OFFICE OF HEALTH REVIEW

ANNUAL REPORT 1998/99

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Statement of Compliance

HON MINISTER FOR HEALTH

In accordance with the provisions of the *Financial Administration and Audit Act 1985*, and the *Health Services (Conciliation and Review) Act 1995*, I submit for your information and presentation to Parliament the Annual Report of the Office of Health Review, for the financial year ending 30 June 1999.

This is the third Annual Report of the Office of Health Review and has been prepared in compliance with the provisions and reporting requirements of both Acts.

David Kerslake

DIRECTOR

26 August 1999

We are committed to making the health system better, through the impartial resolution of complaints.

Director's foreword

The year under review in this Annual Report has seen a major focus on public awareness to ensure that the services of the office are available to the whole community.

The critical ingredients of a credible health complaints system are independence, impartiality, accessibility and competence. An office charged with responsibility for resolving health complaints must earn the confidence of both the public it serves and the providers with whom it interacts, and whom it seeks to influence. We strive to achieve this confidence by being thorough in our investigations and accurate in our findings.

We also have a major responsibility to inform the community of our existence, our role and our powers. This responsibility has special relevance to the most vulnerable people in the community who, research shows, are the least likely to complain.

Consumers have a right to complain if they are concerned about the quality of any health service they receive, and about the manner in which that service is delivered. Charters of patient rights, both public and private, in Western Australia, include this right. The Private Patients' Hospital Charter specifies that consumers have the right to be advised on how to make a complaint. The Medicare Public Patients' Hospital Charter specifies that the procedure for making a complaint must be simple.

Accessibility of the complaints process, and knowledge that the Office of Health Review exists to receive and act upon complaints, are especially relevant to groups such as indigenous people, the elderly, people from a non English-speaking background, mental health patients, people on lower than average incomes, people in nursing homes and people in prisons. All these groups, for a variety of quite different reasons, are less likely to complain.

There has been limited research, in Australian health care complaints jurisdictions, into how aware people are of the existence of bodies such as the Office of Health Review. The kind of research that has been conducted has involved people who have already accessed the process. The kind of research that would be most instructive would randomly survey the whole community, most of whom have never made a formal complaint against a health service provider.

Work of this kind has been done by the Ontario Ombudsman in Canada. Although the Ombudsman deals with complaints against government, rather than about health, as a review body it has a similar role to ours and, like the Office of Health Review, faces problems of awareness in the community it serves. The findings of surveys conducted by that body are therefore food for thought for Western Australia.

Firstly, it was found that the most vulnerable in the community are the least likely to complain. Secondly, many more people are unhappy with services than ever complain. Thirdly, the lower the level of education attained by a person, the less likely it is that they will know about the complaints body. Fourthly, people prefer a conciliatory approach, rather than an adversarial approach, to complaints resolution. Fifthly, most complainants say they want changes to procedures and practices they have complained about to benefit everyone.

While these findings are from a different country, there are sufficient similarities between the Canadian and Western Australian contexts for us to find the results of the Canadian surveys useful. Like Western Australia, Ontario has a large number of immigrant people, people from a non English-speaking background, indigenous ("First Nation") people and seniors.

I am firmly of the belief that most people who bring their complaints to this office prefer the conciliatory to the adversarial approach. We also find that the independent, confidential, no-cost option is empowering to people and encourages them not to lose faith in "the system" overall, even after a very negative experience with a provider.

Many people still don't know we exist. I believe, extrapolating from the Canadian research, that many more people would complain to us if they knew we were here. This is not to suggest that there are major deficiencies in health services generally. Rather, in a community where expectations of the health system are high, and millions of individual services are delivered each year, people want to exercise their right to complain when they believe they have not received reasonable service. For this reason the Office of Health Review's public awareness strategy is especially focused on raising awareness of our role and powers among people who are less likely than others to complain.

The Office's outreach to indigenous, migrant and rural communities will be continued in 1999-2000, with a focus on more remote areas of the State. We shall also increase our efforts to reach as many seniors as possible. The Office presented a paper at the National Health Care Complaints Conference in March this year, on Access and Equity for the Elderly. Our relationship with the Office of Seniors' Interests has led to consumer information about our role being available on that office's Information Touchscreens. I am aware, however, that there is still a long way to go before the Office's profile is well established.

This Office will continue to work with health providers to improve services through the feedback we can supply from complaints, and to encourage providers to make their customers aware of the complaints process. A number of provider organisations have taken a particularly positive approach to the Office's role, and have actively invited our input. It has been helpful to be able to include articles about the Office in professional newsletters, for instance, and to send out our posters to members of professional organisations. One of the best places for consumers to encounter our message is in a health care setting. The great value of providing consumer information about patient rights and the complaints process in a hospital clinic, GP surgery or pharmacy is that the information is provided in a setting where people are already focused on their health care needs.

Finally, the best message health providers can send their clients, apart from professional competence, is that they are happy for their service to stand scrutiny.

David Kerslake

DIRECTOR

Analysis of complaints

There were 1,238 complaints to the Office of Health Review in 1998-99, an increase of 21.8% on 1997/98. Closed cases for the year numbered 1,123. We recorded 95 additional inquiries about issues outside our jurisdiction, and referred these elsewhere.

Outcomes of complaints, where the complaint was completely or partly upheld

Five hundred and seventy cases proceeded to informal investigation. Ninety-nine (17.3%) were resolved completely or mainly in favour of the complainant, and a further 83, (14.5%) were resolved partly in favour of the complainant. There were multiple objectives, and multiple outcomes, for a number of complaints. The outcomes achieved in these cases were as follows –

Changes to procedure, policy and practice	57 cases
Costs refunded or accounts waived	47 cases
Compensation awarded	10 cases
Service obtained	28 cases
Apology given	33 cases
Explanation given	156 cases

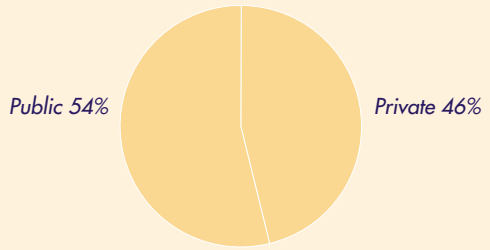
Other outcomes

191 complaints (17%) were not upheld. Fifty-five complaints were withdrawn, or lapsed because the complainant did not respond to multiple contacts by the office. Twenty-three cases were closed as "Unable to be Determined", usually because the central issue of the complaint was unable to be proved, and the parties gave contradictory accounts that could not be verified. There were 14 complaints referred for further action by Registration Boards.

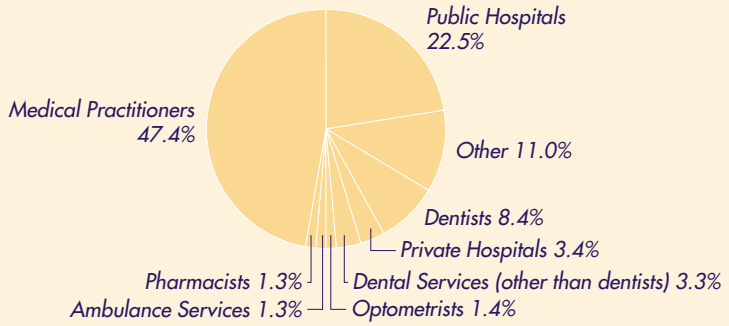
Closure outcome categories

So that the Office can keep track of what has happened at the end of the assessment, conciliation or investigation process of a complaint, outcome categories were developed. These enable the case officer to readily classify the outcome of the matter,

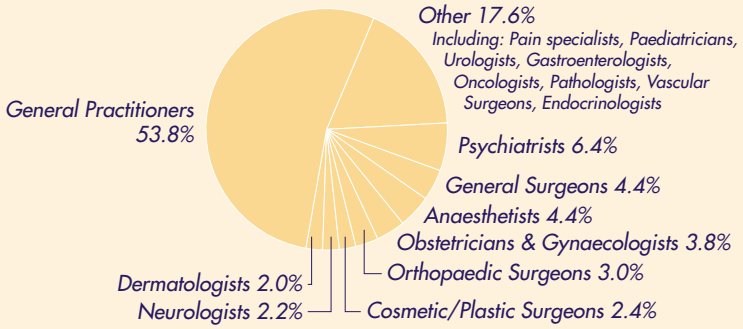
Proportion of Complaints against Service Providers during 1998/99



Which Service Providers did people complain about?



