received a request by any medical officer for the man's admission. The hospital's response indicated the Nurse Manager was unaware of the man's impending arrival until only two minutes before his actual arrival. As there were no doctors on site to treat the man's condition, it was thought to be in his best interest to divert him to the Accident and Emergency Department of a nearby public hospital, before he was removed from the ambulance. The man accepted the explanation and the complaint was closed.

Despite the efforts of the Commission, some consumers remained dissatisfied with the health service they received and/or with the way their complaint was handled by the Commission. Some sought legal redress and/or contacted the Minister for Health or the Ombudsman as a result of their dissatisfaction. The following narrative falls within this category:

Narrative 11

A woman complained that nursing staff at a private hospital failed to provide adequate pain control during her delivery or reasonable attention to her and her baby's needs. She said she had a traumatic and difficult birth, which left her in a weakened condition and that nursing staff failed to assist her. The woman stated that her baby was left for one and a half hours before being bathed and that he did not have mucus sucked from his lungs. She believed this resulted in breathing difficulties three days later, which necessitated him being moved to the special nursery. In assessment the hospital stated that at the woman's request, only gas and air was provided as pain relief and this mix was later increased also at the woman's request. The hospital provided an extract from the nursing record showing that mucus was sucked from the baby's lungs but that he still vomited on day 2 and 3. The hospital explained that they were aware of the difficulties the complainant experienced following delivery and sought to assist only when requested in order to allow the woman and her husband a degree of privacy. The woman told the Commission that she was not offered any other pain relief; disputed the nursing record about the suctioning of mucus and remained concerned at the lack of support provided both during and after the birth, with her only being told of a counselling service upon discharge. The Commission informed the hospital that the woman had outstanding concerns that would be noted on the Commission's file. The complaint was closed.

The Commission can accept complaints outside one year of the incidence of the complaint occurring or one year of awareness of the complaint issue, if the Commissioner reasonably believes the allegations in the complaint warrant cancellation or suspension of a provider's registration. During 2000/2001 the Commission received a number of complaints which did not meet the legislative timeframes for making a complaint.

The complaint described below was made outside of the prescribed timeframe. It was considered to be of a serious nature, based on the information provided by the complainant. The complaint was assessed to determine whether there was sufficient evidence of breach of professional standards, which would warrant suspension, or cancellation of the provider's registration. In such instances, complaints can be referred to the appropriate registration body which do not have the same time constraints as the Commission.

Narrative 12

A man said his wife underwent a stomach stapling and banding operation by a general surgeon in a private hospital some years ago. He said that his wife developed a severe infection in the wound, began bleeding internally and the mesh implanted in his wife's stomach had gone through the stomach wall. He complained that due to these complications, his wife's stomach was unable to resume normal functioning and that nerves had been severed. He said that his wife became addicted to painkillers and had since died of a drug overdose. The man said his wife would not let him make a complaint. He believed the doctor should not have operated on his wife as she was in a depressed state. He wanted the doctor's professional standards to be explored and for the surgeon to stop performing such operations. A response was received from the doctor stating that he had performed several stomach stapling/banding operations on the woman from 1988 to 1997. He said between

these procedures the woman had periods where she would keep her weight down, but would return to him when she regained it. He said that following the latest procedure, the mesh came away from the stomach wall several times and he had operated to correct the problem. He said he believed the last procedure he performed on the woman was successful. An independent opinion was obtained from another surgeon who stated that the mesh separating from the stomach wall might have been as a result of the woman gaining weight rather than a lack of skill. He said that such complications were rarely painful, nor would the nerves become involved. He felt that given that the woman was regaining weight between procedures, the surgeon had a duty of care not to perform multiple operations on her. For such procedures to be successful, a 'partnership' between surgeon and patient was required. A delegated representative of The Medical Board of Queensland declined to accept the complaint, as there were insufficient grounds to warrant suspension or cancellation of the provider's registration. The complaint was closed.

The complainant in the next narrative was dissatisfied with the Commission's handling of his complaint. It would appear that the complainant was seeking the Commission to provide him with evidence to use in a potential claim for civil damages against a hospital. The complainant's expectations about the outcome of his complaint were not met, either through the hospital's response or the Commission's complaint handling process.

Narrative 13

A man went to a public hospital to have his back x-rayed. He said that he had to get onto an examination table without assistance, which caused him to tear muscles in his left shoulder. He said that he had to wait twelve months to have an operation to repair the shoulder, but has now found that the doctor at the hospital did not record the injury. He wanted to make a civil claim for damages and wanted to know why the doctor had not recorded the injury at the time. The hospital responded by stating that there was no record in the man's progress notes of the man initially telling the doctor that he had injured himself. Neither was there an incident report regarding the alleged injury, no mention of an incident in the radiographer's report and no mention of an incident in the ambulance report form. The hospital explained that the man had not put a complaint in writing at the time of the incident or at any time afterwards. The hospital further explained that the general response to such an incident would be to write an incident report, note the incident in the radiographer's report, and institute a workplace health and safety investigation. The man agreed that he had not written to the hospital but maintained that the records were inaccurate and wanted them changed, although he was unable to provide evidence to substantiate his claim. The man was given information about applying for an amendment of his files through Freedom of Information and the complaint was closed as unsubstantiated.

The following narrative not only deals with a complainant's unmet expectations, but those of the provider. The doctor concerned was of the view that the Commission should not have accepted the complaint as he was of the opinion the complaint was misconceived. A number of concerns were expressed by practitioners about the Commission assessing complaints which the practitioners believed did not warrant the Commission's attention. An inherent aspect of complaint handling is that it is not always possible to identify a complaint as being misconceived or lacking in substance initially. Thus, information is often sought to clarify the facts of a complaint. The majority of complaints are accepted on face value and then assessed to ascertain whether or not the service provided was reasonable. In this complaint, the reasonableness of the doctor's actions was unclear, until the complaint had been fully assessed.

Narrative 14

A woman complained that a doctor failed to diagnose an unpleasant odour coming from her daughter's head. The woman said three doctors in the one medical centre had each given a different diagnosis. She stated that her daughter was referred to a specialist after trying numerous antibiotics and it was discovered that her daughter had a rotting Band-Aid stuck up her nose. The woman said this particular doctor had seen her daughter on two occasions before referring her to the specialist. The doctor responded by explaining his diagnostic decisions and included a copy of the daughter's medical record. The doctor said he was satisfied that he had acted appropriately given the presenting symptoms. An independent opinion indicated that although a retrospective view clearly showed an incorrect diagnosis had been made, given the symptoms and information available to the doctor at the time, duty of care to the patient had been upheld. The woman accepted that the complaint was to be closed based on the doctor's response and the independent opinion. She did, however, remain dissatisfied with the level of care provided to her daughter and held the view that it was her insistence on further investigation that had been the key factor in a referral to the ear, nose and throat specialist. The doctor did not believe the Commission should have handled the complaint, as he believed it was misconceived. The complaint was closed as unsubstantiated following consultation with a delegated representative of The Medical Board of Queensland.

INVESTIGATION

The Commission undertakes investigations into complaints about non-registered providers. These include services provided by private and public health facilities. Where concerns are raised about the professional skills of a registrant, for example a nurse or doctor in a public hospital, the Commissioner may decide, following consultation with the appropriate registration body, to refer the actions of the registrant to that body.

As reported in the last Annual Report, unavoidable delays occurred in the commencement and completion of investigations of a number of complaints. Formal triaging principles for prioritising investigations were implemented. The principles are based on determining identifiable risk factors in a complaint which impact directly on the priority given for the commencement of the investigation. The principles also take into account public interest issues and the particular requirements of consumers and complainants identified as having a special need. During 2000/2001 all of the outstanding complaints awaiting investigation were allocated to staff for action.

The increase in assessment numbers directly impacted on the number of matters allocated for investigation. There was a direct correlation between the difficulties in completing the assessment of complaints within the legislative timeframes and increased recommendations for complaints to be investigated. A number of complaints, which may otherwise have been resolved in assessment but were not sufficiently explored to warrant their closure under provisions in the Act within the specified time, were allocated for investigation.

This situation resulted in new delays in commencing investigations. The triaging principles continued to be applied. Many complainants expressed concern at not receiving expeditious handling of those complaints they believed should have been given priority. The impact on gathering evidence and being unable to reach a determination on the complaint was equally frustrating for providers. The greater the delay in commencing an investigation, the more difficult evidence gathering becomes.

Complaints Unit

Back Row: (L-R) Patricia Bartz, Caroline Jeffs, Owen Davies, John Cake, Fiona Jackson, Karen Harbus

Front Row: (L-R) Wayne Bolton, Michele Mrozik, Linda Morley, Sarah Henderson, Bruce Bassett

Absent: Lester Bock, Susan Hart

As reported previously, new disciplinary procedures were prescribed for the professional registration boards in the *Health Practitioners (Professional Standards) Act 1999*. Amendments to the *Nursing Act 1992* also partially reflected these procedures. Associated changes to the *Health Rights Commission Act 1991* moved responsibility for investigating complaints about registered providers from the Commission to the registration bodies.

These new procedures require that the registration bodies provide the Commission with a report about each investigation completed into the conduct of registered health practitioners. Recommendations subsequent to the investigation are included in each report, which is presented to the Commission, prior to the registration body taking any action. In addition to the demands on the Commission's three investigators outlined above, they have had to absorb the task of reviewing these reports within specified time frames.

The investigation staff of the Commission reviewed 44 reports from the Boards and the Queensland Nursing Council between January and June 2001. Reliable figures for the first six months of the reporting period are unavailable. Of these 44 reports, 16 (36%) were from the Pharmacy Board and 13 (29%) from the Medical Board. Recommendations were made with regard to several of these reports, mainly relating to investigation methodology, comprehensiveness of the information provided to the Commission, and the efficacy of proposed actions. The Commission concurred with the recommendations in 34 (77%) of the reports reviewed.

The legislation requires that the registration bodies are to have regard to the comments of the Commissioner and in a small number of cases, the feedback provided has resulted in a review of the evidence and proposed actions. If, following the feedback and review process, the Commissioner has any significant unresolved concerns, the legislation allows for the Minister to be notified accordingly. This option has not had to be utilised to date.

The professional registration bodies have generally been receptive to the feedback provided by the Commission. Some discrepancies still exist in terms of what the registration bodies and the Commission view as reasonable reporting standards and expectations. Nevertheless, the year saw negotiation and dialogue between the Commission and these bodies, aimed at establishing the baseline reporting requirements needed to facilitate a fair and comprehensive review process.

New opportunities for the sharing and developing of investigation and reporting expertise were developed during the year. Representatives from the Health Practitioner Registration Boards, Queensland Nursing Council and the Commission formed an Investigators Interest Group. It is anticipated that this collaborative process will be further developed during the forthcoming year for the benefit of each agency and its stakeholders. Some areas of interest which have been identified to date include mutual training, investigation approaches and strategies, common challenges and problems in investigations, interviewing techniques and how to deal with system issues.

The facilitation of a meeting between the complainant and an independent practitioner is very helpful for the complainant and is an avenue that complainants do not necessarily expect to occur during investigation. The availability of independent practitioners to assist complainants understand their traumatic experience undoubtedly goes some way in redressing the complainant's view of the health system. If during the course of an investigation about a non-registered provider, such as a public hospital, it becomes apparent a registrant is implicated in the complaint, the Commission refers that registrant to the appropriate registration body.

At 30 June 2001, there were 96 investigations open within the Commission including five Ministerial Investigations. Sixty three (63) complaints were closed during the year following investigation including five Ministerial Investigations. Of the complaints closed following investigation, 36 (57%) were unsubstantiated, 11 (17%) were partially substantiated and seven (11%) substantiated. Additionally two Ministerial Inquiries were closed.

Investigators Owen Davies (left) and Fiona Jackson presented a paper at the National Complaints Conference

A number of obstetric complaints were finalised in investigation during the year. The following examples highlight ongoing concerns raised by complainants in this area:

Narrative 15

A woman who was admitted to a public hospital at 21 weeks gestation with premature rupture of membranes, complained about the actions of the obstetrician who cared for her. She said that, after remaining in hospital for a week, it was decided to induce her. However, the obstetrician did not wait for the induction to work and during a vaginal examination attempted to manually deliver the baby. The woman said the obstetrician did not explain what he was doing or arrange for appropriate pain relief. She said it was her belief that her baby was still in her uterus at this time, but that she was subsequently taken to theatre and her baby had to be de-capitated in order to be delivered. The woman said she was not given sufficient information to consent to this procedure. The woman stated that she knew her baby was not going to survive, but felt the experience had been unnecessarily traumatic and extremely painful. During investigation of the complaint, the obstetrician said that the baby was lying in the vagina and after attempting to deliver the baby, it was his impression the baby was stuck in the cervix. The obstetrician acknowledged the procedure was distressing but felt he had taken an appropriate course of action. Interviews with staff raised concerns about the information provided to the woman and the inadequacy of pain relief. Advice from an independent obstetrician raised some questions about the appropriateness of the attempt to deliver the baby. During the investigation, the Commission facilitated a meeting between the complainant and the independent obstetrician to discuss the complaint, the care the woman had received and its ongoing impact on her well being. The woman advised that this process was helpful. The Commission recommended that The Medical Board of Queensland give consideration to the obstetrician's action in this matter. As there were no outstanding systemic issues in relation to the hospital, the complaint was closed.

Narrative 16

A 40-year-old pregnant woman was admitted to a public hospital at 17 weeks gestation because her membranes ruptured and she developed a womb infection. She said the treating obstetrician made callous and inappropriate comments to her during the admission. She said the baby was subsequently induced and that during a difficult delivery the obstetrician was rough, uncaring and used excessive force. The woman said she spent the following eight days on life support and was then informed her uterus and spleen had been removed. She held the obstetrician responsible for this situation. The woman was seeking compensation, as she felt that the hospital's management of her condition had been negligent, and disciplinary action against the obstetrician. In response to the complaint it became apparent that the obstetrician told the woman the pregnancy had to be terminated as there was no chance of the foetus surviving. The obstetrician also identified that factors in the woman's past medical history put her at a high risk of needing a hysterectomy. The obstetrician recommended the latter but gave the woman the choice of proceeding with an induced vaginal delivery. Hoping to avoid surgery, the woman chose the latter. Following the delivery of the foetus she suffered a torrential haemorrhage and required major surgery then prolonged hospitalisation to save her life. She continues to suffer further health problems related to the haemorrhage and the subsequent surgery. The Commission consulted an independent obstetrician/ gynaecologist for an opinion regarding the woman's treatment. The independent specialist was complimentary of the medical care provided to the woman, but identified that she had not been warned there was a known 10% risk of the life-threatening haemorrhage occurring after the induced delivery. The woman stated that if she had been warned of this risk she would have elected to undergo the hysterectomy rather than knowingly risk her life. The complaint is yet to be finalised.

Narrative 17

A woman was admitted to a public hospital in labour at full term. She complained that a midwife failed to inform a doctor of her unborn baby's distress. She said that when her waters subsequently ruptured, meconium was detected in the fluid (the baby had passed a bowel motion in the amniotic fluid). She also complained about inadequate pain relief. An emergency Caesarean section was eventually performed and the baby died soon after. The woman claimed that if the surgery had been performed earlier, the baby would have survived. She wanted an explanation from the hospital and the midwife's actions assessed. The Commission investigated the complaint and an opinion from an independent obstetrician/gynaecologist was obtained. It was considered that errors of clinical judgement and knowledge were displayed by the principal house officer involved in the woman's care during the early part of her labour. The independent specialist also considered that the hospital's policies regarding midwifery management of labour were deficient in that the circumstances warranting medical review of a patient needed to be prescribed in more detail. The independent specialist also suggested that additional foetal monitoring equipment could have been used to assess the baby's condition in this case. The Commission consulted an independent midwife who reported deficits in the midwifery care provided to the woman by two midwives. The criticisms related in particular to their interpretation of readings provided by standard foetal monitoring equipment. The Commission referred the matters regarding the principal house officer and the midwives to The Medical Board of Queensland and the Queensland Nursing Council respectively. The hospital provided the Commission with evidence that it had undertaken considerable revision of its protocols for the midwifery management of labour. The issue of additional equipment availability, as raised by the independent obstetrician/gynaecologist was explored and found to be an unreasonable expectation for a hospital of that size. The Commission closed the complaint.