Complaints about Medical Practitioners by Speciality



so that such outcomes may be both reliable and valid. That is, that they measure the same concept on each occasion, and that they measure that concept in a robust way. Outlined below are the categories which are used at the OHR to classify the outcome of each case, with a brief explanation of the meaning of each category.

A. RESOLVED MAINLY OR COMPLETELY IN FAVOUR OF COMPLAINANT

This category is used where the circumstances of the complaint have been wholly or substantially found to support the allegations of the complainant. In such cases, the type of remedies available to the complainant which could resolve the dispute are: an apology; that they obtain the service which they had sought and which was the subject of the complaint; that they obtain compensation or an ex gratia payment; that costs are refunded or waived, or that an explanation is provided. In some cases, the circumstances of the complaint may have referred to unreasonable policies or procedures and this Office would recommend that these be reviewed as a result of the allegations being substantially or wholly upheld. In some cases, the Director may consider the allegations to be so serious that they are referred to the appropriate provider Registration Board.

B. RESOLVED PARTLY IN FAVOUR OF COMPLAINANT

This category is used where the circumstances of the complaint have not been wholly or substantially found to support the allegations of the complainant, but there is some aspect or aspects of the complaint which have been upheld. In such cases, the type of remedies available to the complainant which could resolve the dispute are the same as for Category A above. However, those remedies will only apply to the portion of the complaint which has been upheld.

C. COMPLAINT NOT UPHELD

Sometimes no portion of a complaint is upheld. The complaint may have arisen through a misunderstanding or unrealistic expectations on the part of the complainant. In such cases, the matter is usually resolved by this Office giving an explanation to the complainant.

D. UNABLE TO BE DETERMINED

Sometimes there is insufficient evidence available to determine a complaint one way or the other. For example, the complainant may assert that the provider behaved abruptly or rudely, but there may have been no witnesses present. In such cases, the Office of Health Review cannot simply prefer one version of events to another. This can be very frustrating for either or both parties, as indeed it is for this Office. Obviously, however, we cannot simply resort to guesswork. Nevertheless, we record such complaints on our database so that, if a pattern of conduct emerges, appropriate action can be taken at that point.

E. COMPLAINT WITHDRAWN OR LAPSED

Occasionally complainants allow their complaint to lapse, for example, by failing to respond to an officer's repeated attempts at contact. This category is also used where a complaint is explicitly withdrawn by the complainant.

F. REFERRED TO REGISTRATION BOARD

Under the Act, the Director may refer a complaint to a provider Registration Board where he considers it is not suitable for conciliation or investigation, or considers that it should be dealt with by such a Board. For example, complaints which have alleged substantiated claims of inappropriate sexual conduct are referred to the appropriate Board.

G. DECLINED

This category is used when it is ascertained that the matter is in some way or another out of the jurisdiction of the Office. For example, the complaint may be out of time or have already been determined by a court.

H. REFERRED ELSEWHERE

A complaint will fall into this category where it has been directly referred elsewhere.

Analysis of complaints

Which services did people complain about?

Complaints were fairly evenly split between the private (46%) and public (54%) sectors.

The largest number of complaints (47.4% of all complaints) was about medical practitioners. Within that category, 53.8% of complaints were about General Practitioners; 6.4% were about Psychiatrists; 4.4% were about General Surgeons; 4.4% were about Anaesthetists, and 3.8% were about Obstetricians or Gynaecologists. A further 3% were about Orthopaedic Surgeons, 2.4% were about Cosmetic Surgeons and Plastic Surgeons; 2.2% were about Neurologists and 2% were about Dermatologists. Ophthalmologists were complained about in 1.4% of cases and Pain Specialists in 1.4% of cases; Paediatricians in 1.2% of cases; Urologists in 1% of cases, Gastroenterologists in 0.8% of cases, and 0.4% of complaints were about Cardiologists. The remaining 11.4% of complaints were spread across all other medical specialities. To put these figures in perspective, it should be noted that the greater the number of services provided within a speciality, the greater is the likelihood of a higher volume of complaints.

The next largest category of complaints was Public Hospitals. These accounted for 22.5% of all complaints received in 1998-99. Complaints about Private Hospitals accounted for 3.4% of all complaints; and complaints about health services in nursing homes were 1% of total complaints.

Other categories of complaints included complaints about Dentists (8.4%) and about other dental health providers (3.3%), Optometrists (1.4 %), Ambulance Services (1.3%), and Pharmacists (1.3%). Complaints about Physiotherapists were 0.5% of all complaints, and 0.5% of all complaints were about Registered Nurses.

The remaining 9% of complaints were about Osteopaths, Acupuncturists, Chiropractors, Naturopaths, other Alternative Health providers, Podiatrists, Psychologists, and Social Workers in a health care setting.

What issues did people complain about in 1998-99?

The principal issue that people complained about was Treatment, including Diagnosis. This was an issue, often the only issue, in 588 (47.5%) cases. The next largest number of complaints was about Cost (181 cases, or 14.6%). Access was the issue in 151 (12.2%) cases, just ahead of Privacy, which was the issue in 148 (12%) complaints. Decision making – that is, matters affecting decisions on treatment, such as failure to obtain consent or consent not being informed, failure to consult the consumer and over-servicing - was the main issue in 34 (2.7%) cases. A total of 136 cases, or 11%, were about other issues, such as information provided about treatment options and costs, and inadequate responses to complaints.

Interaction with community groups and other bodies

The Office maintains contact with a variety of boards, committees and interest groups as part of its normal business. Additionally, the Office has made submissions to a number of inquiries. These included the New South Wales Committee of Inquiry into Cosmetic Surgery, the Australian Natural Therapists' Association survey of complaints about unregistered providers of natural therapies and the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical. The Office responded to the Victorian Department of Human Services (Mental Health) Review of Mechanisms for Complaint with regard to complaints about unregistered providers of psychotherapy and therapeutic counselling. The Director was a coopted member of the Metropolitan Health Services Board's Working Party on Informed Consent.

The Director and three complaints investigation officers attended the Health Care Complaints National Conference in Hobart in March 1999. The Office presented a paper on Access and Equity for the Elderly at this Conference, and presented a paper on the role and functions of the Office of Health Review to the Australian Podiatry Association's 1999 Annual Conference.

The Director's speaking engagements during the year included addresses to students in the Masters in Public Health programme at the University of Western Australia, the School of Oral Health Sciences, the Nursing Administration Committee of the Private Hospitals Association and the GP Training Programme. He also addressed the Cosmetic Physicians Society, Sir Charles Gairdner Hospital Lunchtime Forum, carers at Cockburn Community Care, and various metropolitan community groups.

The Director met regularly with the Health Consumers' Council of Western Australia, made presentations to the Health Department's Future Leaders Program and to anaesthetists at Sir Charles Gairdner Hospital, and attended every meeting of the Health Complaints Commissioners Conference. He addressed final year Law students at the University of Western Australia on dispute resolution, the Psychiatry Ethics Committee, and the Q Club Network Group of the Australasian Association for Quality in Health Care (Inc.).

Additionally, as part of the Office's public awareness strategy, the Director travelled to centres in the South West, Lower Great Southern and Goldfields, meeting with a wide range of private and public health providers and community groups.

Consumer information brochures, complaint forms and posters were sent to public hospitals, nursing posts and prisons throughout the State. Legal Aid, many Aboriginal Legal Service offices, Aboriginal Affairs Department offices and Community Law Centres also have stocks of these materials. The Director took consumer inquiries on regional talkback radio in a number of rural areas, including Bunbury, Albany, Esperance and Kalgoorlie-Boulder, was interviewed on regional network television and visited, in addition to the above centres, Mandurah, Busselton, Manjimup, Collie, Ravensthorpe, Norseman and Coolgardie. Meetings were held with representatives of bodies such as the Goomburrup Aboriginal Corporation in Bunbury, the Bega Garnbirringu Health Service in Kalgoorlie and with individual Aboriginal Health Workers in a variety of locations.

Medical opinions: when we request them and why

The gathering of and circumstances in which the OHR requests and pays for medical opinions is a matter which is dealt with on a case by case basis. However, there are some generalities which can be expressed as a guide for this part of our assessment work.

In assessing complaints, the benchmark used by this Office is whether or not the provider's conduct was reasonable. In deciding whether or not unreasonable conduct has occurred, this Office considers issues such as whether there was a failure by a provider to comply with any professional standards commonly accepted by members of the provider's profession.

A complaint may raise issues which cannot be resolved by a provider's response, or which are sufficiently complex to warrant seeking an independent or expert opinion. This Office works closely with the Royal Colleges and professional Associations and we often approach these organisations to recommend practitioners who are appropriate for the type of complaint we are assessing.

Confidentiality of the consumer and provider is generally assured by de-identifying material sent to the independent practitioner. This is not possible where the consumer will need to be personally reviewed by the practitioner (as for example, in a complaint about the result of a face-lift). Nor is it possible where a subsequent provider (in the chain of events following the circumstances of the complaint) needs to be approached so that we may discuss the condition in which the consumer came to them for remedial treatment.

In cases where an independent or expert report is requested, this Office will pay the associated consultation and report fee. The Office would not, however, pay for consumers' ongoing treatment should they decide to follow up treatment suggested by that practitioner. The report would only be used to clarify the nature and extent of the injuries.

In one case, for example, a consumer complained that a general practitioner had acted unreasonably at the birth of her child (who weighed over 5kg) and that his unreasonable action resulted in the child being stillborn. This complaint raised complicated medical issues, as the consumer had gestational diabetes and the birth had been complicated by shoulder dystocia. (That is, the baby was unable to move through the birth canal as the bone of the child's shoulder became caught on the bone of the mother's pelvis).

In this case, the Royal College of General Practitioners recommended three practitioners, of whom two were approached. One gave detailed advice about the problems of shoulder dystocia and one gave information about the control and management of gestational diabetes. This information was provided in circumstances whereby the confidentiality of the opinions was assured. This enabled a frank discussion of the matters raised in the complaint.

In another matter, a consumer complained that her general practitioner had failed to diagnose mastitis and that as a consequence, she had required surgery to remove abscesses and would suffer from problems in the future if she wanted to breastfeed. The provider gave this Office a copy of his progress notes, which outlined the treatment programme, and he also provided a detailed written response. This did not resolve the matter, as it was not clear whether the treatment programme he had followed was in fact reasonable. We approached the general surgeon who had recommended the abscesses be surgically removed (and who had performed that surgery) and asked him a series of questions in order to determine whether or not the treatment programme had been reasonable.

In a third case, a woman complained to our Office about scarring resulting from the surgical excision of a number of small, benign skin tags. The woman had asked her general practitioner to remove a mole from beneath her breast. At the appointment scheduled for the procedure, the doctor

noted four other benign-looking skin tags on her sternum and offered to remove these at the same time. The woman agreed.

The doctor had warned the woman, at her previous appointment, that surgical excision of the mole would result in a visible scar. She had been unconcerned about this, because the mole she had asked to have removed was in an area that would usually not be exposed. There was, however, no discussion of the risk of an unattractive result from surgery on the sternum, an area that is more prone to hypertrophic scarring than most parts of the body.

The excision of the skin tags in the woman's sternal area resulted in four raised, shiny and itchy scars. These did not respond to treatment with injections of silicone. The woman felt her appearance had been marred by the surgery, and wanted compensation on the ground that she had not given informed consent to the excisions.

The provider admitted he had caused the scarring, and that he had not expected the woman's sternum to scar hypertrophically. However, he denied liability and maintained that his treatment had been reasonable.

The Office of Health Review sought opinions from two medical practitioners. One was a peer general practitioner; the other was a medical educator. We asked what the conservative treatment of skin tags was, and what was the preferred method of removing them. Both opinions made the point that the sternum is particularly prone to hypertrophic scarring and, in about 2% of cases, keloid scarring. In the view of both these practitioners, the doctor should have known this and the patient ought to have been warned of the possibility. Both said that the preferred treatment for benign skin tags (if they were to be removed at all) was cryotherapy with liquid nitrogen. There would still be risks – such as loss of pigmentation of the treated area – and these would need to be discussed with the patient. However, the alternative of cryotherapy ought to have been offered, in both practitioners' view. The likely result, they said, would have been minimal residual scarring.

Assoc. Professor Geoff Riley, of the Medical Board discusses approaches to complaints about providers of psychiatric services

On the basis of these opinions, and advice from a plastic surgeon the patient had consulted, the case was conciliated by the Office dealing directly with the provider's solicitor. The complainant received compensation.

When is compensation a realistic outcome?

Complainants are asked to detail what they want to achieve from making their complaint. In many cases, they hope to achieve an apology, or an explanation of what happened during their treatment, and this is sufficient for them to consider the matter resolved. In other cases the complainant wants monetary compensation. Alternatively, a complainant may initially request an explanation or apology, but as further information is gathered during the process of review, it may become apparent that the question of compensation should be considered. These scenarios and others are considered below, in an exploration of when compensation is a realistic outcome.

In assessing complaints, the OHR must consider whether the service/s of the health provider were reasonable or unreasonable in the circumstances. OHR staff use a variety of means to make such assessments, including reviewing medical records and reports, discussing the matter with the complainant and provider separately, obtaining a written response from the provider to the circumstances outlined in the complaint, and obtaining informal or formal advice from an independent provider in a relevant field. This advice is generally obtained on de-identified facts.

In some cases it becomes apparent that the complainant has misunderstood some part of their treatment and that compensation is not warranted. In these circumstances, this analysis and recommendation would be explained to both the complainant and the provider.

In one case, the complainant was a woman whose child had died during delivery. She blamed the GP who attended at the delivery and wanted compensation, among other things, as an outcome. She was concerned that the GP had delayed performing an episiotomy and believed this had caused the baby to asphyxiate in the birth canal.

The Office sought advice from two GPs who had a special interest in the area of obstetrics. During analysis of the case, and with the assistance of these medical practitioners, it became apparent that the baby suffered from shoulder dystocia, which could not have been diagnosed prior to the delivery. The significance of this was that performing the episiotomy earlier would not have assisted the baby through the birth canal, as the baby's bony shoulder was trapped on the mother's bony pelvis. In this case, compensation was not a recommended outcome for those reasons. The provider had not been unreasonable in the manner of providing the health service.

Even in cases where unreasonable conduct has been found on the part of the provider, this does not necessarily lead to a recommendation of compensation. For example, a woman saw two different specialists, and went to six hospitals, during the course of the specialists' attempts to find the source of her abdominal pain following an appendectomy. She was concerned that their treatment had worsened her condition and believed they had not acted in a reasonable way.

After reviewing medical records, and obtaining a response from both providers, it became apparent that much of the complaint arose from poor communication on the part of the providers. For example, one provider stated he was unconcerned at the pain and wound drainage and he believed that continuous wound drainage was the best course of action rather than a further operation. However, he omitted to tell the complainant that this was the course of action he had decided upon, thereby leaving her with concerns when her wound continued to drain for some weeks following surgery. She did not appreciate that this was a deliberate course of action adopted after consideration of the clinical issues. Had she been so aware, it may have given her less cause for concern.

The other provider stated that he feared the complainant may have been developing an abscess in the abdomen. He did not inform her that this was to be the next path of investigation, if the problems he suspected she was having with her colon were discounted. Again, he had not informed the complainant of this considered course of action.

In this case then, the providers had acted unreasonably in the *manner* of providing a health service, in that their communication on these and other issues was found to be poor. However, the clinical management had been sound, and as a result, the providers were given strong feedback as to the importance of sound communication, and compensation was not recommended.

Compensation is generally a recommended outcome where the case officer has reviewed all the relevant, available evidence and serious concerns have arisen about the nature and/or extent of the treatment.

For example, a woman had some substantial work performed on her teeth, and this Office requested a report from a peer dental practitioner about the quality of the work done by the first dentist. The report advised that this work was not reasonable and that much of it would need to be re-done. The provider was contacted with the result of this advice. He contacted his insurer, who is in the process of negotiating a financial settlement with the complainant and her solicitors. This Office is acting as an impartial party to facilitate that process.

In other cases, providers' insurers have themselves suggested that the matter be settled by financial compensation, on the basis of information and advice which they have gathered, after being notified of a complaint to this Office. The Office again acts as an impartial third party to help facilitate negotiations. In such circumstances, we strongly suggest that complainants take legal advice on the likely quantum of the claim, so that they have all the information they need to help them decide whether to settle, and for what amount.

In one such case, this Office approached the provider, a surgeon, with the complainant's allegations that he had not diagnosed a condition of appendicitis when it was plainly apparent. This had led to the rupture of the appendix with subsequent peritonitis. The peritonitis had led to an infection of the bowel and further surgery and complications.

Before this office could recommend compensation, the provider's solicitors agreed in principle to a settlement of the matter based on financial compensation. This decision was based wholly on their own investigation of the circumstances leading to the complaint. The complainant drafted her settlement submissions with the assistance of her legal adviser, and presented them to the provider's solicitors, through this Office. Negotiations then took place by way of written offers and counter offers, until the matter was settled by payment of a mutually agreeable sum.