The following narrative demonstrates how improvements to service delivery can be negotiated during the course of an investigation:

Narrative 18

A woman complained about a staff member from a community organisation for people with a psychiatric illness where she was a client. She claimed the staff member had a personal and intimate relationship with her after she approached him for support during a difficult period in her life. The woman said that when she complained to the organisation, they were biased and told her she had misinterpreted the situation as part of her illness. A separate complaint was registered against the individual staff member who was by then no longer employed by the community organisation. Assessment of the complaint about the organisation indicated that it had no documented processes relating to the supervision of staff and the management of grievances. During the investigation, a number of changes were made to the position previously held by the staff member, and appropriate reporting networks were implemented. After the need for a documented grievance procedure was highlighted by the Commission, the organisation developed an appropriate written grievance procedure. The complainant was provided with a copy of this document, but did not respond to the Commission's invitation to make further comment. The complaint was closed.

Seven cases investigated by the Commission during the past twelve months involved suicide. Some of these complaints were made by parents complaining that a family member admitted to a psychiatric ward should reasonably be expected to be safe and unable to walk out and take their own life. Several of the cases included elements of concern that hospital staff were not listening to the family. The next collection of narratives relate to these complaints.

Narrative 19

A man was admitted to a public hospital psychiatric unit for his own protection after threatening suicide. His mother complained that her son committed suicide on the day he was being discharged and that the hospital should have been aware his suicide threats were genuine. According to the mother, it took five hours for the family to be notified of her son's death. The mother complained that she was contacted by another public hospital requesting donation of her son's body parts within minutes of her being advised of his death. She had also requested to be allowed to view her son's body and was told by police that she could do so the following day at the morgue. However, this was refused. A number of matters were declined as out of the Commission's jurisdiction. The hospital submitted that considerable correspondence had been sent to the complainant dealing with the clinical reasons for discharge, the arrangements for this and for the son's planned accommodation. Evidence obtained in investigation indicated that the man was resistive of attempts at assistance and had not been assessed as at risk when he absconded from the hospital. Attempts to locate him following his absconding were unsuccessful, and subsequent concerns of the mother were found to be unrelated to the respondent hospital. The complaint was closed.

Narrative 20

A young woman was placed into a psychiatric hospital, where staff were aware of her condition. Her parents called the ward, as usual, to speak with their daughter on three different occasions between 9.00 a.m. and 3.30 p.m. on the day she died. According to her parents, the woman had not been woken during this time for food or medication. The daughter was found dead in bed at night; rigor mortis had set in. Consequently, the parents believed the hospital had failed in its duty of care to their daughter, as hospital staff did not monitor her condition appropriately. The complaint occurred at the time of an independent review by Queensland Health of the hospital's mental health service. The report from this review and the Coroner led to changes being made relating to the provision of care. The complaint was closed as being appropriately dealt with by the Coroner and Queensland Health.

Community perceptions about the nature of psychiatric care do not necessarily reflect the current practice. In the following case, a woman complained about the suicide of a cousin in psychiatric care. The complainant herself had been a patient in another psychiatric facility some 20 years before. It was her expectation that, as was the case then, the cousin would be locked up and not let out of sight whilst in treatment. The approach today is much more open and involves establishing a "therapeutic relationship" and thus a relationship of trust with the patient. Experience has shown this does not occur if patients are being forcibly locked up or held against their wishes. Nevertheless, there is a significant risk of the person absconding and an adverse outcome.

Narrative 21

A woman complained that her male cousin was admitted to a psychiatric ward of a public hospital and was able to leave unobserved. According to the woman, her cousin committed suicide a short time later. The woman said that she was told that her cousin was placed under 15 minute observations. The woman said that the man's son went to visit him but was told that his father could have been out taking a walk. According to the complainant, the son waited for more than half an hour and did not see his father. The woman wanted to know how a patient who was supposed to be on 15 minute observations could leave the hospital unnoticed. During investigation it was established that a nurse noted the man was missing but failed to take action. The nurse was referred to the Queensland Nursing Council. The hospital gave evidence of improved policies and procedures for monitoring patients. The complaint was closed.

From time to time, the Commission receives complaints about unregistered providers in relation to allegations of inappropriate touching. As there are no registration bodies to which these complaints can be referred, the Commission has to rely on the relevant professional associations in determining appropriate action and outcomes. The following is an example:

Narrative 22

A woman stated that she consulted a naturopath for relief of neck pain. The naturopath advised her to have a neck massage to relieve tension. The woman said that when she attended for a second massage, she was told that most people lay on their back. This she did and was covered with a thin sheet. She was not wearing a shirt or bra. She said the naturopath massaged her neck before massaging her stomach and breasts. She said she felt violated and sought advice from a massage therapist, who thought it was inappropriate to massage in this manner. The woman subsequently made a complaint to Queensland Police and the Manager of the centre. The Manager advised the woman that the naturopath had said this massage was part of his normal practice. The woman wanted him to be refrained from massaging clients. In investigation, the naturopath argued that the massage was intended to induce overall relaxation and therefore did not only target the neck area. He also argued that he had informed the woman his massage would include the pectoral area and that he understood she had consented to the massage. The Commission pointed out to the practitioner that not all members of the public would understand that the pectoral area referred to the chest region. The Commission consulted the Australian Traditional Medicine Society (ATMS), of which the naturopath was a member, for an opinion on the ethics of applying massage to the breast area. The ATMS Code of Ethics specifically excludes this practice and the practitioner was subsequently struck off their membership list. The naturopath advised that he had been unaware of the ATMS Code because he had been too busy to read the literature regularly sent to him from that organisation. The Commission reinforced the need to constantly update clinical knowledge in all areas relating to patient care. The practitioner acknowledged this need and provided the Commission with evidence that he had revised his massage technique and had developed a written massage agreement for use with his clients in an effort to prevent any further misunderstandings. The practitioner is also a member of another representative body and the complaint remains open while the Commission awaits a decision from that body on the issue of the breast massage.

Investigation of complaints can reveal issues which are not immediately apparent on reading the initial written complaint. The following narrative demonstrates that, in looking at the systemic issues, other problems were discovered which were not identified initially. These problems were subsequently rectified for the benefit of future consumers of public health services.

Narrative 23

A complaint was received from the Minister for Health, directing the Commission to investigate the death of a woman who died while waiting for a heart valve replacement at the respondent public hospital. The complaint suggested that the woman was to be transferred to a second public hospital for the procedure, but the transfer was cancelled and the woman died. Investigation of the complaint indicated that staff from the respondent hospital had requested an appointment at the second hospital and had also notified the second hospital two months later that the appointment was urgent. However, the second hospital's administrative procedure had failed. A number of possible causes were identified, including the absence of any process for reviewing correspondence addressed to specialists who were on leave. The woman was subsequently seen at her local hospital and

transferred to the respondent hospital, as she was unwell. At that time, medical staff from the hospital attempted to arrange transfer to the second hospital, but were advised that there were no available beds. The woman died before a bed could be found for her. During the investigation it became apparent that the second hospital's process for reviewing and prioritising requests for transfer were not adequate. The Commission made a number of recommendations to this second hospital about the need for appropriate systems to acknowledge referral letters, make appointments and arrange inter-hospital transfers. The second hospital advised the Commission that steps would be taken to ensure correspondence and referral for consultants on leave would be reviewed by a medical officer on a daily basis and action had been taken in response to the recommendation concerning acknowledgement of referral letters, appointments and inter-hospital transfers. After reporting the recommendations to the Minister for Health, the respondent hospital, the second hospital and the complainant, the complaint was closed.

Table 1: Complaints Resolved by Stage 2000/2001

Stage of Complaint Process	Number of Complaints
Oral Complaints	1,026
Pre-Assessment	45
Assessment	360
Conciliation	163
Investigation	58
Ministerial Inquiry	2
Ministerial Investigation	5
Multiple Action	1
Referred to Other Entities	3
Referred to Registration Boards	51
Total	**1,714**

Table 2: Complaints Open as at 30 June 2001

Stage of Complaint Process	Number of Complaints
Oral Complaints	539
Pre-Assessment	225
Assessment	176
Conciliation	181
Investigation	91
Ministerial Investigation	5
Multiple Action	17
Referred to Other Entities	2
Referred to Registration Boards	123
Total	**1,359**

Table 3: Outcomes of Complaints Closed in 2000/2001

ACTION	NUMBER
Oral Complaints	
Allowed to lapse by user	6
Apology	33
Commission took no action	44
Dealt with by another agency	3
Disciplinary action	24
Ex gratia payment	15
Explanation	80
Fee waived or reduced	14
Misunderstanding resolved	21
No co-operation	3
Not confirmed in writing	101
Other remedial action	5
Out of time	51
Policy change	1
Procedural change	17
Refund	5
Remedial action	102
Service expedited	5
Unsubstantiated	5
User's view recorded	485
Withdrawn by user	6
Total	**1,026**
Pre-Assessment	
Apology	1
Commission took no action	12
Dealt with by another agency	2
Ex gratia payment	1
Explanation	5
Out of time	10
Remedial action	1
Unsubstantiated	5
User's view recorded	2
Withdrawn by user	6
Total	**45**
Assessment	
Apology	10
Commission took no action	19
Dealt with by another agency	2
Ex gratia payment	2
Explanation	172
Fee waived or reduced	2
Misunderstanding resolved	6
No co-operation	1
Other remedial action	1
Outside jurisdiction	1
Out of time	6
Refund	1
Remedial action	5
Service expedited	2
Unsubstantiated	71
User's view recorded	41
Withdrawn during assessment	18
Total	**360**

ACTION	NUMBER
Conciliation	
Agreement not reached	13
Agreement reached	10
Disagreement fully explored	70
Disagreement fully explored – partial agreement	15
Settlement negotiated	21
Withdrawn from conciliation	22
Withdrawn from conciliation to take legal action	12
Total	**163**
Investigation	
Board consideration recommended	1
Complaint partially substantiated	11
Complaint substantiated	7
Complaint unsubstantiated	36
Investigated and advice given	2
Other agency consideration	1
Total	**58**
Ministerial Inquiry	
Complaint partially substantiated	1
Complaint unsubstantiated	1
Total	**2**
Ministerial Investigation	
Board consideration recommended	1
Complaint partially substantiated	1
Complaint unsubstantiated	3
Total	**5**
Multiple Action	
Disciplinary action – censure or reprimand	1
Total	**1**
Referred to Other Entities	
Report received from agency	2
Resolved by other agency	1
Total	**3**
Referred to Registration Boards	
Disciplinary action – censure or reprimand	4
Disciplinary action – conditions of practice	4
Disciplinary action – de-registration	10
Disciplinary action – fine	1
Disciplinary action – suspension	10
No further action needed	22
Total	**51**

TOTAL – 1,714

REFERRALS TO HEALTH PRACTITIONER REGISTRATION BODIES

Seventy four (74) complaints were referred to five of the Health Practitioner Registration Boards at the completion of assessment. Forty five (45) (60%) were referred to The Medical Board of Queensland. The other board referrals were the Dental Board (16) (21%), the Chiropractors and Osteopaths Board (6) (8%), the Pharmacy Board (5) (7%) and the Psychologists Board (2) (4%).

Fifty one (51) (70%) complaints were closed following action by these bodies. The registration bodies took no further action on 22 (30%) complaints.

Disciplinary action was taken against 29 registrants, including ten registrants who were de-registered and ten who were suspended from practice. Four registrants received a censure or reprimand, another four had conditions of practice placed on their registration and one registrant was fined. As at 30 June 2001, 123 complaints referred to the registration bodies were still outstanding.

Examples of the types of complaints referred to registration bodies at the end of assessment follow:

Narrative 24

A woman said she required root canal treatment by a dentist and was quoted $700 for a series of treatments. She said she made part payments at each treatment as arranged. She said that after the final treatment the balance should have been $270. The woman said her husband telephoned the dental surgery to provide bankcard details for that amount to be charged. However the receptionist told her husband the amount was $480. The woman said she telephoned the receptionist and requested that they stop the transaction until she had discussed the matter with the dentist. The woman said the dentist did not contact her and a week later, $510 was charged to her husband's bankcard account. The woman said she had attempted to resolve the matter with the dentist but had not received a response. She requested a refund and was prepared to pay the quoted price. The dentist and her receptionist provided a response to the Commission that indicated that there was a clear difference of opinion as to the costs of the respective treatments. However, it was apparent the receptionist simply took the disputed amount from the husband's bankcard. A delegated representative of the Dental Board of Queensland was consulted and agreed that the complaint warranted the Board's investigation.

Narrative 25

A woman said that a doctor was insensitive and extremely abusive towards her when she presented at his practice after her young son had swallowed a piece of broken glass. She said that the doctor was reluctant to perform x-rays as he said the glass would not show up. The woman said that after the x-rays showed nothing unusual, the doctor told her to go home and wait for her son to pass the glass. She said when she became upset at this, the doctor became abusive and called her a "fool" and "cheap gutter tripe" and said that she had "no brains". She stated that he refused to give her back the x-rays and continued the abuse in the waiting room, in the hearing of others. The woman said that when she advised the doctor she was studying law he stated that he understood that they used to use law students in laboratory experiments but then started to use rats as they had more brains. She said when she picked up her son, the doctor threatened to call the Department of Family Services to report her for abusing her son, when that was not the case. The woman said that she had not provoked the doctor's reaction. She said the doctor then spat on her. She said several days later when she was in the vicinity of the doctor's practice, the doctor approached her without provocation and continued to abuse her including calling her a "f..... schizophrenic". In response the doctor stated that the woman had become upset after he gave her the news about her son. He said that he believed she was aggressive. He denied swearing or spitting at the woman but admitted to calling her a "guttersnipe" and to making the comments about law students and laboratory rats. The doctor stated

that he had informed his receptionist to call the police if the woman did not leave, and admitted to threatening to call the Department of Family Services. He said he felt his behaviour was justified and did not regret it. After consultation with a delegated representative of The Medical Board of Queensland, the case was referred to the Board to investigate professional standards issues in relation to communication. The complaint is not yet finalised.

REFERRALS TO OTHER ENTITIES

Three complaints were referred to other entities for investigation, at the end of assessment, following consultation with those entities. One complaint was referred to the Australian Competition and Consumer Commission (ACCC) with regards to hair transplant surgery and alleged misleading promotional material. Following review, the ACCC decided the complaint was not within its jurisdiction. A second referral was made to the Public Trustee in respect of the financial management of residents in supported accommodation and the third referral was to the Health Insurance Commission about the management of the safety net card system for an elderly resident in an aged care facility. The latter two complaints were resolved by the entities concerned.

MINISTERIAL INQUIRIES

Previous annual reports have mentioned a direction from the Minister for Health to undertake an inquiry into a number of allegations about health services provided at a private psychiatric hospital.

Narrative 26

In this Inquiry, one of the complainants alleged that he experienced physical and sexual abuse by a therapist and other clients as part of confrontational therapy. The man claimed that he was touched between his legs when he was clearly distressed by such touching. Other complaints related to the appropriateness of treatment offered, inadequate supervision of patients and misleading information about treatment options.

The allegations of inappropriate therapeutic approaches related primarily to incidents that occurred in one therapy group. Enquiries were directed toward past staff members, and client members of that therapy group. The Commission obtained the last known contact details of 16 former patients of the group who were invited in general terms to contact the Commission if they wished to provide information in respect of treatment they had received at this facility some years previous. Eight letters to past patients were returned undelivered, and of the remaining eight that were delivered, six former patients agreed to provide evidence about their experience in the therapy group, and at the facility. There was no corroborating evidence of the specific allegations relating to assault. There was mixed feedback about the benefits or otherwise of the particular therapeutic approach. Some former patients spoke positively, others had some reservations about their experience.

One ex-staff member summarised the treatment model at the time by saying they operated as a "therapeutic community" where one had to face their inner fears, and as such, interpersonal confrontation was expected.

From a review of patient medical charts, discussions with current staff and management, and a review of the hospital's current treatment modality and accreditations, it was clear that the therapeutic community approach was no longer being applied. The hospital had moved to a more traditional medical treatment model for mental illnesses. It was apparent that the therapeutic community approach worked well for some people, and perhaps for some illnesses, but did not work well for others. In this case, one of the therapy group leaders was referred to the Psychologists Board for review of his understanding of the importance of interpersonal boundaries in therapy. The inquiry has now been closed.