It is clear from the above analysis that the decision as to whether compensation is an appropriate remedy for the disputing parties is a complex one, and must be based on the evidence which is available to the case officer assessing the dispute. This Office provides its services on a no cost basis. This provides any member of the WA public with the opportunity to have complaints reviewed and an appropriate settlement of the matter facilitated, whether by way of apology, explanation, compensation or some other form of settlement which is available and appropriate to the facts. As has been noted in the *Australian Professional Liability – Medical*, series, a thorough examination of the facts and circumstances of a matter:

> *" is time consuming and expensive, and few plaintiffs [complainants] could afford the cost if they were not legally aided or entered into speculative arrangements with their lawyers. "*

This Office provides consumers of health services with another avenue by which their complaints can be reviewed, and recommendations made, which does not involve either the complainant or the provider participating in expensive litigation. Legal action often does little to preserve the relationship between parties, or the confidence of the public in the health system in general, two objectives that case officers at the Office of Health Review pursue where appropriate.

Cosmetic Medicine – an area of increasing concern

Cosmetic surgery and related procedures, once considered something that only film stars or people with significant facial imperfections would consider having done, is now available to, and sought by, many more people in the community. With more widespread practice, higher community expectations, and given that the reason why some people will seek such procedures may lie in a lack of self-acceptance, it is not surprising that the Office of Health Review is seeing more complaints about cosmetic medicine. Some of these do fit the description of being based on an image of perfection that has not been achieved. Others, such as burns from lasers and other high intensity light sources, and scarring from a variety of procedures, are cause for serious concern.

It has been said that the demand for cosmetic surgery is "consumer driven", and to an extent that is true. However, it is also a fact that cosmetic procedures are being enthusiastically promoted by their providers. On most days, the largest circulation newspaper carries advertisements for cosmetic procedures ranging from hair removal and laser resurfacing of facial skin, to collagen implants, cheek and chin implants, Botox injections and liposuction. An informal survey of newspapers by this office found that, on some days, there are as many as seven different advertisements, some close to the front of the paper, for cosmetic medicine.

Not all these procedures would normally be thought to qualify as health issues. Obviously, though, some could have health implications in the event of an unplanned outcome. However, the *Western Australian Radiation Safety Act 1975* makes it an offence for some classes of lasers to be operated by anyone other than a qualified medical practitioner who also has been licensed to use a medical laser. These sorts of lasers are used in procedures such as dermabrasion, hair removal, skin resurfacing and erbium laser treatment of wrinkles. Hence a procedure carried out purely for the sake of appearance will qualify as a "health service", because only a medically qualified person may lawfully perform it.

The Radiation Health Unit at the Queen Elizabeth II Medical Centre estimates that, in Western Australia, some three hundred medical practitioners use medical lasers, across a whole range of specialties. This number includes about forty medical practitioners who use medical lasers for hair removal and skin resurfacing.

Interestingly, a number of advertisements for cosmetic procedures feature photographs or graphic designs that are at first glance indistinguishable from the images that are used to advertise non-medical beauty and body products and services. Others endeavour to give the consumer a realistic idea of what is offered, and what can be achieved. It is in the area of consumer expectation, sometimes fuelled by advertising that promises excellent results, that many complaints arise.

The *Medical and Surgical Specialist Referral Directory (Western Australia) 1999* lists twenty-one surgeons as having a special interest in aesthetic surgery. Procedures in this category include face lifts, implants to the cheeks and chin, breast augmentation, breast reconstruction and reduction surgery, and rhinoplasty (surgery to modify the nose). Problems that can arise with these sorts of surgery include infection and unacceptable scarring. Complaints also arise because the result the consumer obtains from surgery is not the result they imagined would eventuate.

There are also general practitioners performing a variety of cosmetic surgery procedures.

We are not advising consumers against having procedures that they believe will enhance their appearance; nor do we believe that cosmetic surgeons ought not to advertise their services. Our message to both providers and consumers is that, in order to make informed decisions, consumers require accurate information.

confidentiality

This Office has suggested to providers of cosmetic surgery that the best protection for themselves and their patients lies in a considered and well informed approach to procedures, with the consumer being given as much accurate information as possible about the potential risks of surgery, and the alternatives available to any procedure they may be considering.

New South Wales has recently completed an Inquiry into Cosmetic Surgery, to which our Office made a submission. The outcomes of that Inquiry may well have implications for both providers and consumers of health services in Western Australia in terms of standards of practice.

We recommend that providers err on the side of caution and conservatism, when explaining the risks of any procedure. The risk of loss of pigmentation from dermabrasion or laser treatment, for instance, while it is a less serious risk than the risk of a major infection, is still sufficiently significant that it should be fully explained to the consumer before the procedure takes place. The risk of hypertrophic or keloid scarring from surgery to excise moles may be an unacceptable risk to the consumer, who could perhaps live more happily with the moles than with the scars.

Practitioners should ensure that "informed consent" is truly informed, and can be demonstrated as such. This might involve the development of more detailed and specific Consent Forms than are commonly used now, so that the practitioner specifies the risks he or she has discussed with the consumer, and the magnitude of those risks, and the consumer signs a form that is far more meaningful than many we see now.

The Office of Health Review takes the view that, while informative videos and pamphlets are useful adjuncts to explanation by the practitioner, they are no substitute for a careful personal explanation of the procedure, during which the patient has time and opportunity to ask questions. We also believe it is appropriate for medical practitioners themselves, perhaps through their Colleges, to set the professional standards that ought to be required in any cosmetic medical practice. Just as medical practitioners learning general surgery do so under supervision and over a reasonable period of time, so those practising new technologies, including those of cosmetic medicine, should learn under supervision.

Discharge from hospital – how the end of the process can go wrong

A number of complaints to this Office have arisen from the circumstances of a hospital discharge. Consumers who complain about this matter frequently have no criticism of the care they or a family member received in hospital; in fact, the point is often made that "the care was excellent". Discharge from hospital, however, needs to be as carefully conducted as treatment, or the potential for serious problems after discharge is increased.

At discharge, it should be made clear to the patient, and any person who is responsible for caring for that person, what the patient's condition is now, what care is indicated, what might be expected in terms of recovery time, and what should be done if recovery seems not to be going to plan. Medications should be checked with the patient and the carer, if there is one. If there are multiple medications, instructions about dosages and what each is for, may need to be written down. This is particularly important for patients who are confused, absent-minded, or whose eyesight makes reading the label on the prescription difficult. Instructions to return to hospital, or attend a general practitioner, if particular symptoms occur, should be made clear. A discharge summary, preferably with a follow-up letter, should be sent to the patient's usual GP, so that their own medical practitioner is aware of what illness or injury caused the hospitalisation, what treatment was provided, and what medications they are now taking.

It is especially important for hospitals to be accurately informed about the circumstances a patient will be returning to on discharge. A patient may seem to be coping well in hospital, where others provide meals, do the laundry, clean the room, give and monitor medication, and so on. It may be a very different situation that the patient is returning to, and one where they are not able to cope well with the demands and activities of daily living. If the patient is not able to care for him or herself fully, care arrangements need to be made, and the patient ought not to be discharged until at least interim care is available.

We have received complaints about patients who were frail and confused being discharged home to an empty house. Others have not been given clear instructions to seek medical advice if recovery falters, or they seem to become worse. Some patients arrive home with prescription medicines, but not knowing what these are for. Most often, hospitals do contact the patient's GP and send at least a copy of the discharge summary for that doctor's information and patient notes. Too often, however, discharge is handled badly, and the consequences for the patient can be serious.

Most hospitals have developed a policy with protocols for discharge. Some of these are excellent. However, a policy is only useful if it is observed. Some of the most distressing experiences related to discharge, that this Office has seen, occurred in hospitals with good or excellent discharge policies. Unfortunately, in some instances not all staff were aware of the procedures that ought to have been followed.

Feedback from complaints on this issue is always provided by this Office to the hospital concerned. Following advice from the Office of Health Review on the issue, the Metropolitan Health Services Board is currently reviewing its policy, and the new standard resulting from this process will be implemented across the public hospital system.

Pictured from left to right, standing: Mr Damon Thomas (Tas), Mr Ken Patterson (ACT), Mr David Kerslake (WA), Ms Mary Perrett (former Private Health Insurance Ombudsman), Mr Peter Boyce (NT), Mr Ian Staib (Qld). Seated: Mr Eugene Biganovsky (SA), Ms Beth Wilson (Vic), Ms Merrilyn Walton (NSW), Absent: Ms Robyn Stent, Health and Disability Commissioner, New Zealand.