Table 4: Respondents to Complaints

Provider	Number of Complaints
Aboriginal Health Service	3
Aged Care Facility – Commonwealth Funded	21
Aged Care Facility – Privately Funded	27
Alcohol and Drug Service	11
Alternative Therapists	13
Audiologist	1
Child Community Health Service	2
Chiropractor	11
Community Health Service	32
Community Mental Health Service	19
Corrections Health	4
Counsellor	4
Dental Clinic	32
Dental Technician/Prosthetist	8
Dentist	127
Fertility Clinic	6
Hospice	2
Hospital Private	123
Hospital Psychiatric	35
Hospital Public General	781
Hostel	4
Insurance	1
Integrated Mental Health Service	7
Masseur	3
Medical Centre	98
Medical Practitioner	938
Nurse	7
Nursing Home	4
Nursing Service	3
Occupational Therapist	1
Optometrist	14
Other Health Service	29
Pathology Service	10
Pharmacist	32
Pharmacy	25
Physiotherapist	3
Podiatrist	3
Prosthetist/Orthotist	1
Psychologist	17
QAS – Ambulance	7
Queensland Health	7
Radiographer	3
Radiology Service	17
Residential Care Worker	1
Respite Care	1
Social Worker/Welfare Officer	1
Supported Accommodation Facilities	4
Unknown	17
Total	**2,520**

RESPONDENTS TO COMPLAINTS

The number of complaints received during 2000/2001 about each type of health service provider are illustrated in Table 4.

Medical practitioners remain one of the most frequently represented respondent groups, with 938 (37%) complaints (390 written), a reduction of 63 written complaints from the previous year. (Doctors in private practice were the largest component of this group.) In part, this reduction is likely to have been linked to the different reporting relationship with the registration bodies, emanating from the introduction of the *Health Practitioners (Professional Standards) Act 1999*.

Hospitals represented the other most frequent group of respondents to complaints, with figures almost identical to those of medical practitioners. Of a total of 939 complaints (349 written), compared to the 448 written complaints reported last year, public hospitals accounted for 781 (31%) (288 written). This apparent reduction was most likely the result of increased referral by the Commission's intake staff to the Patient Liaison Officers within the public hospital system for direct resolution. Private hospitals and psychiatric hospitals were respondents to 123 and 35 complaints respectively.

One hundred and twenty seven (127) complaints were received about dentists and 32 about dental clinics. A further 98 complaints were received about medical centres of which only 12 (12%) were confirmed in writing. Pharmacists were respondents to 32 complaints (1%).

ISSUES IN COMPLAINTS

Refinements were undertaken during the year to the Commission's two operational databases. These are the Enquiry/Oral Complaints database and the Case Management database which provide information on the complaint handling aspects of the Commission's activities.

The content of the tables in this section differs from representations of statistics relating to complaint handling in previous annual reports. Consequently, a direct comparison with figures of previous years is not appropriate. Nevertheless, comments have been made where trends have been apparent. Interestingly, the issues most frequently complained about were replicated in both databases.

The primary issues in complaints are classified into six areas, as illustrated in Table 5.

Table 5: Primary Issues in Complaints Received

Treatment	
Medication	174
Misdiagnosis	268
Negligent treatment	122
Other treatment	72
Painful treatment	47
Unskilful treatment	651
Wrong treatment	32
Total	**1,366**

Communication	
Arrogance	91
Discourtesy	68
Failure to consult	76
Lack of care and consideration	68
Misinformation	55
Other communication	39
Undignified service	8
Total	**405**

Rights	
Access to records	50
Accuracy of records	13
Assault	18
Confidentiality	58
Discrimination by public/private status	1
Discrimination by sex, age, race etc.	6
Insufficient consent	19
Other code breach	11
Sexual misconduct	48
Unprofessional conduct	62
Total	**286**

Access	
Delay in treatment	31
Discharge	29
Failure to refer	15
No/inadequate service	33
Non attendance	6
Other access	21
Refused treatment	104
Transport	8
Waiting list	16
Total	**263**

Administration	
Administration	51
Advertising breach	3
Hygiene	30
Inadequate response to complaint	4
Other (unclassified)	23
Policy	8
Public health	3
Quackery	7
Reprisal	1
Total	**130**

Costs	
Amount charged	18
Fraud	5
Inadequate information about costs	12
Medicare	1
Other cost or insurance	9
Overservicing	5
Private Health Funds	2
Unfair billing practices	18
Total	**70**

TOTAL OF ALL ISSUES – 2,520

Treatment

There were 1,366 new complaints (572 written) about treatment including a variety of concerns. Of these, 651 (47%) related to unskilful treatment. Complainants who experience an adverse outcome as a result of a health service are frequently of the view that the skill of the practitioner is responsible for their situation. Complainants have an expectation that their complaints will be proven. When a review of their complaint is finalised and the complainant's view is unable to be substantiated, they often express dissatisfaction with the Commission's process.

The second most frequent concern within the treatment issue was misdiagnosis (268) (19%). Complaints about the diagnosis of cancerous conditions remain a major concern for these complainants. These complaints can be difficult to substantiate, even with advice from independent practitioners, due to the progression of some of these conditions. Health service consumers sometimes have high expectations of service delivery based on strong perceptions that in such a technological era with highly trained and skilled medical staff, misdiagnosis should not occur.

As in previous years, complaints about medication (174) (12%) included prescribing, dispensing and administering errors.

Communication

There were 405 complaints (136 written) about communication. Ninety one (91) (23%) concerned the arrogance of the provider. A further 76 (18%) related to a failure by the provider to adequately consult with their patients. The arrogance displayed by a provider and their lack of care and consideration accounted for 68 complaints each.

Rights

Complaints about breaches of rights accounted for 286 complaints (105 written). The most common concerns related to unprofessional conduct (62) (21%), confidentiality (58) (20%) and sexual misconduct (48) (16%). Twenty (20) complaints about sexual misconduct were confirmed in writing, one more than last year.

Access to records accounted for 50 complaints (13 written) and appeared to reflect a growing awareness in the community of the need to provide new treating practitioners with medical records, to ensure continuity of care. Written complaints about assault amounted to 18 in 2000/2001 as compared with 17 in 1999/2000.

Access

There were 263 complaints (83 written) about access to health services. During 1999/2000, 139 written complaints were received about access. One hundred and four (104) (39%) complaints were regarding refusal of treatment. A number of these involved providers withdrawing services because of the perceived threat from consumers displaying challenging behaviour, such as aggression, harassment and abuse. In these situations, the Commission endeavoured to ensure that appropriate alternative treatment was available for consumers, especially those who had difficulties with their mental health.

Thirty three (33) (12%) of these complaints related to inadequate service provision. These complaints most typically represented lack of general and specialist services or facilities in rural areas. The most prominent of these were treatment services for patients suffering from cancer or provision of mental health services for children and adolescents.

Twenty nine (29) (11%) complaints related to discharge from hospital. Most commonly this was with respect to the consumer's view that discharge was premature.

Administration

Administrative issues were cited in 130 complaints (48 written). Fifty one (51) of these complaints typically included concerns about administrative support staff (communication, efficiency) and administrative systems (appointments, waiting times, notification of test results). A further 30 complaints (23%) related to hygiene standards in health facilities.

Costs

Seventy (70) complaints (20 written) were about costs. During 1999/2000, there were 34 written complaints about costs. The most significant concerns were in relation to the amounts charged for services and unfair billing practices.

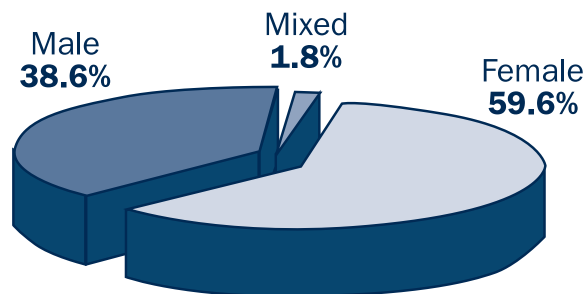
It was noticeable that during the year, some practitioners (e.g. psychologists, natural therapists and other alternative health care providers) requested payment from consumers in advance for a prescribed number of consultations. Difficulties were experienced in situations where a dissatisfied consumer endeavoured to obtain a refund. It could also be argued that such a practice places undue pressure on a consumer to continue with a service which does not meet their needs or expectations. Whilst the number of complaints about this type of billing practice remains too small to indicate a trend, discussions have taken place with a number of the registration bodies and associations to alert them to this practice.

COMPLAINANTS

During the year under review, 575 (59.6%) complaints were received from females, 372 (38.6%) from males and 17 (1.8%) of complainants represented a mixed group, for example, residents in an aged care facility. These figures continue to follow the trends of previous years.

Figure 1

Complainants by Gender



RESIDENTIAL FACILITIES FOR THE AGED, INFIRM AND PEOPLE WITH A DISABILITY

Supported Accommodation Facilities

During the year, the Commission made submissions to the Hostel Industry Development Unit in conjunction with the preparation of legislation in respect of the regulation and registration of hostels in Queensland. The Commission is presently one of the few agencies with jurisdiction to investigate complaints about the provision of services in the currently unregulated hostel industry.

The Commission received eight complaints (two confirmed in writing) during 2000/2001 about the provision of health services at supported accommodation facilities. These complaints related to the living conditions at the premises along with concerns about the adequacy of services and appropriateness of supervision provided to residents.

Unfortunately, there was another theme amongst hostel complaints. This related to the physical and sexual abuse of residents. These matters are taken extremely seriously and, as appropriate, the Commission liaised with the Queensland Police Service about such allegations.

Complaints about the standard of services in a hostel can be difficult to resolve. Staff are often reluctant to speak up for fear they may lose their employment and not all residents are prepared, or able, to comment. The Commission continued to investigate a number of complaints relating to the provision of services at a particular hostel, which accommodates primarily elderly dementia patients. The majority of the residents were unable to make any comment about the provision of services or alleged incidents that took place in the hostel. In this case, the Commission relied on a number of strategies for collecting evidence including conducting confidential interviews with current and former staff, discussions with friends and family of the residents, a survey distributed to parties associated with the hostel allowing for anonymous comments, and liaison with the Brisbane City Council, Aged Care Assessment Teams of the Department of Health and Aged Care (Commonwealth) and the Adult Guardian. A number of concerns about the standard of care and the safety of residents were identified and the evidence and proposed recommendations were presented to the owners.

At times, questions are raised about the Commission's ability to impact on the provision of health services given the Commission only has powers of recommendation. However, as in this case, it is the Commission's experience that often health service providers respond positively when presented with a concise and clearly argued overview of the health issues under consideration. A well reasoned argument is often an effective tool to implement change. This is further assisted by strong discussion with a provider about their duty of care, civil liability and potential exposure to litigation. The Commission works pro-actively with providers to encourage them to recognise the benefits of improving the quality of their services.

The Commission supports the proposed introduction of legislation to further enhance the protection of residents in supported accommodation facilities in Queensland.

Residential Aged Care Facilities

The residential aged care sector and the processes available for monitoring the quality of care provided by that sector received a considerable amount of attention during 2000/2001. Much of the public discussion related to the ability of regulatory and complaint agencies to act promptly when concerns were raised about the standard of care provided to elderly residents in "nursing homes".

During 2000/2001 the Commission received 51 complaints (12 of which were confirmed in writing) about residential aged care services. The majority of the facilities in the confirmed complaints received Commonwealth funding as opposed to being privately funded.

There were a number of significant issues impacting on the Commission's handling of complaints about aged care facilities and its inability to take action immediately upon a complaint being made to the Commission. The delay in addressing complaints continued because of a backlog of complaints awaiting investigation. These delays make this work more difficult due to the availability of witnesses and people's recollection of events. The investigative process requires the collation and analysis of information. The legislation requires that where adverse comment is made, the respondent has an opportunity to comment before the report is finalised.

During the year, procedures were developed with both the Department of Health and Aged Care (Commonwealth) and the Aged Care Standards and Accreditation Agency (Commonwealth) for handling these complaints. Representatives from the Commission met with the Department of Health and Aged Care to discuss shared jurisdiction and relationships with respect to complaints about aged care facilities. This was an opportunity to discuss the circumstances in which information could be shared on a regular basis. An agreement was reached for meetings between the two agencies to be held on a regular basis.

The following matter was first reported in the 1999/2000 annual report as being referred to the Agency:

Narrative 27

A woman complained that her father, who lived in an aged care hostel, fell at around 2.30 a.m. and was left on the floor until approximately 5.20 a.m. She said that her father was told that the staff member on duty could not lift him on her own and she would wait until the morning shift staff arrived. The woman said her father was reviewed later that morning and transferred to the adjacent hospital where he was diagnosed as having suffered a stroke. She said her father subsequently died at the hospital and, although she did not necessarily think that being left on the floor contributed to her father's death, she thought that the care was not satisfactory. The woman had approached the management of the hostel about her concerns and said she had been advised that steps had been taken to ensure this did not happen in the future. She said that she asked for confirmation of the action taken but was not given that information. In addition, the woman said that her sister, who worked for the organisation, was told that there was a conflict of interest and it was suggested that she should not work there. The organisation responsible for running the aged care hostel did not respond during assessment of the complaint and the complaint was investigated.

During investigation of the complaint, a Commission Officer visited the hostel and staff were interviewed. The information obtained indicated that the man was left on the floor because the staff member could not lift him and did not think she could or should contact the ambulance, the nursing supervisor, the doctor or the hospital next door for help. Since the complaint was made, the hostel had implemented a procedure for obtaining assistance at night. This aspect of the complaint was referred to the Aged Care Standards and Accreditation Agency for its consideration. There were limitations on the amount of information the Agency was able to provide to the Commission, because of the protected information provisions in part 6.2 of the *Aged Care Act 1991*. However, the Commission reviewed the Executive Summary of the Assessment Team's Report in relation to the Accreditation Decision which was publicly available and which indicated that the Agency was satisfied with the processes in place for arranging emergency review.

The inability of the Agency to share information with the Commission remains a limitation to effective discussion about complaints and complaint issues.

A number of the complaints addressed by the Commission during the year related to allegations of physical or sexual abuse of residents by nursing staff or by non-residents, such as visitors to the facility. The Commission was concerned that in some of these cases, there was a delay in reporting the allegations to the police by senior staff at the facility.

In the following example, the matter was not referred by the proprietors to the Queensland Police Service at all:

Narrative 28

A Registered Nurse at a private nursing home complained that a man who was visiting his wife in the home's dementia unit was seen committing a sexual act on another resident. The Registered Nurse said the Director of Nursing, in conjunction with the Visiting Medical Officer, covered up the incident. With the complainant's permission, the Commission provided the Queensland Police Service with a copy of the complaint. A complaint about the medical officer was referred to The Medical Board of Queensland, which made a finding of no misconduct in a professional respect. The conduct of the Director of Nursing was referred to the Queensland Nursing Council. The Council decided not to particularise and investigate this issue. The complaint was also referred to the Department of Health and Aged Care (Commonwealth) with a request that the Department address the nursing home's policies regarding complaint handling and the follow up of serious matters. The Department advised the Commission that as a result of discussions with the nursing home's management, the nursing home had agreed to alter its procedures to include automatic referral to the police in cases of allegations of criminal activities against residents by visitors or staff. The nursing home facility subsequently advised the Commission that this had occurred and all staff had been advised in writing. However, they added that while this was their documented procedure, in practice this did not always occur, as the police did not always think it was appropriate to refer matters. The nursing home advised the Commission that it was holding further discussions with the Queensland Police Service. The Commission is waiting for advice about the outcome of those discussions.

It is the Commission's expectation that allegations of criminal activities against residents of aged care facilities by visitors or staff be referred to the police promptly and the Commission will continue to apply that standard to aged care facilities.

In the next narrative, the Queensland Police Service advised they were not officially notified of the incident until 20 days after it had occurred.

Narrative 29

A man complained that the management of a nursing home had advised him that an incident had occurred involving a staff member and his mother who was a resident of the nursing home. He said he was not given any details concerning the nature of the incident. The man explained that the management advised him that the police had become involved and that the police had advised the nursing home not to tell him what had been alleged. He thought he should have been advised as he was the next of kin and his mother was unable to take action on her own behalf. During assessment of the complaint, the man asked if his mother had been given appropriate medical attention. The Commission contacted the nursing home and was advised that a member of the nursing staff had alleged that she witnessed a possible sexual assault of the resident by an enrolled nurse. The nursing home advised that the matter had not been reported to management in sufficient time to enable tests to be conducted that would provide evidence of assault. Further, the Commission was informed that as a consequence, medical attention had not been sought. However, the nursing home acknowledged it would be appropriate to conduct tests for sexually transmitted diseases.