The Australasian Council of Health Complaints Commissioners

A national and trans-Tasman perspective on consumer experiences of the health system is made possible by the Australasian Council of Health Complaints Commissioners, which meets twice a year, in a different city on each occasion.

The Council comprises the Chief Executives of all the health care complaints jurisdictions in Australia and New Zealand, and is a valuable forum for exchange of information, developing consistency in approaches to systemic health issues, and sharing knowledge about trends in the complaints each jurisdiction receives.

Council members report on the issues reflected in current investigations, to their counterparts from New Zealand and the other States and Territories. Together, they are an effective voice in proposing improvements to health services and in relaying to governments the concerns and experiences of consumers. For example, it was the Council that initiated the National Health Complaints Information Project as a forum to promote quality issues in health care. This has become a valuable resource that will produce information directly applicable to health service provision in every State in Australia.

Case studies 1998/99

However good a health system is, there will always be occasions where a patient's care does not go according to plan.

The role of the Office of Health Review in such cases is to assess whether the standard of care was reasonable. 'Reasonableness' may well depend on the circumstances in which treatment was provided. For example, a mother in a rural area of WA complained that her infant son had eaten part of a plant and she was worried that he would have an adverse reaction. She rushed him to the local hospital where he was treated by a nurse. The complainant wished him to be seen by a doctor. She was referred to a doctor who was on call at the hospital, but saw him at his private rooms and was billed for a consultation. She complained that the doctor should have seen her son at the hospital. She refused to pay the account.

The hospital responded promptly with an outline of their practice and procedure in the area. They highlighted the difficulties rural hospitals have in terms of resources and explained that a doctor would only be called in to the hospital where the case warranted it. In this case, our assessment was that the child was treated adequately by the nurse and had been in no danger.

The complainant understood the rationale behind the hospital's policy but felt that she was being disadvantaged by being in the country. She acknowledged, however, that there were limits to the level of services that could be made available. She paid the outstanding medical account for the doctor's services. She thanked us for our prompt attention to her complaint.

In another case, a forty-seven year old woman consulted a GP at a regional hospital about a breast lump discovered three weeks earlier. The lump had grown and become painful. She was referred to a general surgeon who saw her the following day. He advised the patient that he was fairly sure it was a fibroadenoma (a tumour of glandular or fibrous tissue). The patient was told not to worry about it.

The patient saw her own GP a month later, when she returned to her home state. She was referred for a mammogram and ultrasound. A fine needle biopsy was performed and revealed a malignancy. A grade three tumour and nodes were removed.

The complainant was concerned that the surgeon had not requested any further investigation of the lump, especially since she had told him her aunt had died of breast cancer. The surgeon acknowledged that he was aware the patient was soon leaving the district, but nevertheless felt that he had acted reasonably. He had been convinced that the lump was benign, but in any event had advised the complainant to have the lump checked again if there were any changes.

Our view, supported by advice from a senior surgeon, was that there had been insufficient follow up. We accepted that the ultrasound machine at the country hospital was unsuitable for diagnosing breast cancer and that mammography was not available in the district. Even if the surgeon suspected only a fibroadenoma, however, he should have written a referral to ensure further checks. Fortunately, the delay in diagnosis did not affect the outcome but this did not alter the fact that the surgeon's treatment had been unreasonable in this instance. Feedback was provided to the surgeon to help improve the standard of services in the future.

Another case arose because both medical and nursing staff in a hospital's obstetrics and gynaecology unit failed to practise established procedures.

A woman having her first baby suffered a third-degree vaginal tear during childbirth. She lost a considerable amount of blood after delivery, and a

surgical pack was placed in her vagina to control bleeding. The wound was then sutured.

It is established practice in all maternity wards that, whoever performs the suturing should also perform an examination of the patient, to ensure that no item has been left inside the wound. It is also established practice that the surgical packs are counted after every procedure, to ensure that all have been accounted for and none is wrongly retained. This is the responsibility of the attending nurse.

In this case, because of the complexity of the tear, two doctors actually sutured the wound. Each thought the other would perform the internal examination. Neither did, and so the pack was not detected. Nursing staff then failed to count the surgical packs, after the suturing. The fact that a pack was unaccounted for, was not noticed.

The woman experienced severe pain and discomfort as a result of the retained pack. Nurses checked her stitches a number of times before she left hospital, but there was no suspicion that the pack was still in her body. As a first-time mother, with a painful tear, the woman was unsure whether the pain she was experiencing was normal. Finally, on the sixth day after delivery, the presence of the pack became obvious. The hospital was notified.

A visiting midwife attended the woman's home to remove the pack and took a swab to test for infection. Fortunately, there was no infection. The doctor who performed the more complex part of the suturing immediately contacted the patient to apologise. He acknowledged the seriousness of the error and offered reassurance and practical assistance. He also contacted her GP. However, the complainant found the response of the hospital itself, which merely acknowledged the woman's dissatisfaction, to be inadequate. After representations from the Office of Health Review, the Director of Nursing apologised on behalf of the hospital for the error of omission by the nursing team.

Medical staff were reminded that it is the responsibility of the person who does the suturing to examine the patient to check for retained packs. Nurses were reminded of the importance of counting surgical packs, as well as instruments, at the conclusion of procedures.

Although it was a most unfortunate set of circumstances, and spoiled the woman's first week at home with her child, the consequences of the hospital's errors were, fortunately, not serious. Given that she did not get an infection, and that her pain, though considerable, was less than she was already suffering from the vaginal tear, the complainant decided not to seek compensation.

Case studies

One of the outcomes most often sought by complainants is to achieve effective changes in practices and procedures to benefit everyone.

In one case, a woman complained to a hospital about the lack of effective practical support given to her as a new mother in the days immediately following delivery of her baby. She had received inadequate assistance with breastfeeding, and was discharged from hospital without breastfeeding having been established. She felt she hadn't received adequate advice on caring for her baby, and was offered no support from the home visiting service or lactation consultant until her husband identified these services and requested help for his wife.

The hospital managers responsible for the maternity area reacted positively to the complaint. They acknowledged the complaint's validity, expressed appreciation for the complainant's praise for other areas of service, and immediately undertook a review of practices.

When the complainant made clear her wish to see the system in place at the hospital improved, so that other women did not share her negative experience, the hospital invited her and her husband to contribute their ideas and suggestions to the review process. They did so, and the hospital undertook to inform them of the specific changes to work practices as these were instituted.

The complainant was satisfied that the hospital had shown willingness and intention to improve its services, and was happy for the case to be closed.

Another case involved a hospital's failure to appropriately manage a patient's discharge from hospital. The complainant's aged father had been hospitalised for stabilisation of his heart condition. He had a number of other serious conditions which complicated his prognosis. His general practitioner described him as "very muddled" and unable to live independently. His son, the complainant, had Power of Attorney for him.

The complainant was told his father was in need of high level care and would not be discharged for some days. In fact, the patient was discharged the following day, into the care of some relatives by marriage who just happened to visit, but with whom no arrangements had been made.

The patient went home to an empty house. There was no communication with his caregivers, his son and his daughter-in-law, as to what to expect, what signs would show their father needed to be seen by a doctor, and no discussion of his medication. There was no discharge summary sent to the patient's GP, and no follow-up call to him. Over the next week, they saw him get worse, without realising what was happening.

The complainant said he kept waiting for the medication to start making his father better. His father needed to be readmitted to hospital.

The patient's son first complained to the hospital. The hospital's response contained a number of inaccuracies, no apology and no acknowledgment of failure. The son then brought his complaint to this Office.

The Office arranged a meeting between the complainant and his sister, the consultant under whom the patient had been admitted to hospital, and the hospital's customer liaison officer, to discuss the issues. The meeting was very frank and the complainant clearly expressed his dissatisfaction with the hospital's discharge procedure and its response to the complaint.

There was discussion of what should be involved in discharge procedure, and the kind of communication that was necessary, especially for those with responsibility for the patient's care. The consultant agreed that this was what was meant to happen. He acknowledged that it had not, and

made an unreserved apology for that. He said he understood the family's feeling that their father suffered more than he would have done had discharge been more careful, and if the family had known to go to their GP if the medication seemed not to be working.

The complainant had the opportunity, during the ninety minutes of the meeting, to ask detailed questions about his father's condition and medications. The consultant gave detailed replies and did not seek to minimise the mistakes made by the hospital. Both he and the hospital liaison officer acknowledged that discharge was an area that needed to be addressed.