The Commission was concerned about the delay in contacting the resident's family and in seeking medical attention. Investigation of the complaint indicated that medical attention was not obtained until almost seven weeks after the incident and that the woman's General Practitioner was not advised of the incident. The police advised that they were officially notified of the incident 20 days after it allegedly occurred. The nursing home maintained that the Police advised not to tell the family. However, the police disputed this. The nursing home stated that there had been ongoing discussions with the police as soon as management became aware of the allegation. However, there was no documented evidence to support this statement. Investigation indicated a number of barriers contributed to the delays in reporting and acting on complaints. The Commission produced preliminary reports relating to the conduct of the enrolled nurse and the systemic issues involving the reporting of abuse and the action taken. Copies of these preliminary reports were provided to the relevant persons and organisations and those parties responded. Once these comments have been reviewed, the final report will be released to the providers, the complainants, the Queensland Nursing Council, the Department of Health and Aged Care (Commonwealth) and the Minister for Health.

COMPLAINTS LIAISON OFFICER

The Complaints Liaison Officer is responsible for providing impartial support and information in matters where the complainant requires additional support. During the year under review, this role was undertaken by one of the Commission's Conciliators.

The Complaints Liaison Officer's duties were originally formulated in recognition of the particular difficulties experienced by complainants when making sexual misconduct complaints and proceeding through complaint and prosecution systems with the allegations. More recently however, the Complaints Liaison Officer has also provided services to people making complaints about other sensitive matters.

During 2000/2001 the Complaints Liaison Officer attended a hearing by the Professional Conduct Committee on charges by the Queensland Nursing Council against a registered midwife. The charges originated from a complaint to the Commission by the parents of a boy who was delivered at a planned home birth. The parents alleged that the two midwives attending the home birth were negligent in their care of the mother and baby, resulting in the boy being born with brain damage. The parents were required to give evidence at the hearing. The Queensland Nursing Council requested the assistance of the Complaints Liaison Officer to support the parents during the hearing.

The Complaints Liaison Officer revised the resource "Preparation for Witnesses", which provides information for witnesses required to give evidence at hearings before the Health Practitioners Tribunal and Professional Conduct Committee. The update included changes to disciplinary structures arising out of the *Health Practitioners (Professional Standards) Act 1999.*

SEXUAL MISCONDUCT

Sexual misconduct continued to be a prevalent issue of complaint to the Commission. There was still a great deal of reluctance expressed by people contacting the Commission about making a formal complaint regarding experiences of sexual misconduct. Often the complainant is concerned about personal safety, emotional wellbeing and possible retribution from the practitioner.

The Complaints Liaison Officer plays an impartial yet supportive role in addressing concerns about making sexual misconduct complaints, and ensuring that complainants have support networks and services to rely on during the process. The Complaints Liaison Officer is notified of all sexual misconduct enquiries received by the Commission so that information and assistance can be offered to the complainant.

During 2000/2001, a total of 48 complaints (28 oral, 20 written) were received about sexual propositioning of patients and sexual relationships between practitioners and patients.

The Health Practitioners Tribunal heard charges against a general practitioner (GP) referred by The Medical Board of Queensland. The GP offered to perform oral sex on a female patient whilst he was examining her genitalia. The Tribunal suspended the practitioner from practice for three months and placed conditions on his registration for a period of two years. Importantly, the Tribunal confirmed that whilst the GP may have genuinely believed that the patient was consenting to his actions, the "real seriousness of the registrant's conduct in this case lies in his preparedness to perform a sexual act on the patient, and his attempting to do so, during the course of a medical examination". In determining the penalty, the Tribunal noted "that the circumstances of the particular offender and the offence must be considered, but so too must the requirement of general deterrence".

COSMETIC SURGERY

The Commission continues to receive complaints about cosmetic surgery. These complaints most typically represent concerns about elective procedures rather than plastic or reconstructive surgery performed by qualified surgeons.

During the year 2000/2001, 24 complaints were received about cosmetic surgery procedures, 11 of which were confirmed in writing. These complaints were about registered medical practitioners, including plastic and cosmetic surgeons, who performed the surgery. They also included matters involving referral agencies who acted as an intermediary between the consumer and the practitioner. Complaints about referral facilities currently under investigation by the Commission will be reported in detail in the next annual report, together with the outcomes of the investigations being undertaken by The Medical Board of Queensland into registered practitioners.

One of the issues of greatest concern to complainants is the disappointment they experience when the procedure does not match their expectations and desired outcomes. This may eventually lead them to having additional surgery in the hope that their expectations can be realised. Consequently, if subsequent procedures are also perceived to be unsuccessful, their disappointment may be compounded and it becomes a difficult task to resolve such complaints.

CONCILIATION

The *Health Rights Commission Act 1991* requires that, if the Commissioner considers a complaint can be resolved in conciliation, the Commissioner is to try to resolve the complaint in that way. The Act is based on the principle of consultation and negotiation.

Desired outcomes stated by complainants in cases referred to conciliation include seeking an explanation or apology, wanting to see a change in practice or policy, ensuring the event does not recur, or seeking compensation for an injury suffered. During the year under review 169 new cases were referred to conciliation and 163 cases were closed following conciliation.

As at 30 June 2001 there were 181 complaints open in conciliation. This represents in excess of a year's work for the four Conciliators.

It is noticeable that there was an increase in the number of complaints in conciliation where the complainant was seeking financial compensation. However, it is equally noteworthy that of the complaints closed following conciliation in 1999/2000, 21 percent involved financial settlements. During 2000/2001, only 13 percent of the complaints closed following conciliation involved financial settlements.

Conciliators

Back Row: (L-R) Joan Welsh, Adrian Nippress

Front Row: (L-R) Carmel Blick, Georgia Hoey

INCREASING PRESENCE OF LAWYERS IN CONCILIATION

One of the concerns held by Conciliators has been the imbalance in cases where the providers are represented during conciliation by a legal adviser or insurer and the consumer is not represented. There has been a marked increase in the number of cases where the complainant has legal representation. In 52 percent of the cases currently open in conciliation, the complainants have legal representation. There are a number of reasons for this change:

- Several plaintiff law firms have recognised the value of conciliation and recommend to their clients that an attempt be made to conciliate the complaint. These complainants often have consulted the law firm prior to the making of the complaint to the Commission.
- Conciliations may involve large financial settlements. If a complainant does not have a legal adviser and a financial settlement appears likely, the Conciliator will recommend to the complainant that legal advice on quantum be obtained before the settlement is negotiated.
- An increase in the number of law firms or agencies which provide consumers with appropriate and low cost advice explicitly for the purpose of conciliation.

The plaintiff law firms which support conciliation as a dispute resolution process provide valuable input which can be beneficial to the consumer. The following is an example of a conciliation which was successfully concluded with the assistance of lawyers for both parties:

Narrative 30

As a child, a woman had contracted rheumatic fever, and as a result had an artificial valve in her heart. The woman understood the risk to her health of contracting infection and when she required a gynaecological procedure to be performed under anaesthetic she went to some pains to discuss her management with the doctors at the public hospital where she planned to have the procedure undertaken. The woman was admitted to the hospital two days prior to the procedure to have prophylactic antibiotics administered and her Warfarin levels monitored.

In spite of the preparations taken by the woman and her treating doctors prior to the surgery, she developed a serious infection during her stay in hospital that required treatment with the antibiotic gentamicin. As a result of this course of therapy the woman was left with a loss of hearing and a vestibular disturbance which severely affected her balance. She was unable to walk independently without hanging on to a wall for balance. The woman believed she had developed the infection initially because of a cannula being left in the one position in her arm for an extended period.

Lawyers for both the complainant and the hospital co-operated to explore the issues in conciliation. The lawyers for both sides had significant input about which experts would be approached and the questions that would be asked of the experts. Opinions were obtained from a cardiologist, a neurosurgeon, and an infectious diseases expert to provide as complete a picture as possible in this case.

There were many clinical issues canvassed during the information gathering for this case. Central to the issue of liability was that of the cannula site that had gone unchanged for an extended period, which on the balance of probability led to the development of the infection, and the need for gentamicin to be used.

A period of negotiation followed with the woman's lawyer providing a Statement of Loss and Damage on behalf of their client. At a conciliation meeting soon after, a settlement figure was negotiated. In spite of the usual debate that is a feature of such meetings there was a genuine sense of goodwill with all parties expressing their satisfaction with the outcome.

In contrast, lawyers who are aggressive and combative can seriously jeopardise the conciliation process.

Narrative 31

A woman had suffered a quite serious burn to her upper leg from a faulty diathermy plate during surgery to pin a broken leg. The original injury was sustained during a bush walk and the woman considered herself as someone usually in good health. The woman suffered complications of infection in the burn which required long term treatment with antibiotics, and some painful debridement of the wound which developed.

The hospital's Chief Executive Officer apologised to the woman for the accident that had occurred with the diathermy plate and agreed that it would be appropriate to consider some compensation. The woman was asked to propose a realistic figure for the hospital's consideration. As she had lost considerable work time with the injury she sustained she decided to seek legal advice to assist in preparing a Statement of Loss and Damage.

The lawyer engaged by the woman took an extremely aggressive role in the conciliation. Although it had taken some time to prepare the Statement of Loss and Damage, the lawyer very quickly started to issue ultimatums to the hospital in relation to the time for a response. The situation deteriorated quite quickly. The woman was inclined to accept an offer made by the hospital which she considered reasonable, but was convinced by the lawyer that would not be in her interests. The woman's lawyer indicated that his client would be withdrawing from conciliation if the hospital did not come back with a "realistic" offer within 14 days. The conciliation very nearly broke down at this point. The woman became convinced that the lawyer wished to pursue the matter in court, which she had consistently said she did not want to do. In addition, when she asked the lawyer to estimate what her fee to him would be at a given point in time, the lawyer quoted an amount that appeared to the woman to be exorbitant.

The woman became anxious about speaking with her lawyer because she said he yelled at her when she disagreed with him. However, she finally told him she did not wish to continue with his services and proceeded to negotiate with the hospital on her own behalf. A settlement between the parties was negotiated and the conciliation was closed.

The increased involvement of lawyers for both parties has resulted in some changes to the conciliation process:

- It is now more likely when a plaintiff law firm is involved that some of the dealings are between the conciliator and the lawyer rather than directly with the consumer as was previously the case. This can result in the consumer being sidelined during the deliberations about the process with a loss of the benefits to be had by contributing and negotiating directly.
- Conciliation meetings involving law firms for both parties are often quite formal, and can be daunting, with the complainant and the provider having little to contribute to the discussion.
- Conciliation involving lawyers for both sides are often reduced to the common denominator of financial compensation. The crucial issues of communication, care and kindness can be relegated to a less important status.
- Those matters where liability is established and financial compensation is appropriate can be settled without the risk of disadvantage to the consumer. The additional advantages of a collaborative and amicable approach are still available within conciliation.

The fact that the conciliation process has evolved along with changes in the external environment is a testament to the inherent capacity and value of this process.

HOPES AND EXPECTATIONS

Expectations are critical as to how people experience the complaint process. The Commission routinely attempts to identify and explore people's expectations during the progress of their complaint and to help them assess whether their expectations are reasonable or achievable.

The conciliation process is collaborative. The Conciliator performs his/her role in a strictly independent and impartial manner. It is important for there to be a mutual understanding between the parties and the Conciliator about what is possible, or even likely, as an outcome to negotiations. It is helpful for the Conciliator to understand what preconceptions or understanding the parties may have about the process they are about to embark upon.

Experience has shown that people who have suffered disappointing outcomes from health care frequently feel something should be done about it, someone should be answerable, there must be an explanation for what happened or someone is to blame. There may be an expectation that things will be put right financially, regardless of the negligence framework, or that the Commission can direct an apology or enforce changes in policies and procedures. People who have suffered adverse events may see the Commission as the agent for providing these outcomes and it is necessary for the Conciliator to be clear and consistent about the limits to the Commissioner's powers and the process of conciliation.

The following examples demonstrate the differing perspective of complainants and providers in matters referred to conciliation:

Narrative 32

A man complained that he went to a general practitioner because of pain in his chest and left arm and thought he may be having a heart attack. The man was concerned that the doctor let him wait for a long period before treatment, then only sprayed something under his tongue before calling the ambulance and leaving the surgery. The complainant expressed concern that the doctor did not take his blood pressure and that there was no oxygen or defibrillator available for emergency use at the surgery. The man was upset that the doctor did not remain with him until the ambulance arrived. He wanted the doctor to explain his actions, apologise for failing to treat him appropriately, and ensure the surgery obtained oxygen and a defibrillator for future emergencies. The Conciliator explained that the Commission did not have the power to require the doctor to do any of the things the man was requesting and could only encourage consideration of his concerns.

Providers of health care may feel that they have been misunderstood or blamed unfairly in a complaint about their care. If they have no understanding of alternative dispute resolution they may see the conciliation process as a quasi-legal mechanism and adopt a defensive role in their initial response. On the other hand, some providers feel concerned about an adverse outcome suffered by their patient and are keen to resolve it.

Providers' expectations of the role of the Commission depend somewhat on whether they have previous experience of the Commission, the accuracy of the information they have received about the Commission's role, and perhaps their perceptions about why the complaint was made. Some providers have unrealistic hopes that the Conciliator will somehow manage to defuse the anger and grief inherent in the dispute, and just make the complaint "go away". A provider will usually be advised by a representative of their medical defence organisation or a solicitor, who will help to explain to the provider the impartial role of the Conciliator and the advantages and limits of the conciliation process.

Narrative 32 (Continued)

In this particular case, the doctor felt there had been a misunderstanding about several aspects of the care he provided and hoped the conciliation process would be able to "mend the broken bridges". He explained that his receptionist had not informed him that the man had pain in his chest and arm on arrival. The doctor said the receptionist had been reprimanded for that omission and instructed to notify the doctors immediately in the future of patients who complained of chest pain. The doctor also said Nitrolingual spray is the first-line treatment for chest pains and it was effective in this man's case. He said while it would be ideal for the practice to have oxygen, an ECG and defibrillator, that equipment was expensive, and the owner of the practice had chosen not to purchase the equipment because patients requiring their use needed to be taken to hospital. He also explained that he had not taken the man's blood pressure and pulse because the man was comfortable at the time, the doctor had called the ambulance and they were only two minutes from the hospital. The doctor apologised that he had not realised the man was anxious and distressed while waiting for the ambulance, which took longer than expected. The doctor offered to meet with the man to provide an apology in person. The doctor said the complaint about his care had assisted him to be a more thoughtful doctor. He explained the man was subsequently found not to be suffering from a heart condition and there had been no adverse physical outcome as a result of the doctor's care. While the man was pleased to receive an apology, an explanation and a change in procedure, he believed the Commission should be able to insist the doctor purchase the equipment he had specified.

It is often necessary during the conciliation process to revisit people's expectations as further information becomes available. This enables the Conciliator to clarify what might be able to be achieved as a result of the negotiations. It is important for Conciliators to continue to stress the limits to the Commission's powers and expertise, and clearly convey what the Commission can or cannot do, or what the parties themselves can or cannot do.

For example, the Commission cannot arbitrate during conciliation when there is a dispute about what occurred. The Commission cannot enforce agreements or make recommendations. The Commissioner can however refer a provider to the relevant registration body if there is information gained in the conciliation process that raises concern about professional standards and practice of the provider. Some of the outcomes being sought by the complainant may only be achieved by an alternative process such as litigation or referral to another entity.

Narrative 33

A woman complained that her husband had died from a cerebral haemorrhage after being admitted to a public hospital with headaches and nausea. The woman believed the man's pre-existing hyperthyroid condition should have alerted the medical staff to the likelihood that her husband might suffer a stroke, and that steps should have been taken to prevent the haemorrhage from developing. She said, at the very least, the hospital staff should have promptly diagnosed her husband's condition given his history of hyperthyroidism. The woman expected her views to be substantiated following examination of clinical information in conciliation. She wanted the doctors involved in her husband's care to be referred to The Medical Board of Queensland, changes made to the hospital's admission procedures and compensation for her husband's death. The Medical Superintendent hoped the conciliation process would help the woman to understand there was no association between the two conditions suffered by her husband and that there was no treatment that was likely to save her husband's life. An expert opinion raised some incidental concerns about aspects of the hospital's care of the man, but noted there was no relationship between the man's history of hyperthyroidism and the cerebral haemorrhage. The opinion noted no clear major errors in assessment or management which would have affected the outcome.

The expectation of complainants may be confirmed during the conciliation process. However, the complainants expectations may also change during the process. Some complainants remain doubtful about the value of conciliation throughout the process and then feel their doubts have been confirmed if the dispute is not resolved to their satisfaction. Other complainants begin negotiations on a hopeful note then become disenchanted due to delays or independent advice which does not support some aspect of their view about what has happened. Others may initially feel doubtful and are then pleased with an outcome that was unexpected.

Conciliators Joan Welsh (left) and Carmel Blick facilitated a workshop at the National Complaints Conference

In this particular case, an independent opinion did not support the complainant's views.

Narrative 33 (Continued)

The woman said she did not accept that the aspects of the care in question had not contributed to her husband's death. She also said she was disappointed the Commission was not able to require the hospital to make the changes she had requested to the hospital's policies and procedures or that there were no grounds to refer any of the doctors involved to The Medical Board of Queensland. The Medical Superintendent was pleased the independent opinion found the hospital's care was reasonable, but was disappointed that the woman did not accept that the hospital was not responsible for her husband's death. The dispute was not resolved in conciliation.

Managing hopes and expectations can become more difficult with third party involvement such as solicitors or family members and friends. These third parties can have a major influence on the success of the negotiations by fostering unrealistic expectations or encouraging negative feelings about the provider. Some solicitors may raise the complainants expectations about what they believe would be appropriate financial outcomes as a result of negotiations in conciliation. The difficulty for complainants is that solicitors manage issues relating to liability and damages associated with adverse outcomes, and not the personal issues which may be the critical component of the complaint for their client.

The media also plays a significant role in fostering public expectations about financial compensation as a result of adverse health outcomes. Publicity associated with some aspects of health care may now result in significant class actions where a large number of people have suffered an adverse outcome and there is an assumption by many that everyone with that particular adverse outcome is eligible for compensation, regardless of the negligence framework.

The most significant impact of a conciliation may be the capacity to foster personal empowerment as a result of participation in a successful process. There can be significant achievements made from reaching new understandings about another person's point of view. Such understandings can radically change the hopes and expectations with which the participants began the process.

REFERRALS TO HEALTH PRACTITIONER REGISTRATION BOARDS AND THE QUEENSLAND NURSING COUNCIL FOLLOWING CONCILIATION

The Commissioner's strong public interest obligation is reflected throughout the *Health Rights Commission Act 1991* including the provisions relating to conciliation of health service complaints. Conciliation is a forum for the legally privileged and confidential resolution of complaints where appropriate. Conciliation is not an alternative forum for dealing with complaints that involve legitimate concerns about a practitioner's professional standards and other public interest issues. The Act specifies that the Commissioner is to be advised of any public interest issues that arise during conciliation. The Commissioner has the power to end conciliation and refer a complaint about an individual registered health care provider to the provider's registration board. The Commissioner also has the power to refer a complaint about a registered health care provider to a registration board where attempts at conciliation of a complaint have been unsuccessful. The health practitioner registration bodies serve to protect the public by ensuring that health care is delivered by individual registered providers in a safe, professional and competent way, and by upholding the standards of practice within a health profession.

Recent legislation removed the Commissioner's powers to investigate complaints about individual registered providers. Consequently, when a matter of professional standards or public interest about a registered provider arises in conciliation, the Commissioner has no alternative than to refer the matter to the registrant's registration body. Because the information gathered during conciliation is confidential and privileged, the Commissioner is unable to provide this information to a health practitioner registration body when a complaint is referred from conciliation.

There was an increase in the number of complaints being referred from conciliation to the various health practitioner registrations bodies during the year. Seven cases were referred to the relevant registration bodies. In these cases information was obtained during the conciliation process that raised issues relating to the professional standards and/or conduct of registered providers or matters of public interest. The following are examples of these cases:

Narrative 34

A family complained about the unexpected death of a male relative during hospital admission, whilst he was under the care of a private specialist. The specialist gave a detailed reply in conciliation, including that, although he was surprised and distressed by the man's death, he had been advised by his colleagues that they would not have managed the man's care differently. The family continued to have some concerns about the specialist's care of their relative. The specialist requested an independent opinion. The independent expert expressed concern that the correct diagnosis had not been considered by the specialist sooner. The specialist made further submissions for consideration by the independent expert, but the expert's opinion did not change. The conciliation process then broke down as the specialist lost confidence in the impartiality of the process. The complaint was closed in conciliation. The Commissioner felt that the independent expert had raised concerns about the professional standards of the specialist that warranted examination by the Board. The matter was referred to The Medical Board of Queensland.

In the next case, the conciliation process broke down and the Commission was not satisfied that the information obtained in conciliation had eliminated the possibility that professional standards of the provider may have been breached.

Narrative 35

A man complained that a General Practitioner (GP) failed to correctly diagnose and treat a cancerous lesion over a number of consultations. The man had engaged a lawyer and was keen to commence legal proceedings if conciliation proved unhelpful. The man felt that his poor prognosis gave him limited time in which to obtain an outcome to his grievance. Arrangements were made for the GP to provide a response in conciliation, but in the meantime the man's solicitor commenced legal proceedings against the GP. The GP's medical defence organisation concluded that the other party was not committed to attempting conciliation of the complaint. The conciliation process broke down. The actions of the provider were referred to The Medical Board of Queensland as there had been no opportunity in conciliation to explore whether there was a genuine basis for concern about the GP's professional standards.

There were instances where it became apparent that an investigation process, by a relevant body with the required authority to obtain information, was more appropriate for handling a complaint than conciliation. The Commission does not have power in conciliation to demand information and gather evidence other than by the voluntary co-operation of the parties involved in the case. The following is an example of such a case.

Narrative 36

A man complained about complications arising from surgery at a private hospital. He made a complaint about a specialist who was involved in the surgery. Difficulties were encountered in arranging for an independent opinion on the case. The hospital declined to provide a copy of the relevant medical records and the evidence of all relevant specialists could not be included in the information to be provided to the independent expert. It became clear that the limited scope of conciliation would not enable a proper review of the case by an independent expert and reveal what really happened in the case. An investigation process, whereby all relevant information could be obtained and assessed by a relevant authority, appeared to be a more appropriate process. Following consultation with a delegated representative of The Medical Board of Queensland, the complaint was referred to the Board for investigation.

In summary, the Commission referred matters to a health practitioner registration body from conciliation where it was considered there was insufficient information on which to determine whether there was a genuine basis for concern about the provider's professional standards, or where the information gathered indicated that an investigation by the provider's registration board was warranted. In the past, the Commission absorbed many of these matters into the Commission's own investigation process. However, with the amendments that removed the powers of the Commission to investigate complaints about individual registered health care providers, these matters are referred to the provider's registration board.

It is important to emphasise that the referral of a complaint to a provider's registration body is not a punitive measure. The Commissioner's duty is to act independently, impartially and in the public interest on all matters before the Commission. It is the role of the registration body to make an adjudication on the professional standards and/or conduct of the practitioner.

POLICY AND LEGISLATION

The principal objective of the *Health Rights Commission Act 1991* is the independent review and improvement of health services in Queensland. In addition to the Commission's complaint handling process, another means of achieving this objective is to have strategic involvement in the development and review of relevant policy and legislation in the health sector. During the year, the Commission contributed to the following processes:

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

The Commission was invited to comment on the Review of the *Health Services (Conciliation and Review) Act 1987 (Vic)* (The HSCR Act). The Act created the Office of the Health Complaints Commissioner in Victoria, the first such body in Australia. The Queensland Health Rights Commission was modelled on the Victorian legislation.

The Health Rights Commission made a submission to the review highlighting matters for consideration based on Queensland's experience in dealing with complaints about health care providers.

Health Complaints Act 1995 (Tas)

The Commission was invited to contribute to the Review of the *Health Complaints Act 1995* (Tas). The Commission made a submission which included comment on time frames within which complaints are resolved, the application of a public interest test in dealing with certain complaints and statutory immunity from civil action for reports made in good faith.

Private Health Facilities Act 1999 and the *Private Health Facilities Regulation 2000*

The *Private Health Facilities Act 1999* and the *Private Health Facilities Regulation 2000* commenced on 30 November 2000.

The policy objective of the *Private Health Facilities Act 1999* is to protect the health and well being of patients receiving services at private health facilities by minimising the risk of harm through ensuring that appropriate standards of care are provided at those facilities. Accordingly, Queensland Health consulted with various stakeholders about the applicable standards. The Commission provided comment on the proposed standards.

Draft *Coroners Bill 2000*

The Commission was invited to provide a submission as part of the consultation process for the draft *Coroners Bill 2000*. The Commission made submissions in relation to situations where both the Commissioner and the Coroner have jurisdiction to investigate a matter.

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical

The Commission provided de-identified statistical data about trends in complaints to the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). ASERNIP-S is a health technology assessment organisation that arose from a Federal Government initiative to review, and formally categorise, new surgical procedures in order to maximise safety and efficacy in clinical practice.

Australian Council for Safety and Quality in Health Care

De-identified statistical data was provided to the Australian Council for Safety and Quality in Health Care to inform the Council's proposed National Action Plan. The Council was established in January 2000 by the Commonwealth Government to lead national efforts in improving the safety and quality of health care. The Commission also provided material for use by the Council in developing a discussion paper that will lay the foundation for the formulation of standards and guidelines for health care providers and facilities when an adverse event has occurred.

Accredited Occupational Therapist Program

The Commission provided comment to Occupational Therapy Australia regarding the development of an accreditation program for its members. The Commission's comment included the interaction between such organisations and the Commission and the importance of the Commission and the health practitioner registration bodies in monitoring the professional standards of registered health care providers.

Quality Improvement and Enhancement Program – Patient Survey/Complaints Program Area Board

The Manager Complaints and Manager Executive Services continued to contribute to the Queensland Health Program Area Board to develop a uniform approach to complaint management and consumer feedback in public facilities.

Queensland Nursing Council Corporate Plan

During the financial year the Commission provided a submission to the Queensland Nursing Council in relation to its corporate plan for the period 2001/2006. This was an opportunity to inform the planning process for the professional development of nurses in Queensland.

ACCESS TO PRIVATE HEALTH RECORDS

When deciding what action to take in relation to a health service complaint, the Commissioner is required, under section 57(2) of the *Health Rights Commission Act 1991*, to consider whether the conduct of the health care provider was reasonable. To this end, the Commissioner must have regard to the generally accepted standards of health services expected of providers.

Section 57(1)(d) of the *Health Rights Commission Act 1991* states that a complaint may be made to the Commissioner "that a provider has acted unreasonably by denying or restricting a user's access to records relating to the user in the provider's possession". A legislative amendment during 2000/2001 altered the generally accepted standard for health service providers in regard to the provision of access to records.

The *Privacy Amendment (Private Sector) Act 2000* (the amending Act) introduced changes to the law that will impact on consumers' access to private medical records. The Act, which was passed on 6 December 2000, amended the Commonwealth *Privacy Act 1988* (the Privacy Act), which deals with protection of information held by Federal Government Agencies through Information Privacy Principles (IPP). The amending Act added new provisions called the National Privacy Principles (NPP) to the Privacy Act. The new provisions, which take effect from 21 December 2001, will apply to private sector organisations which hold personal information.

There are ten NPP. The sixth NPP provides that where an organisation holds personal information about an individual it must provide the individual with access to the information on request by the individual, except in certain circumstances. NPP 6 also requires that the organisation must take reasonable steps to correct the information if the individual can establish that the information is not accurate, complete and up-to-date.

Thus, for private medical practitioners and other private sector health care providers, these amendments are a significant change from the common law position set down in the case of *Breen* v *Williams* 1996 186 CLR 71. Essentially, the common law position was that private medical practitioners own the patient records that they have created, and are not under any obligation to provide access to those records on request by the patient.

As stated at the outset, when deciding what action to take in relation to a health service complaint the Commissioner is required to consider whether the conduct of the health care provider was reasonable, having regard to the generally accepted standards of health services expected of providers of that kind. The amendment to the Privacy Act has changed the law in relation to access to privately held health records.

When considering complaints about access to records the Commission has been obliged to consider the common law position, that a health care provider in the private sector was not obliged to provide access to their records. Thus the action the Commission has been able to take has been limited. However, upon commencement of the Privacy Act amendments in December 2001 the generally accepted standard will be that required by the Privacy Act. Accordingly, the Commission will be in a position to take action on complaints about access to records by facilitating the release of information when appropriate or by forwarding such complaints to the Federal Privacy Commissioner for action.

EXECUTIVE SERVICES

Efficient and effective management of the Commission's financial, human and information technology resources is essential if the Commission is to provide quality, equitable, and accessible services to the people of Queensland.

The Executive Services Program works to ensure the complaints management activities of the Commission are supported in a conscientious and timely manner. Many organisational objectives were achieved during the year within a framework of limited resources.

The following reports provide a snapshot of some of the work undertaken during the course of the year.

HUMAN RESOURCES

As indicated in the Commissioner's Review, the strain of increasingly unacceptable caseloads and the high turnover rate of staff are of major concern. Staff turnover results in a loss of expertise and skills from the Commission, which in turn results in a constant cycle of training and development of new staff.

During the 2000/2001 financial year the Commission experienced the following staff changes:

- One new position was created: Review Officer
- Four positions were upgraded/re-evaluated/redesignated: Conciliator, Communications Officer, Manager Executive Services and Legal Services Officer
- Four positions became available due to resignation: Review Officer, Enquiry Officer (2) and Administrative Officer

Back Row: (L-R) Helen Taylor, Victoria O'Brien, Tracey Jenkins, Anissa Lee
Front Row: (L-R) Beverley Burns, Mark Simpson, Helen Adcock
Absent: Colin Robertson, Melinda Wagner-Munro, Lisa Faci

- Three temporary positions became available due to secondment: Review Officer, Investigator and Complaints Co-ordinator
- Two temporary part-time Enquiry Officer positions became available due to maternity leave; and
- One temporary position (Conciliator) became available due to leave of absence.

Accordingly, during the 2000/2001 financial year, recruitment was undertaken to fill 15 positions. This represents over half of the entire staff complement of the Commission.

Nevertheless, as at 30 June 2001, all positions were filled and actually occupied (except for officers on leave). This was a first in the life of the Commission.

INFORMATION TECHNOLOGY

A number of information technology projects were undertaken during the year to enhance the Commission's network architecture and data systems. The continued upgrade and maintenance of the information technology hardware included the capability of 24 x 7 systems support through the use of laptop/mobile computing.

Full functionality of the Enquiry/Oral Complaints database was achieved during the year. This has enabled the Commission to incorporate relevant statistical information from the Enquiry/Oral Complaints database with that of the Complaints Management database.

In August 2000 corporate e-mail was implemented. This was well received by all staff. However, the implementation of Corporate Internet access was delayed for a number of reasons; firstly the initial setup costs, and secondly the ever advancing technologies available. At present, internet access is available at one central location. The Commission will undertake a review of the introduction of Corporate Internet access during the 2001/2002 financial year.

A number of enhancements to the Commission's Complaints Management database (ProActive) were successfully implemented. The Complaints Management database will come under further review in 2001/2002 for its capability to meet the future requirements of complaints management.

The Systems Administrator conducted an audit of the Commission's software and licensing to ensure any breaches of the software licensing were rectified in accordance with the key stakeholders Microsoft and Lotus. Following completion of the audit and the purchase of additional licences, the Commission meets its obligations for all current versions of software.

AUDIT REPORT

As indicated in the Commissioner's Review, the Auditor-General raised the matter of funding for the Commission as a "Going Concern" following the completion of the audit of the Commission's finances as at 30 June 2000. This matter was discussed at length with the Minister for Health and the Director-General of Queensland Health.

In January 2001, BDO Kendalls, Chartered Accountants and Business Advisers, were appointed by the Commission to provide an independent review of the Commission's financial operations based on the issues raised in the Auditor-General's 1999/2000 report.