The liaison officer also apologised for the inaccuracies in the hospital's earlier responses and for the length of time it had taken to address the issues. The complainant's additional grievance with the hospital was over an account for his father under the CAP (care while awaiting placement) policy. This complaint was also resolved. The complainant had argued that the charge was unfair, since his father had been discharged to his own home, not a nursing home, and that it had been applied on a technicality. It seemed an unjust charge, and the consultant agreed that it ought not stand. The hospital withdrew the account.

The matter of discharge procedures was also referred to the Metropolitan Health Services Board and procedures are currently being reviewed for all hospitals under the Board's control.

Another case details the failure of communication between a hospital and a patient's family leading to a review by the hospital of its procedures with regard to resuscitation of very ill patients.

An elderly woman who suffered from emphysema, (a chronic obstructive disease of the airways), was admitted to hospital through the Emergency Department. She was in a coma and close to death when admitted. Hospital records showed that her condition was due to a chest infection and dehydration, in addition to her chronic disease. She then suffered renal failure as a result of dehydration. Her condition was so severe, that she received the last rites that night. Hours later, she stopped breathing, but was resuscitated and moved to the Intensive Care Unit.

Blood tests and other investigations pointed to the possibility that this patient also had cancer. Her prognosis was poor. She had suffered cardio-respiratory arrest and two near fatal infections in that month. It was believed unlikely she could survive this or another episode of respiratory arrest.

The patient's family made clear to the medical staff that they wanted "everything possible" to be done to save her. This occurred when she was resuscitated and admitted to Intensive Care, but did not occur subsequently.

The patient was later transferred to a ward, where she again suffered respiratory failure. On

this occasion, the doctor who was treating her discussed the situation with the doctor in charge. He said he also discussed it with the patient's daughter. The doctors agreed that it would be inappropriate to resuscitate the patient, intubate her, or refer her to Intensive Care, if her condition deteriorated further. The decision was noted on the patient's record and included a note to the effect that this had been agreed to by her daughter. A further note, ten days later, indicated that the patient and family were keen to have treatment continued. The decision not to resuscitate was reiterated in the same note.

The following day, the patient suffered another cardio-respiratory arrest while her daughter was with her. The arrest button was pressed by a junior nurse, indicating an emergency, but no staff came to resuscitate the patient. The family was later told that the emergency call had been cancelled by a senior nurse, because of the instruction not to make aggressive efforts to revive the patient.

The patient died, and the family complained to the Office of Health Review that there had been no agreement by them to the instruction not to resuscitate. They were distressed that the daughter's repeated calls for the patient to be resuscitated had been ignored. The hospital responded with the view that an agreed decision had been followed.

The family made the point, borne out in the notes, that they had continued to voice a desire for whatever treatment was necessary to continue. The complainant said it was never made explicitly clear to them that their mother would not be resuscitated again. It appeared, from our investigation, that this was indeed the case. The hospital's own policy is that the relatives of a patient who is not to be resuscitated should be involved in that decision. The decision should be recorded in the patient's notes and made known to nursing staff, so that they will not initiate emergency action. The policy also notes that family members should be spared the distress of either an unexpected absence of attempted resuscitation, or futile attempts to revive someone whose prognosis is hopeless.

In this case, the family was not forewarned that attempts to resuscitate their mother would be futile and only prolong her dying. Whatever the doctor believed had been agreed to, the family was not prepared for what happened.

Following extensive investigation by this Office, it was found that the decision not to resuscitate the patient was not unreasonable in the circumstances. As the hospital's medical manual explains, cardiopulmonary resuscitation involves a vigorous assault on the body. To have done this in the case of this patient would only have served to prolong her suffering. The hospital acknowledged, however, that communication of this fact had failed on this occasion. The doctor who had initiated the decision not to resuscitate the patient expressed his regret for not having discussed the matter further or more clearly with the family. The hospital reviewed its protocols in this area and produced a revised Decision Form. This specifically lists all communication on the issue with the family as well as the patient, and requires the doctor concerned to detail the rationale for the decision. This is then discussed with the family.

In this case, the complainant expressed satisfaction that her family's negative experience had resulted in an improvement to procedures, and that this would benefit other patients and families in the future.

negotiation

One of the key reasons for establishing the Office of Health Review was to provide an alternative to the more time consuming and expensive court system.

The Office provides a free service and the opportunity to resolve complaints in a non-adversarial atmosphere, such as in the following example. A woman was referred to her GP by a physician after chest X-rays identified a mass on her lung. Although she was found to be well, the probability of malignancy was thought to be high and she was referred for fine needle aspiration. The test report identified cancer and the woman was referred to a surgeon for removal of part of her lung. The pathology report on the tissue removed found the mass to be a non-malignant condition. The woman was referred to a microbiologist and she was diagnosed with a fungal disease.

The woman complained to this Office that she had undergone unnecessary major surgery. She was seeking compensation, admission of the error and a change to the procedure to ensure such a misdiagnosis could not occur again.

The provider agreed to conciliation. A meeting was held during which the provider admitted the error reading the sample and advised of the changes to procedures that were already in place. The matter was resolved in conciliation with a compensation payment that included reimbursement of all her medical costs and a payment for damages. In this case, a substantial amount of compensation was agreed in a timely way and without recourse to litigation.

Case studies

The Office of Health Review can also assist the parties to explore a range of possible remedies that might not otherwise have been contemplated.

One case involved a woman who attended a hospital for an endoscopy and colonoscopy. She complained that she had been awake during the colonoscopy. An investigation into the complaint showed that she had gone 'too deep' with the anaesthesia for the first procedure, and she was given different medication for the second. This took longer to work, as the cannula was not working correctly. The medical records showed that the patient had been in pain. In her complaint, the woman made it clear that she had no wish to pursue compensation. She did, however, wish to have counselling and all costs related to this met by the hospital, as well as to have them admit the truth to her.

The doctor who performed the procedure agreed to meet with the complainant and her husband. The issues of her complaint were discussed and the doctor admitted that his judgment in this case was poor and apologised to the woman. The hospital arranged for her counselling and met the costs of this and medication. They also involved her in the revision of their patient pamphlet. The complainant was completely satisfied with this response.

Another case related to an elderly female patient who died in a metropolitan hospital. Her family felt that they had been asked to collect the body and make funeral arrangements too hastily. The hospital reacted very promptly once they received a copy of the complaint from the Office of Health Review. They organised a meeting with family members to explain hospital policy and procedures. The meeting was in the form of an

informal morning tea. The meeting was by all accounts very emotional for some family members. The family received an explanation and an apology and stated they were then able to move on with their lives and felt the complaint had been resolved as far as possible and saw the events as a culmination of various events at a very emotional time. The family wanted a written apology and the hospital provided this, confirming the positive nature of the meeting.

Sometimes a complaint is satisfactorily resolved through a gesture of goodwill on the part of the provider, who may not previously have been fully aware of the complainant's concerns.

By way of example, a woman complained that she was charged one hundred dollars for a missed psychiatrist's appointment. She felt the amount charged was unreasonable and unfair. She said she had never had an appointment longer than five minutes and could not understand why the charge was one hundred dollars.

This Office investigated the complaint and found that the woman had been charged previously according to the length of time of her appointments, as can be done under Medicare. However, there is no Medicare item for missed appointments and the amount was therefore determined by the cost involved in the administration of the fee by the surgery.

The psychiatrist explained that there are signs in the waiting area about the charge explaining that it will be effected if less than twenty-four hours notice of cancellation is given. However, as a gesture of goodwill the psychiatrist waived the fee.

Case studies

Previous annual reports have referred to inadequate communication as the source of many complaints.

Successful communication requires an open exchange of information between provider and patient: the provider fully explaining risks and benefits of the proposed treatment, other options, possible side effects, costs and so on; the patient providing open and honest information about their health to the provider.

A complaint was received from a woman who chose to have a home birth for her first child. She decided to participate in a community based programme whereby her care was shared between a midwife and GP during the pregnancy, and if a hospital birth was necessary she could be admitted under that GP to an appropriate hospital.

When the woman went into labour, the midwives attended her at home. However, it was realised in the late stages of labour that there was foetal distress and the doctor was called. The doctor diagnosed a breech birth.

The woman assumed from the information she had received from the programme that the doctor was bound by the guideline that hospitalisation was required for a breech presentation. However, the guidelines did not make it clear that the contract was only between the patient and the programme. It did not include the doctor. The guidelines were binding on the patient, but the doctor could make other clinical decisions.