This review was carried out under the following terms of reference:

- Provide comment and recommendations in regard to the Auditor-General's report concerning the financial operations of the Commission with particular reference to non-cash items as listed below:

  (a) Long Service Leave Liability

  (b) Recreation Leave Liability

  (c) Depreciation

- Provide advice to the Commissioner and Manager Executive Services in regard to moving to a full accrual based budget allocation.
- Assess the current budgetary arrangements between the Commission and Queensland Health.
- Assess and provide comment on the Commission's TSC Financials Package in regard to accrual accounting compliance.
- Develop options for an Asset Plan for the Commission with particular reference to asset management including purchasing, disposal and leasing options.

As a result of the findings of this review the following outcomes were achieved:

- The Commission was accepted into the Queensland Treasury Long Service Leave Levy Central Scheme as from 1 January 2001. The liability for long service leave reported in the 1999/2000 Annual Financial Statements of $102,878 has been removed from the 2000/2001 Annual Financial Statements. This commitment will become part of the whole of government liability reported through the government's consolidated financial statements.
- The Minister for Health granted approval on 8 May 2001 for the Commission to be funded on an accrual basis with effect from 2000/2001. Accordingly, funding supplementation of $40,000 was made to the Commission's budget allocation for that year for Depreciation and the Long Service Leave Levy.
- The TSC Financials package, installed in May 1999, is now fully operational with Accounts Receivable, Accounts Payable, General Ledger and the Asset Register. These modules are fully integrated and facilitate reporting. TSC Financials fully complies with the relevant Australian Accounting Standards (AAS29) for financial reporting by government departments and agencies, and the accounts have been prepared in accordance with the *Financial Administration and Audit Act 1977*.
- With the introduction of an endowment for asset depreciation, the Commission is now able to effectively plan for asset purchasing. The acquisition of a Fixed Assets Register from TSC Financials enabled the Commission to effectively plan and monitor all assets.
- The Financial Accounting package was also upgraded in January 2001 to better meet the needs of GST reporting. Full Input Tax reports are now included which assist greatly with the preparation of the Commission's Business Activity Statements.

COMMUNITY OUTREACH STRATEGY

As reported last year and mentioned in the Commissioner's Review, public relations consultants firm Media Link Communication Group was appointed to develop a community outreach strategy for the Commission.

The primary purpose of the strategy was to formalise a process for the Commission to inform the community of its existence and the educational role required of the Commission in the legislation. Further, it was considered necessary to prioritise the Commission's energies in the area of community outreach and education to focus on the areas of greatest need.

The Community Outreach Strategy was presented by Media Link Communication Group in September 2000. Following consideration of the Strategy by the Promotions Committee and the Health Rights Advisory Council and with some modification, work commenced on the implementation of the Strategy. A position of Communications Officer was advertised, and an appointment made.

The Communications Officer, who commenced duty in April 2001, made a substantial impact with the key consumer and provider groups. The officer works closely with the Commission's Promotions Committee to ensure that the collective experience of staff is considered as the strategy evolves.

ACCOMMODATION

The Commission has an establishment of 26.2 when fully staffed and occupies Level 19, 288 Edward Street, Brisbane. The Commission moved to these premises in 1996 under a five-year lease arrangement. During the year, the Commission exercised a two year option on the lease providing accommodation until May 2003.

The design and layout of the floor is not conducive to the work practices of the Commission. The current layout will not sustain any increase in staff establishment and creates corridors of unusable space, in particular, in the reception and foyer areas.

The physical location is ideal for the Commission as it is close to public transport to ensure reasonable access for clients and staff. For this reason, the preferred option would be to remain on a long-term basis at the present location, subject to the floor layout being addressed to provide a more suitable environment for staff and clients.

Discussions were held with Space Doctors Pty Ltd in May and June 2001 to develop concept plans for accommodation changes with a view to maximising the use of the available floor space. The reception and foyer areas have been specifically targeted and a scope of works and proposed floor plans were developed with appropriate costing. It is considered imperative for this work to be undertaken in order to continue providing the best possible service to the Commission’s clients.

ENTERPRISE BARGAINING (EBA4)

The Commission is a party to the "Queensland Public Health Sector Certified Agreement (No. 4) 2000". This agreement was executed in October 2000 following extensive negotiations with the Queensland Council of Unions and Affiliated Health Unions.

ANNUAL EXPENDITURE REPORT

In terms of section 95 (1)(f)(vi) of the *Financial Management Standard 1997* and in accordance with part c section 7.1.10.1 of the Queensland State Purchasing Policy, the following information is provided in relation to consultancy expenditure incurred by the Commission during 2000/2001:

Table 6: Consultancy Expenditure

Category of Consultancy	Amount
Management	$14,063
Human Resource Management	$2,892
Information Technology	$9,296
Communications	$6,216
Finance/Accounting	$4,970
Professional/Technical	$7,906
Total Expenditure	**$45,343**

MENTAL HEALTH WEEK

The Commission was actively involved in the promotion of Mental Health Week conducted in October 2000.

Mental Health Week was organised by the Mental Health Week Brisbane Organising Committee. Organisations represented on the Organising Committee included the Mental Health Association Queensland, Queensland Division of General Practice (Mental Health Program) and the Indigenous Youth Health Service. Two officers represented the Commission on the Organising Committee.

The theme for Mental Health Week was "Healthy Mind – Healthy Body".

SPEAKING ENGAGEMENTS BY HEALTH RIGHTS COMMISSION STAFF

During 2000/2001, staff of the Health Rights Commission responded to requests for presentations from the following agencies.

Government

Mackay Base Hospital
National Patient Representative Symposium 2000 (Gold Coast Hospital)
Disability Services Queensland

Industry

Queensland University of Technology Law School
Royal Children's Hospital – Graduate Certificate in Paediatrics
AUSMED Publications
LAAMS Group
University of Queensland, School of Dentistry
Australian Physiotherapy Association

Community

Rural Women's Network, Central Downs Branch
Asthma Foundation

STAFF TRAINING AND DEVELOPMENT

The Health Rights Commission is committed to developing a work force that is highly skilled in all areas across the Commission. To this end the following training and development activities were undertaken by staff during 2000/2001:

- Investigative Interviewing Techniques
- Government Decision Makers – Advanced Training
- Improving Health Services through Consumer Participation Conference
- Microsoft Office XP Conference
- PageMaker 6.5 Comprehensive
- Investigators Training Workshop
- Managing Client Aggression
- Guardianship and Administration Act 2000 Seminar
- National Patient Representative Symposium
- Public Sector Business Activity Statement Workshop
- The Internet Seminar
- Microsoft Project 98

The Commission also facilitated a number of in-house staff development activities. These sessions were presented by guest speakers and Commission officers covering the following topics:–

- Use of drugs and the various categories
  Mr Andrew Petrie, Manager, Pharmaceutical Advisory Service, Queensland Health
- Assessment of quantum for claims
  Mr David Bray, Partner, Walsh Halligan Douglas Lawyers
- Complexities for Premature Babies
  Dr Peter Steer, Executive Director, Mater Children's Public and Private Hospital
- Cataracts and Laser Eye Surgery
  Dr Bill Glasson, Terrace Eye Centre
- Obstetric interventions and Caesarean sections
  Professor Jeremy Oats, Director of Obstetrics and Gynaecology, Mater Mother's Hospital
- Ethics Training
  Mr Mark Lauchs, A/Principal Policy Officer, Integrity Commission
- Overview of the Freedom of Information Act and changes to the Commonwealth Privacy Act
  Ms Victoria O'Brien, Legal Services Officer, Health Rights Commission
- Aboriginal Health Issues
  Ms Jackie Huggins, Deputy Director, Aboriginal & Torres Strait Islander Studies Unit, University of Queensland
- South Sea Islander Health Issues
  Ms Lauriann Trevy, South Sea Islander Health Liaison Worker, Queensland Health

EQUAL EMPLOYMENT OPPORTUNITY REPORT

In accordance with the *Equal Opportunity in Public Employment Act 1991*, the following information is provided in respect of age, gender and classification statistics.

Table 7: Staff by Age and Gender

	15-24	25-34	35-44	45-54	55+	Totals
Male	0	1	6	0	2	9
Female	1	10	3.2	2	1	17.2
Totals	**1**	**11**	**9.2**	**2**	**3**	**26.2**

Table 8: Staff by Administrative Classification Stream

	AO2	AO3	AO4	AO5	AO6	A07	PO4	AO8	SES	Totals
Male	0	0	1	3	2	2	0	0	1	9
Female	2	5.2	1	1	3	3	1	1	0	17.2
Totals	**2**	**5.2**	**2**	**4**	**5**	**5**	**1**	**1**	**1**	**26.2**

ANNUAL REPORT

Responsibility for the production of this annual report was delegated to the Communications Officer. In accordance with government procedure, design and printing quotes were sought from three printing providers. Each of these providers met with the Communications Officer to discuss the needs of the Commission and the expertise of the respective providers.

Studio 55 provided the most competitive quote in terms of both financial cost and quality of final product. The Communications Officer has liaised closely with Studio 55 to co-ordinate the production of the 2000/2001 Annual Report.

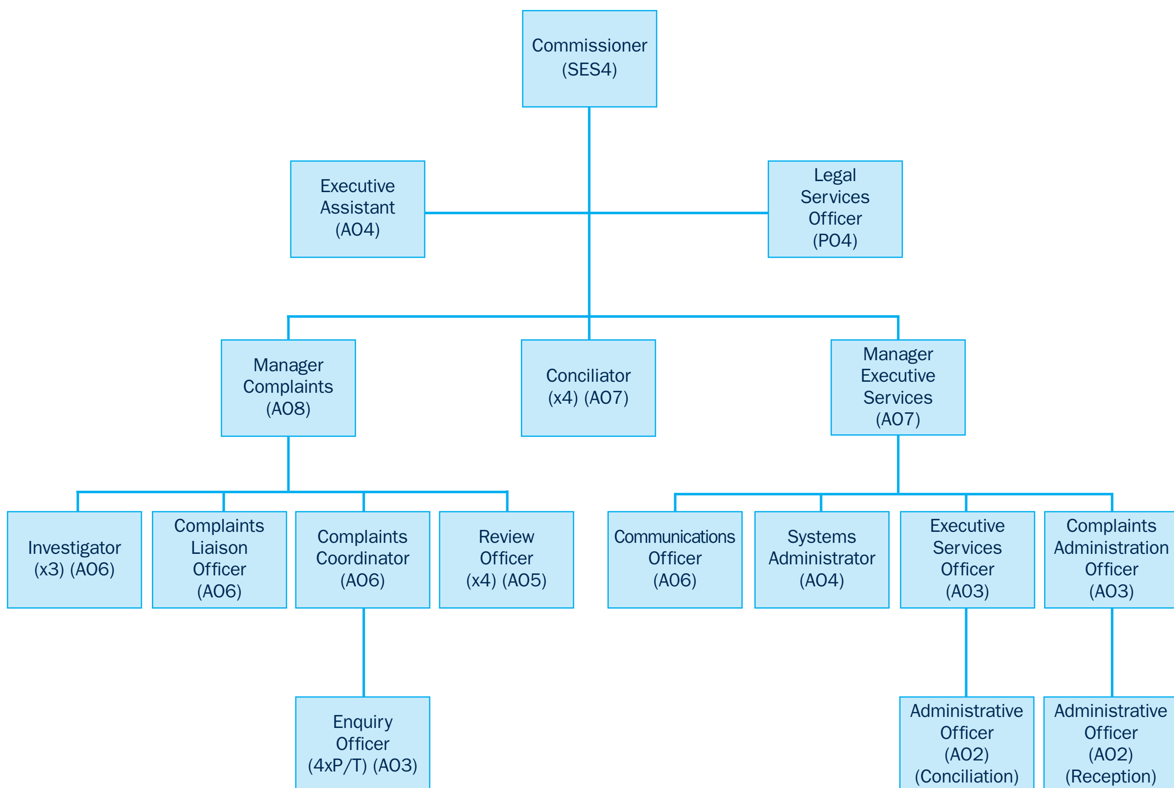
COMMISSION STAFF 2000/2001

Name	Position	Dates
Ian Staib	Commissioner	
Helen Adcock	Executive Assistant	
Victoria O'Brien	Legal Services Officer	From 14/08/2000
Greg Ouglitchinin	Temporary Corporate Projects Officer	Until 22/08/2000
Carmel Blick	Conciliator	
Joan Welsh	Conciliator	
Peter Last	Conciliator Leave of Absence	Until 23/03/01 From 26/03/01
Georgia Hoey	Temporary Conciliator Conciliator	Until 31/01/01 From 01/02/01
Adrian Nippress	Temporary Conciliator	From 08/05/01
Linda Morley	Manager Complaints	
Annette Anning	Investigator Seconded to Princess Alexandra Hospital	Until 15/09/00 From 18/09/00
Fiona Jackson	Investigator	
Owen Davies	Investigator	
Patricia Bartz	Temporary Investigator	From 30/10/00
John Melit	Complaints Coordinator Seconded to Criminal Justice Commission Seconded to Queensland Health	Until 27/10/00 Until 27/04/01 From 30/04/01
John Cake	Review Officer Acting Complaints Coordinator	Until 27/10/00 From 30/10/00
Lorraine Bettinson	Review Officer	Resigned 12/11/00
Wayne Bolton	Temporary Review Officer Review Officer	Until 04/07/00 From 05/07/00
Kate Whitehouse	Temporary Review Officer Seconded to Queensland Health	Until 28/07/00 From 31/07/00
Sarah Henderson	Review Officer	From 09/01/01
Bruce Bassett	Review Officer	From 09/01/01
Michele Mrozik	Temporary Review Officer	From 09/01/01
Kate Houlihan	Part-Time Enquiry Officer	Maternity Leave From 16/10/00
Robyn McLaren-Round	Part-Time Enquiry Officer	Maternity Leave From 28/09/00
Karen Harbus	Part-Time Enquiry Officer	
Kym Crane	Temporary Part-Time Enquiry Officer	Resigned 22/09/00
Ken Burge	Temporary Review Officer	Until 16/02/01

Susan Hart	Temporary Part-Time Enquiry Officer	From 06/11/00
Caroline Jeffs	Temporary Part-Time Enquiry Officer	From 14/02/01
Lester Bock	Temporary Part-Time Enquiry Officer	From 12/02/01
Michael Baker	Temporary Part-Time Enquiry Officer	Resigned 06/02/01
Colin Robertson	Manager Executive Services	
Melinda Wagner-Munro	Executive Services Officer	Returned from Maternity Leave 05/05/01
Mark Simpson	Systems Administrator	
Helen Taylor	Communications Officer	From 02/04/01
Anissa Lee	Complaints Administration Officer	
Beverley Burns	Temporary Administrative Officer	
Lisa Faci	Administrative Officer	
Tracey Jenkins	Temporary Administrative Officer	
Teresa Ellson	Administrative Officer	Resigned 12/01/01

Where the date is vacant, the officer was engaged in that position for the full year

ORGANISATIONAL CHART



COMMITTEE REPORTS

NATIONAL HEALTH CARE COMPLAINTS CONFERENCE

A number of staff from the Commission attended the 3rd National Health Care Complaints Conference conducted in Melbourne in March 2001. The conference was organised by the Australian and New Zealand Council of Health Care Complaints Commissioners. This conference was hosted by the Health Services Commissioner, Victoria. Queensland was well represented by Patient Liaison Officers (Queensland Health), representatives from registration boards, the Queensland Nursing Council and health service providers, in addition to officers from the Commission.

The theme of the conference was *"Getting Better Together – Using Complaints to Improve the Quality of Health Services"*. The papers and workshops presented covered a wide range of topics relating to the link between complaints and improvements within the health care sector.

Two investigators from the Health Rights Commission presented a paper entitled *"Turning the Scrutiny Inwards – Some Reflections on Best Practice Investigations"*. The paper outlined the fundamental elements of an investigation and discussed a number of topics including the use of peer review and conducting investigations with a "no blame" approach. The conference was preceded by a two day workshop on Investigation Methods, facilitated by the Health Care Complaints Commission, New South Wales and attended by Investigators from the health complaints bodies throughout Australia and New Zealand.

Two conciliators from the Commission conducted a workshop entitled *"The scope and limitations of conciliation in resolving health care complaints"*. The workshop examined case studies to explore some of the early decisions which may need to be considered by a conciliator such as: the likely predictors for successful resolution, strategies for clarifying the predictions with the parties, identifying the boundaries of conciliation with the parties, and discussing alternative processes to deal with issues which are not suitable for conciliation.

MEETING OF AUSTRALIAN AND NEW ZEALAND COMMISSIONERS RESPONSIBLE FOR HEALTH CARE COMPLAINTS

A meeting of Australian and New Zealand Council of Health Care Complaints Commissioners was conducted in Melbourne on 28 March 2001 in conjunction with the 3rd National Health Complaints Conference. Topics discussed at the Commissioners Conference included:

- Proposal for a National Information System for Health Care Complaints to replace the National Health Complaints Information Project
- Consumer Issues
- Commonwealth/States Health Care Agreements
- Legislation
- Nursing Homes and Aged Care Facilities

The Honourable Rob Knowles, Aged Care Complaints Commissioner, Victoria, conducted a presentation on the recently established Complaints Resolution Scheme.

HEALTH RIGHTS ADVISORY COUNCIL

Consumer Representatives

Mr Pat Nolan (President)	Auditor General of Queensland (retired)
Ms Colleen Cartwright	Senior Research Fellow, University of Queensland

Provider Representatives

Ms Kym Barry	Assistant Director of Nursing
Dr Jean Collie	Medical Superintendent (retired)

Other Representatives

Dr Derek Lewis	Dentist
Ms Jane Sligo	Legal Officer

Health Rights Advisory Council
Back Row: (L-R) Dr Derek Lewis, Dr Jean Collie, Jane Sligo
Front: Seated (L-R) Pat Nolan, Colleen Cartwright
Absent: Kym Barry

The Council met on four occasions during the year: 12 September 2000, 12 December 2000, 13 March 2001 and 12 June 2001.

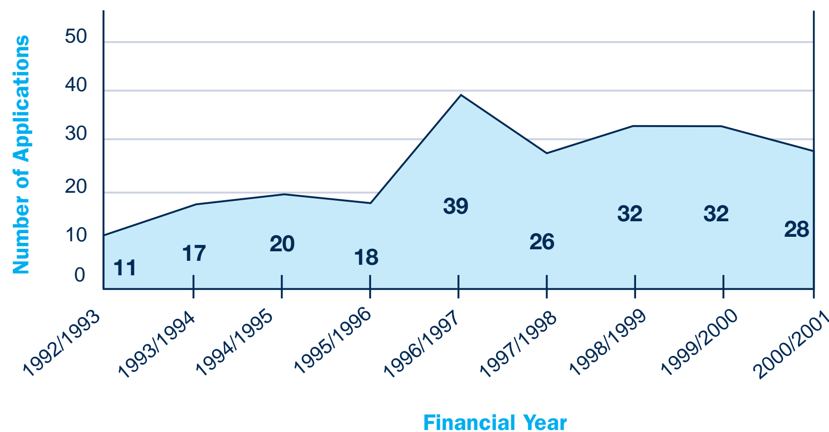
The Council considered such issues as promotions and outreach, the Commission's communications strategy, provisions of the legislation, Quality Assurance Committees and the Code of Health Rights and Responsibilities.

FREEDOM OF INFORMATION REPORT

The number of applications made to the Commission for access to documents under the *Freedom of Information Act 1992* (the FOI Act) was slightly lower this financial year. Twenty eight (28) applications were received for access to documents, compared with 32 applications in the previous financial year. Figure 2 shows a comparison of the number of access applications received since the commencement of the Commission.

Figure 2

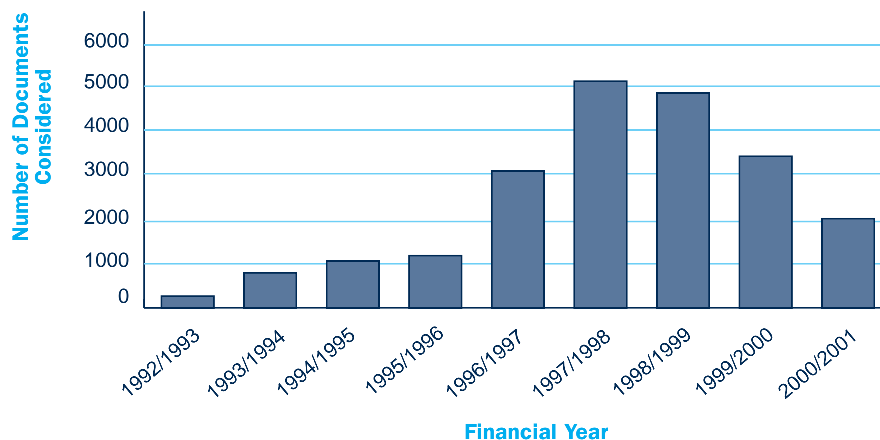
Comparative Chart of Applications Received in
Each Financial Year of the Commission's Operation



Given the reduction in the number of applications received, it is not surprising that the number of documents considered by the Commission in relation to the applications also dropped. However, as can be seen by comparing Figures 2 and 3, the rise and fall in access application numbers does not always correlate with the number of documents considered. In the 1996/1997 financial year, when the highest number of access applications in the history of the Commission were received (39), only a little over 3,000 documents were considered. The next year, when 26 access applications were received, over 5,000 documents were considered. This is a symptom of the various statutory actions that the Commission may take in relation to a complaint. The Commission may need to undertake a detailed and lengthy investigation in relation to one complaint but only a short assessment of another. Accordingly, the size of Commission files, and thus the number of documents to consider in an application for Freedom of Information can vary significantly.

Figure 3

Number of Documents Considered in
FOI Applications each Financial Year



Of the applications received in the year under review, 21 were for access to documents of a personal nature and seven requests were for access to non-personal documents.

A total of 1,657 documents were considered in the applications for access to documents of a personal nature and 99.7 percent of those documents were released in part or in full. This represents an increase in the number of documents of a personal nature being released to applicants in part or in full from the previous year. In the 1999/2000 financial year, 97 percent of documents considered in applications for documents of a personal nature were released. This comparison can be seen in Figures 4 and 5.

Figure 4
Personal Documents 2000/2001

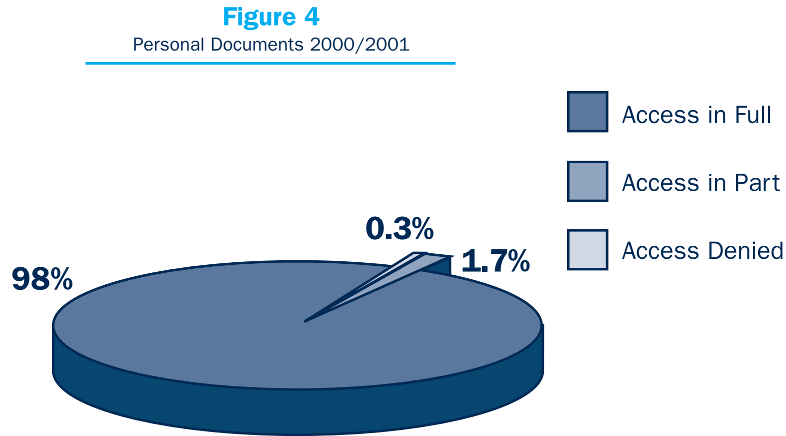
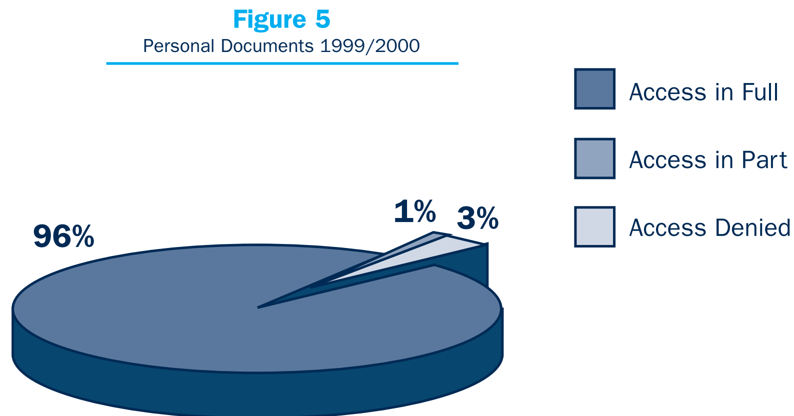


Figure 5
Personal Documents 1999/2000



A total of 444 documents were considered in the applications for non-personal documents during the 2000/2001 financial year. Of the documents released, 59 percent were released in part or in full with the remaining 41 percent being exempt from access. These figures demonstrate a decline in the rate of release of documents in non-personal applications.

In 1999/2000, 80 percent of the documents sought in non-personal applications were released in part or in full (see Figures 6 and 7).

Figure 6
Non-Personal Documents 2000/2001

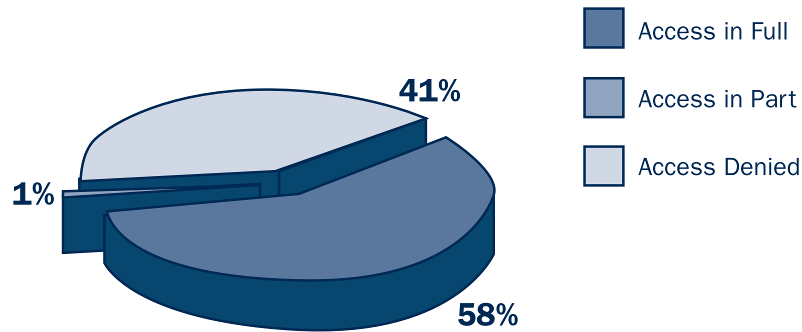
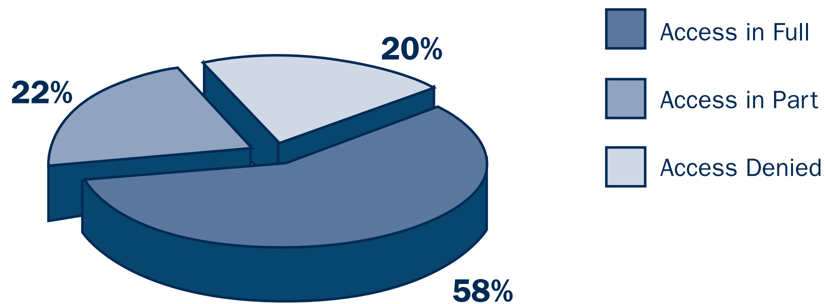


Figure 7
Non-Personal Documents 1999/2000



There were no applications for amendment of information under the FOI Act made to the Commission in the year under review.

STATUTORY OBJECTIVES

Purpose

The purpose of the *Health Rights Commission Act 1991* is to provide independent review and conciliation with respect to services provided by health service providers to health service users and for improvements to those services.

Objectives (Section 4)

The principal objectives of this Act are –

(a) to provide for oversight, review and improvement of health services by establishing an accessible, independent facility that will –

  (i) preserve and promote health rights; and

  (ii) receive and resolve health service complaints; and

  (iii) enable users and providers to contribute to the review and improvement of health services; and

  (iv) provide education and advice in relation to health rights and responsibilities and the resolution of complaints about health services, whether or not made under this Act; and

  (v) assist users and providers to resolve health service complaints; and

(b) to provide for the development of a Code of Health Rights and Responsibilities; and

(c) to provide for the appointment, functions and powers of a Health Rights Commissioner; and

(d) to provide for the establishment, functions and operation of a Health Rights Advisory Council.

Commissioner's Functions (Section 10)

The functions of the commissioner are –

(a) to identify and review issues arising out of health service complaints; and

(b) to suggest ways of improving health services and of preserving and increasing health rights; and

(c) to provide information, education and advice in relation to –

  (i) health rights and responsibilities; and

  (ii) procedures for resolving health service complaints; and

(d) to receive, assess and resolve health service complaints; and

(e) to encourage and assist users to resolve health service complaints directly with providers; and

(f) to assist providers to develop procedures to effectively resolve health service complaints; and

(g) to conciliate or investigate health service complaints; and

(h) to inquire into any matter relating to health services at the Minister's request; and

(i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and

(j) to provide advice to the council: and

(k) to provide information, advice and reports to registration boards; and

(l) to perform functions and exercise powers conferred on the commissioner under any Act.

FINANCIAL STATEMENTS

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL PERFORMANCE
For year ended 30 June 2001

	Note	2001 $	2000 $
Revenue from Ordinary Activities			
Government Endowment	4(a)	2,101,148	1,905,000
Other Income	4(b)	40,024	37,835
Total Revenue from Ordinary Activities		2,141,172	1,942,836
Expenses from Ordinary Activities			
Salaries	11	1,417,462	1,324,501
Executive Services	2	503,321	534,465
Health Rights	2	59,362	111,675
Depreciation	7(a)	50,212	56,449
Total Expenses from Ordinary Activities		**2,036,357**	**2,027,090**
Net Surplus/(Deficit) from Ordinary Activities		**104,815**	**(84,254)**
Extraordinary Items	3	102,078	-
Net Surplus/(Deficit)		**207,693**	**(84,254)**
ACCUMULATED FUNDS AS AT 1 JULY		(50,988)	33,266
ACCUMULATED FUNDS AS AT 30 JUNE		**156,705**	**(50,988)**

The above statements should be read in conjunction with the accompanying notes.

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL POSITION
As at 30 June 2001

	Note	2001 $	2000 $
CURRENT ASSETS			
Cash	6	215,174	112,019
Receivables	8	8,869	5,000
Prepayments		2,447	5,179
Total Current Assets		**226,490**	**122,198**
NON-CURRENT ASSETS			
Property, Plant and Equipment	7	104,653	140,167
Total non-current assets		**104,653**	**140,167**
Total assets		331,143	262,365
CURRENT LIABILITIES			
Creditors		32,403	70,283
Payroll Accrual		28,562	26,219
Other Accruals		-	840
Provisions	8	113,473	113,133
Total current liabilities		**174,406**	**210,475**
NON-CURRENT LIABILITIES			
Provisions	8	-	102,878
Total non-current liabilities			102,878
Total liabilities		**174,406**	**313,353**
Net Assets (Liabilities)		156,705	(50,988)
EQUITY			
Accumulated Funds		156,705	(50,988)
Total Equity		156,706	(50,988)

The above statement should be read in conjunction with the accompanying notes

HEALTH RIGHTS COMMISSION

STATEMENT OF CASH FLOWS
For year ended 30 June 2001

	Note	2001 $	2000 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Inflows:			
Government Endowment		2,101,148	1,505,000
Interest received		37,824	25,774
FOI Application Fees		93	210
Honorarium Revenue		-	250
GST Received From Endowment		210,114	-
GST Received From ATO		7,374	-
Outflows:			
Salaries and Wages		(1,415,120)	(1,301,633)
Suppliers		(599,079)	(637,495)
GST Paid on Purchases		(53,809)	
GST Paid To ATO		(171,652)	-
PAYG Withholding Paid to ATO		(703)	-
Net cash provided by operating activities	9	**116,391**	**2,106**
CASH FLOWS FROM INVESTING ACTIVITIES			
Inflows:			
Sale of Assets		2,718	2,371
Outflows:			
Payments for Purchase of Plant and Equipment		(15,954)	(44,106)
Net cash used in investing activities		**(13,236)**	**(41,736)**
Net increase / (decrease) in cash		**103,155**	**(39,628)**
Cash at beginning of reporting period		**112,019**	**151,648**
Cash at end of reporting period	10	**215,174**	**112,019**

The above statement should be read in conjunction with the accompanying notes

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2001

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The significant accounting policies which have been adopted in the preparation of these statements are as follows:

(a) Basis of Accounts

This financial report is a general purpose financial report that has been prepared in accordance with the Financial Administration and Audit Act 1977, the Financial Management Standard 1997 and applicable Australian Accounting Standards. The financial report is prepared on an accrual basis and is based on historical costs and does not take into account changing money values or, except where stated, current valuations of non-current assets.

(b) Going Concern

As detailed in the financial statements, the Commission has a surplus on net assets. As at 30th June 2001 the Commission was able to pay its debts as and when they fall due. The Commission relies on the continual funding from Queensland Health to meet those debts.

(c) The Reporting Entity

The financial statements include all assets, liabilities, equities, revenues and expenses of the Commission.

(d) Revenue

Endowment revenue is recognised when received. Queensland Health provides a quarterly endowment that is determined annually by budget submission to the Minister. Funding for capital expenditure is required to be quarantined in a separate fund. Other revenue is principally derived from short term investment of surplus cash.