As the woman had assumed that the doctor was bound by the guidelines, she had not discussed her wishes or what could happen in this type of situation, with the GP.

This Office found that the guidelines could lead patients to believe that they were making a contract with the doctor as well as the programme, and suggested changes to the information given to patients to avoid similar situations in the future.

It was suggested that, since the doctor is not a party to the agreement between the patient and the programme, the information be changed to explain that patients need to discuss their wishes with the doctor before the birth. The provider accepted this suggestion and changed the patient information accordingly.

Not all complaints made to this Office are substantiated. This does not mean they were not made in good faith.

Unsubstantiated complaints are far more likely to reflect a misunderstanding or, sometimes, unrealistic expectations on the part of the complainant. It is therefore important that we provide a full and clear explanation for the reasons for our findings. This is also only fair from the point of view of the provider who, after all, has usually been asked to provide a written response to the case.

In one case, a woman complained about a number of issues relating to her diagnosis and treatment by two oncologists. She had been successfully treated and was in remission at the time of complaint. She did not agree with the original diagnosis and complained about many details of the management and manner of the two clinicians. Following the complaint, she was referred by her GP to a third oncologist. The responses of the first two oncologists were considered and the opinion of the third oncologist was sought regarding the woman's management.

The woman's complaints were not upheld and the management by the first two oncologists was found to have been reasonable. Although the reasons for coming to this view were explained to the complainant, it was very difficult to convince her. Although three oncologists came to the same conclusion, she could not accept the findings. We could do no more than reiterate the reasons for our findings.

It is quite understandable that a person who has gone to the trouble of lodging a complaint may feel disappointed if the outcome does not go in their favour. We would nevertheless wish to assure all parties – complainants and providers – that all complaints to this Office are viewed in a careful and impartial manner.

Operational report

Programme Objective

The objective of the Office of Health Review is to resolve complaints about health services by providing systems for dealing with complaints that meet the needs of consumers and providers and to suggest ways of removing and minimising causes of complaints.

Performance Indicators

Four indicators, two for efficiency, and two for effectiveness, are reported on. The efficiency and effectiveness indicators are the same as those used in last year's Annual Report.

Efficiency Indicators

a) Cost per finalised complaint. (based on the accrual costs for the period 1 July 1998 to 30 June 1999). — $681.70

b) Number of days taken to finalise a complaint (calculated from the date of receipt of the complaint form to the date of closure of the file). — 85 days

Effectiveness Indicators

a) Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendation. — *57*

b) Percentage of complaints finalised this financial year. (The number of complaints closed reflects the overall effectiveness of the OHR in dealing with a complaint.) — 91%

National Health Complaints Information Project

The Office of Health Review has continued to provide input to the National Health Complaints Information Project (NHCIP) through its membership of the Data Reference Group. The Data Reference Group has achieved agreement on the data to be collected and the definitions that will be used. These are consistent with the National Data Directory published by the Institute of Health and Welfare. The group is currently working on a consistent system for the classification of health service providers across Australia. All States have provided the NHCIP with the first batch of de-identified complaint data for analysis.

Customer Feedback

The Office of Health Review sends client survey forms to all complainants and providers at the conclusion of a complaint. These surveys provide us with valuable feedback about our services, our manner and our efficiency. The providers and complainants are asked to add any comments that they feel are relevant as well.

Provider responses are, on the whole, positive. 77% of providers indicated that they were satisfied or very satisfied with the outcome of the

complaint. 80% said that the staff were very prompt in responding to letters and telephone calls, 91.5% indicated that staff were very polite in dealing with them and 88% said that staff listened very well to what they had to say.

Over 80% of providers said that the staff dealt with the complaint very efficiently, 83% said they were very satisfied with the way the complaint was handled and 79.5% said that they would feel very comfortable about going through the Office of Health Review process again.

75% of complainants said that staff were very prompt in responding to letters and phone calls, 88% said that staff were very polite in dealing with them, 80% said that the staff listened very well to what they had to say and 76% said that staff explained the complaints handling process very clearly. The dissatisfied responses for these questions were all very low percentages, indicating that complainants were generally happy with the manner in which staff dealt with them. Nevertheless, in terms of overall satisfaction, 62% of complainants indicated that they were very satisfied and 24% that they were very dissatisfied. 67% of complainants said that they would be very happy for the Office of Health Review to deal with a health complaint in the future and 23.5% said they would be very unhappy.

On the other hand, only 44% of complainants said they were satisfied or very satisfied with the actual outcome of the complaint and 39% of complainants said they were dissatisfied or very dissatisfied with the outcome of the complaint. 12% selected the middle option and 5% elected not to answer the question.

The level of complainant satisfaction seems to be affected by whether people achieve the outcome they were seeking. As an impartial organisation, the Office of Health Review is not always able to achieve complainants' objectives.

It is clear that most of our clients are happy with our service and the manner in which that service is provided. Clients are also given the opportunity to make any additional comments they feel are relevant. These comments are carefully noted by staff. We have noticed this year that people are concerned about staff communicating the outcome of a complaint to the provider and the complainant. Complainants are also concerned that they can feel intimidated by providers in the process of their complaints being resolved. Other comments include positive feedback about the impartiality of the office and the professionalism of the staff involved.

Statutory report

Enabling Legislation

The Office of Health Review exists by virtue of the *Health Services (Conciliation and Review) Act 1995.*

Mission Statement

We are committed to making the health system better, through the impartial resolution of complaints.

Objectives

To resolve complaints about health services, by providing systems for dealing with complaints that meet the needs of consumers and providers, and to suggest ways of removing and minimising the causes of complaints.

Functions

The functions of the Director of the Office of Health Review, specified in s.10 of the Act, are –

- to undertake the receipt, conciliation and investigation of complaints and to perform any other function vested in the Director by law;
- to review and identify the causes of complaints, and to suggest ways of removing and minimising those causes and bring them to the notice of the public;
- to take steps to bring to the notice of users and providers details of complaints procedures under this Act;
- to assist providers in developing and improving complaints procedures and the training of staff in handling complaints;
- with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;
- to cause information about the work of the Office to be published from time to time; and
- to provide advice generally on any matter relating to complaints under this Act, and in particular –

  (i) advice to users on the making of complaints to registration boards

  (ii) advice to users on other avenues available for dealing with complaints.

Ministerial and Parliamentary Directives

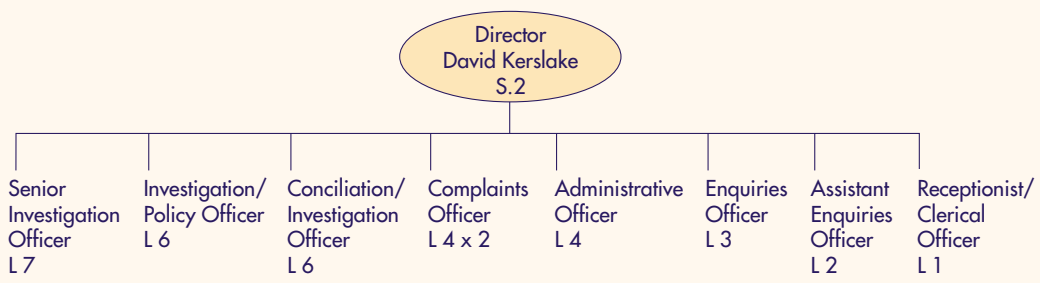
Under s.11 and s.45 of the *Health Services (Conciliation and Review) Act 1995*, the Minister for Health may give directions to the Director of the Office of Health Review for health complaint matters to be investigated. No directions were given during the year ending 30 June 1999.

Under s.56 of the Act, reports may be made by the Director to Parliament or at the request of Parliament. No reports were requested by or made to Parliament in 1998-99.

Administrative

The Director, David Kerslake, was appointed in January 1998 for a five-year term.

Organisational Chart



Office of Health Review staff numbered 10 as at 30 June 1999 compared with 8 at the same time last year.

The positions of Senior Investigation Officer, Conciliation/Investigation Officer and Investigation/ Policy Officer were appointed. Two new positions were created, the Enquiries Officer and Assistant Enquiries Officer. As at 30 June 1999, the Enquiries Officer had been appointed and the Assistant Enquiries Officer position was being finalised. The Receptionist/Clerical Officer position is currently filled on a temporary contract.

Workers Compensation (Occupational Health and Safety)

No workers compensation claims were made in 1998-99.