(e) Cash

For financial reporting purposes, cash includes all cash and cheques receipted but not banked as well as deposits at call with financial institutions.

(f) Receivables

Sundry Debtors comprise only a minor component of the Commission's receivables and are recorded at nominal amounts. Debtors are generally in the form of salaries reimbursement and only with other government Departments or Agencies. The amounts have no material credit risks and are normally settled in 30 days.

(g) Payables

Creditors are recognised at the amount expected to be paid for the goods and services received.

(h) Property, Plant and Equipment

The depreciable amount of all fixed assets are depreciated on a straight line basis over the useful lives of assets to the Commission commencing from the time the asset is held ready for use. The depreciation rates used for each class of depreciable asset are:

Class of Fixed Asset	Depreciation Rate
Computer Equipment	30%
Office Equipment	20%
Furniture & Fittings	10%

As per Section 45(7)(a) of the Financial Management Standard 1997 the following Revaluation Thresholds have been established.

Class of Fixed Asset	Revaluation Threshold
Computer Equipment	$300,000
Office Equipment	$100,000
Furniture & Fittings	$200,000

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2001

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES CONTINUED

(i) **Employee Entitlements**

Wages, Salaries and Annual Leave

Liabilities for wages, salaries and annual leave are recognised in the Statement of Financial Position as the amount unpaid at reporting date in respect of employee entitlements accrued and related on-costs.

Long Service Leave

In 2000-2001, a new long service leave scheme became operative for the Commission whereby a levy is made on the Commission to cover this expense and amounts paid to employees for long service leave are claimed from the scheme as a reimbursement. The liability is held by Government on a whole of government basis and accordingly, a provision for long service leave is no longer required.

Superannuation

Employer contributions for superannuation expenses are determined by the State Actuary. No liability is recognised for accruing superannuation benefits as this liability is held on a whole of Government basis and reported in the whole of Government financial statements prepared in terms of AAS 31 "Financial Reporting by Governments".

(j) **Taxation**

The Commission's activities are exempt from Commonwealth taxation except for Fringe Benefits Tax and Goods and Services Tax ("GST"). As such, input tax credits receivable and GST payable from/to the Australian Taxation Office are recognised and accrued.

(k) **Comparative Information**

Comparative information has been restated where necessary to be consistent with disclosure in the current reporting period.

(l) **Leases**

A distinction is made in the financial statements between finance leases, that effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership, and operating leases under which the lessor retains substantially all risks and benefits.

Where a non-current physical asset is acquired by means of a finance lease, the asset is recognised at an amount equal to the present value of the minimum lease payments. The liability is recognised at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and accordingly, are charged to the Operating Statement in the periods in which they are incurred.

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS (CONTINUED)

		2001 $	2000 $
NOTE 2	**OPERATING EXPENSES**		
	Executive Services		
	Administrative Expenses	24,940	25,442
	External Audit Fees	5,400	4,900
	Catering Expenses	3,600	943
	Committees	-	(714)
	Consultancy	45,340	76,700
	Fringe Benefits Tax	14,378	9,757
	Library Expenses	8,982	4,528
	Maintenance Costs	11,420	5,383
	Motor Vehicle Expenses	21,228	31,993
	Plant & Equipment Purchases <$1,000	4,786	6,685
	Printing Expenses and Postage	26,151	36,776
	Network Support	14,594	23,971
	Rent	189,920	198,700
	Software Licenses	18,853	10,413
	Staff Development	8,544	8,057
	Stationery and Office Supplies	17,794	16,192
	Telephone Expenses	54,233	52,177
	Temporary Staff Expenses		3,803
	Travel Expenses	10,392	8,748
	GST Input Credit Balance	-	(916)
	Translation Services	2,524	-
	Memberships	501	-
	Asset valuation write-off	-	1,021
		503,321	**534,456**
	Health Rights		
	Consultancy	35,164	85,617
	Library Expenses	2,813	2,831
	Staff Development	12,990	14,265
	Travel Expenses	14,395	8,967
		65,362	**111,675**

			2001 $	2000 $
NOTE 3	**EXTRAORDINARY ITEMS**			
	Transfer of Provision for Long Service Leave	Note 1(l)	102,878	-
			102,878	-

		2001 $	2000 $
NOTE 4 (a)	**GOVERNMENT ENDOWMENT**		
	Salaries	1,439,748	1,299,000
	Asset Depreciation*	34,400	-
	General	627,000	606,000
	* Additional funding for Depreciation (Refer Notes 1(c) and 5)	**2,101,148**	**1,905,000**
NOTE 4 (b)	**OTHER INCOME**		
	Interest earned	38,469	36,026
	Profit on sale of equipment	1,121	895
	Other sales	341	455
	Honorarium	-	250
	FOI Application Fees	93	210
		40,024	**37,836**

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS (CONTINUED)

		2001 $	2000 $
NOTE 5	**CASH**		
	Cash at bank	12,930	11,719
	Cash On Hand	300	300
	QTC General Investment	145,930	100,000
	QTC Asset Depreciation Investment	56,014	-
		215,174	**112,019**
NOTE 6	**RECEIVABLES**		
	Accrued Interest	645	2,732
	Sundry Debtor	2,059	1,459
	GST Input Credits	6,165	818
		8,869	**5,009**
NOTE 7	**PROPERTY, PLANT AND EQUIPMENT**		
	Computers & Equipment	233,504	265,325
	Less Accumulated Depreciation	(138,185)	(134,398)
	Furniture & Fittings	12,257	11,114
	Less Accumulated Depreciation	(2,923)	(1,876)
	Total Office Furniture & Equipment	**104,653**	**140,167**
NOTE 7(a)	**ACCUMULATED DEPRECIATION**		
	Accumulated Depreciation 1 July 2000	135,272	162,228
	Total Depreciation Charge for 2000/2001	50,212	56,449
	Less Depreciation of Assets Written Off 2000/2001	(45,376)	(82,405)
	Accumulated Depreciation as at 30 June 2001	**140,108**	**136,272**
NOTE 8	**PROVISIONS**		
	Long Service Leave - Non-Current	-	102,878
	Annual Leave - Current	113,473	113,133
	Total Provisions	**113,473**	**216,011**
NOTE 9	**RECONCILIATION OF NET CASH USED IN OPERATING ACTIVITIES TO OPERATING RESULT**		
	Net surplus (deficit)	207,693	(84,254)
	Depreciation	50,212	56,449
	Profit on Sale of Plant & Equipment	(1,452)	(1,350)
	(Increase)/Decrease in Receivables	(3,855)	(2,521)
	(Increase)/Decrease in Prepayments	2,732	2,478
	Increase/(Decrease) in Creditors	(27,000)	7,596
	Increase/(Decrease) in Payroll Accruals	2,343	12,261
	Increase/(Decrease) in Other Accruals	(540)	840
	Increase/(Decrease) in Provisions	(102,538)	10,607
	Net Cash Used in Operating Activities	**116,391**	**2,106**

NOTES TO AND FORMING PART OF THE ACCOUNTS (CONTINUED)

NOTE 10 CASH AT END OF YEAR

For the purpose of financial reporting, the entity considers cash to include cash on hand and at bank. Cash at the end of the reporting period as shown in the statement of cash flows is reconciled to the related item in the Statement of Financial Position as follows.

	2001 $	2000 $
Cash at Bank	214,874	111,719
Petty Cash Imprest	300	300
Reconciliation of Cash	**215,174**	**112,019**

NOTE 11 OPERATING EXPENSES - SALARIES

Salaries do not include superannuation contributions made on behalf of employees. These costs are met by the Department and for the year ended 30 June 2001 totalled $153,866 (2000: $154,090).

NOTE 12 LEASING COMMITMENTS

Operating lease commitments
Non-cancellable operating leases contracted for but not included in the accounts payable.

	2001 $	2000 $
Within 1 year	211,822	172,000
1 to 5 years	359,668	157,667
	571,490	329,667

NOTE 13 CONTINGENT ASSETS/LIABILITIES

There were no contingent assets or liabilities of a significant nature at 30 June 2001.

NOTE 14 FINANCIAL INSTRUMENTS

The Commission's exposure to interest rate risk, which is the risk that a financial instrument's value will fluctuate as a result of changes in market interest rates and the effective weighted average interest rates on those financial assets and financial liabilities, is as follows.

Interest Rate Risk

	Weighted Average Effective Interest Rate		Floating Interest Rate	
	2001	2000	2001	2000
FINANCIAL ASSETS	%	%	$	$
Cash	4.00	3.3	13,230	12,019
Asset Depn Investment A/c	5.13	-	56,014	-
General Investment A/c	5.13	5.7	145,930	100,000
TOTAL FINANCIAL ASSETS			215,174	112,019

Credit Risk

The Commission does not have any material credit risk exposure to any single debtor or group of debtors under financial instruments entered into by the Commission.

Net Fair Values

Methods and assumptions used in determining net fair value

The net fair values of listed investments have been valued at the quoted market bid price at balance date adjusted for transaction costs expected to be incurred. For other assets and other liabilities the net fair value approximates their carrying value. No financial assets and financial liabilities are readily traded on organised markets in standardised form other than listed investments. Financial assets where the carrying amount exceeds net fair values have not been written down as the economic entity intends to hold these assets to maturity.

The aggregate net fair values and carrying amounts of financial assets and financial liabilities are disclosed in the balance sheet and in the notes to and forming part of the financial statements.

CERTIFICATE OF THE HEALTH RIGHTS COMMISSION

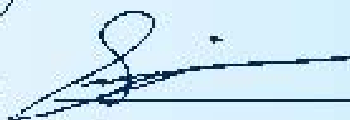
The foregoing annual financial statements have been prepared pursuant to the provisions of the *Health Rights Commission Act 1991* and the *Financial Administration and Audit Act 1977* and other prescribed requirements. We certify that:

(a) the foregoing financial statements and notes to and forming part thereof are in agreement with the accounts and records of the Health Rights Commission; and

(b) in our opinion

(i) the prescribed requirements in respect of the establishment and keeping of accounts have been complied with in all material respects; and

(ii) the foregoing annual financial statements have been drawn up so as to present a true and fair view in accordance with prescribed accounting standards of the transactions of the Health Rights Commission for the period 1 July 2000 to 30 June 2001, and of the financial position as at the end of that year.



Ian Staib
Commissioner

Mark Simpson
(Acting) Manager Executive Services

21.09.2001.

INDEPENDENT AUDIT REPORT

HEALTH RIGHTS COMMISSION

Scope

I have audited the general purpose financial statements of the Health Rights Commission for the year ended 30 June 2001 in terms of section 46F of the *Financial Administration and Audit Act 1977*. The financial statements comprise the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows, Notes to and forming part of the financial statements and certificates given by the Commissioner and the Acting Manager Executive Services.

The Commission is responsible for the preparation and the form of presentation of the financial statements and the information they contain. I have audited the financial statements in order to express an opinion on them.

The audit has been conducted in accordance with *QAO Auditing Standards*, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included the examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with prescribed requirements which include Australian Accounting Standards so as to present a view which is consistent with my understanding of the entity's financial position and the results of its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

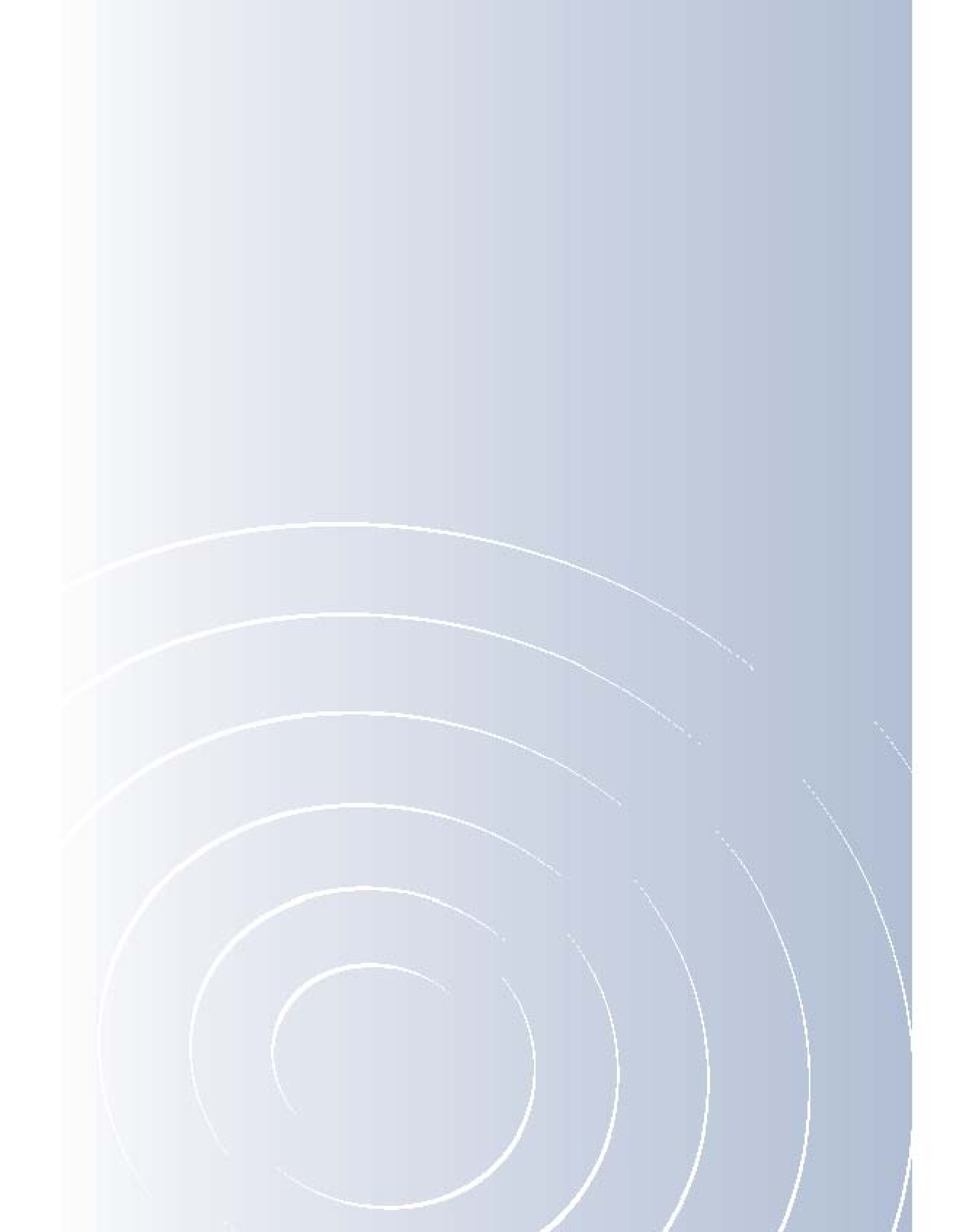
Audit Opinion

In accordance with section 46G of the Financial Administration and Audit Act, I certify that I have received all the information and explanations I have required and, in my opinion -

- the prescribed requirements in respect of the establishment and keeping of accounts have been complied with in all material respects; and
- the statements have been drawn up so as to present a true and fair view in accordance with prescribed accounting standards and other prescribed requirements of the transactions of the Health Rights Commission for the financial year 1 July 2000 to 30 June 2001 and of the financial position as at the end of that year.

P G SHIPPERLEY
Assistant Auditor-General
(Delegate of the Auditor-General)

Queensland Audit Office
Brisbane



30 September 2001

The Honourable Wendy Edmond MP
Minister for Health
Level 19
Queensland Health Building
147 - 163 Charlotte Street
BRISBANE QLD 4000

Dear Minister

I am pleased to present the ninth Annual Report and Financial Statements of the Health Rights Commission for the year ended 30 June 2001.

In preparing the Report, attention has been given to the requirements of section 34 of the *Health Rights Commission Act 1991*, section 46J of the *Financial Administration and Audit Act 1977* and section 95 of the *Financial Management Standard 1997*.

The Report documents the work of the Commission in the receipt and resolution of health service complaints, the maintenance and improvement of health services and the promotion of health matters.

Comment has been made on the development of collaborative working relationships with the health practitioner registration bodies, as required by the amendments to the *Health Rights Commission Act 1991*, effective from 7 February 2000.

Yours sincerely

Ian Staib
Commissioner

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