An Occupational Physiotherapist visited the Office of Health Review in early 1999 to discuss the physical requirements of staff and make suggestions for some changes to staff posture and ergonomic needs. This step was taken with the intention of increasing safety for staff in the office and reducing the potential for workers compensation claims to be made.

Two staff members received a rebate for purchase of spectacles.

Statement of Compliance with Public Sector Standards

The Office has complied with the *Public Sector Management Act 1994* and the Code of Ethics in Managing Human Resources and conducting appropriate internal checks of our processes. There were no applications against the Office for breach of Public Sector Standards in 1998-99.

Promotions, Publications and Research

(a) The Office of Health Review has consumer and provider brochures, complaint forms and posters available from the Office on request. These are also distributed at all community engagements.

(b) The Office of Health Review has a limited research capacity, because of time and budgetary constraints and the need to focus on the main business of the office, which is the investigation and resolution of complaints.

(c) The Director and staff of the Office of Health Review gave several presentations and undertook a number of promotional activities during the 1998-99 financial year. These included stalls at Seniors Week, the inclusion of our promotional poster in newsletters for the Pharmacy Guild of WA, articles about the role of the Office in various provider and community publications and presentations to community and provider groups.

Declaration of Interests

The Office of Health Review has no contracts in which a senior officer has a substantial interest or is in a position to benefit from the appointment of these contracts. The Office has no capital in the form of shares to report on.

Subsequent Events

No events have occurred that may significantly affect the operations of the Office of Health Review since 30 June 1999.

Advertising and Sponsorship

The Office of Health Review produced a promotional poster in 1998-99. This poster has been sent to several hospitals, community groups, community advice centres and medical practices throughout Western Australia. These posters were designed by Glendinning Ratten and printed by Muhlings at a total cost of $2,318.

Year 2000 Compliance

All of the hardware of the Office of Health Review has been tested for Year 2000 compliance. Most of the software is already compliant and the database will be updated in September 1999. This upgrade will mean that the entire computing system of the Office is compliant by the end of September 1999.

Anti-Corruption Commission

There was no matter which required reporting to the Commission in 1998-99.

Report on Equity, Access and Customer Focus

Disability Services Plan

The Office of Health Review has submitted a Disability Services Plan to the Disability Services Commission. The Commission has provided feedback on this plan and this feedback is currently being used to improve the plan and implement further change.

The process of completing the plan has identified areas of training requirements within the Office as well as some areas of concern involving access. These issues are to be addressed in the short term. We have also brought to the attention of staff the importance of being aware of the potential problems a person with a disability may face in accessing the services of this Office and the importance of flexibility in relation to these circumstances.

Evaluations

There were no evaluations undertaken by the Office of Health Review in 1998-99.

Freedom of Information

The Office of Health Review is an independent statutory body operating under strict confidentiality clauses. People who are directly involved in a complaint can access the information on their case file by applying to this office.

In the 1998-99 financial year the Office of Health Review received 5 Freedom of Information requests, four of which were for personal information and one for non-personal information. Of the personal information applications, four received edited access and the non-personal application also received edited access. There were no internal reviews and no amendments. The average time to process these applications was 39 days.

Customer Focus Outcomes

In the last year, the office determined that it would be desirable to increase awareness of our existence, particularly among groups who most require our services, such as seniors, people in rural areas and people of Aboriginal descent. As part of achieving this aim, the Director has travelled throughout various parts of the state visiting health services, community groups and Aboriginal communities and speaking on local radio. We have also had a presence at Seniors Week and a staff member presented a paper at a conference on Access and Equity for the Elderly.

Family and Domestic Violence Plan Outcomes

The Office of Health Review has nothing to report against this requirement.

Plan for Women Outcomes

90% of staff at the Office of Health Review are women and 75% of senior positions in the Office are held by women.

Equal Employment Opportunities Outcomes

Staff of the Office of Health Review numbered 10 on 30 June 1999. There were nine women and one man. Three main ethnic groups are represented in the staff, with two members of minority ethnic groups.

Language and Cultural Diversity Outcomes

The Language Services strategy has been implemented in the Office and we have introduced signage to advise of the availability of translation services. Staff have used interpreters in dealing with people from non English-speaking backgrounds.

Training

Staff have attended several training sessions this year including courses on: simple procurement for the public sector, communication and listening skills for officers dealing with distressed clients, managing a diverse workforce, using surveys to monitor customer satisfaction, the effect of competition policy on health providers, media skills, dealing with difficult people, appearing in the Coroner's Court, fire warden training, job application and interview skills training, using the internet and various computer package courses.

Certification of Performance Indicators

I hereby certify that the Performance Indicators which follow are based on proper records and fairly represent the performance of the Office of Health Review for the financial year ending 30 June 1999.

David Kerslake

DIRECTOR

26 August 1999

Opinion of the Auditor General

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW

PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 1999

Scope

I have audited the key effectiveness and efficiency performance indicators of the Office of Health Review for the year ended June 30, 1999 under the provisions of the Financial Administration and Audit Act 1985.

The Director is responsible for developing and maintaining proper records and systems for preparing and presenting performance indicators. I have conducted an audit of the key performance indicators in order to express an opinion on them to the Parliament as required by the Act. No opinion is expressed on the output measures of quantity, quality, timeliness and cost.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, evidence supporting the amounts and other disclosures in the performance indicators, and assessing the relevance and appropriateness of the performance indicators in assisting users to assess the Office's performance. These procedures have been undertaken to form an opinion as to whether, in all material respects, the performance indicators are relevant and appropriate having regard to their purpose and fairly represent the indicated performance.

The audit opinion expressed below has been formed on the above basis.

Audit Opinion

In my opinion, the key effectiveness and efficiency performance indicators of the Office of Health Review (identified as Audited Performance Indicators) are relevant and appropriate for assisting users to assess the Office's performance and fairly represent the indicated performance for the year ended June 30, 1999.

D D R PEARSON

AUDITOR GENERAL

October 18, 1999

Certification of Financial Statements

The accompanying Financial Statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 1999 and the financial position as at 30 June 1999.

At the date of signing, we are not aware of any circumstances which would render the particulars included in the Financial Statements misleading or inaccurate.

David Kerslake

Wade Starkie

Principal Accounting Officer

Date: 26 August 1999

Opinion of the Auditor General

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW

FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 1999

Scope

I have audited the accounts and financial statements of the Office of Health Review for the year ended June 30, 1999 under the provisions of the Financial Administration and Audit Act 1985.

The Director is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing and presenting the financial statements, and complying with the Act and other relevant written law. The primary responsibility for the detection, investigation and prevention of irregularities rests with the Director.

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, the controls exercised by the Office to ensure financial regularity in accordance with legislative provisions, evidence to provide reasonable assurance that the amounts and other disclosures in the financial statements are free of material misstatement 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 Accounting Standards, other mandatory professional reporting requirements and the Treasurer's Instructions.

The audit opinion expressed below has been formed on the above basis.

Audit Opinion

In my opinion,

(i) the controls exercised by the Office of Health Review provide reasonable assurance that the receipt, expenditure and the acquisition and disposal of property and the incurring of liabilities have been in accordance with legislative provisions; and

(ii) the Operating Statement, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and the Treasurer's Instructions, the transactions for the year ended June 30, 1999 and the financial position at that date.

D D R PEARSON

AUDITOR GENERAL

October 18, 1999

Statement of Financial Position

As at 30th June 1999

	Note	1999 $	1998 $
CURRENT ASSETS			
Cash resources	8	191,151	17,032
Total current assets		191,151	17,032
NON-CURRENT ASSETS			
Property, plant and equipment	9	69,262	72,331
Total non-current assets		69,262	72,331
Total assets		**260,413**	**89,363**
CURRENT LIABILITIES			
Accounts payable	10	4,829	0
Accrued salaries	11	8,036	6,058
Employee entitlements	12	46,229	33,818
Total current liabilities		59,094	39,876
NON-CURRENT LIABILITIES			
Employee entitlements	12	27,103	13,079
Total non-current liabilities		27,103	13,079
Total liabilities		**86,197**	**52,955**
Net assets		**174,216**	**36,408**
EQUITY			
Accumulated surplus		174,216	36,408
Total equity		**174,216**	**36,408**

Operating Statement

For the year ended 30th June 1999

	Note	1998/99 $	1997/98 $
COST OF SERVICES			
Operating Expenses			
Salaries and wages		508,161	422,290
Superannuation		32,989	34,219
Workers compensation insurance		2,744	14,688
Fuel, light, power		24,786	25,644
Communications		14,591	22,307
Repairs, maintenance and consumable equipment		63,145	40,726
Other administrative expenses		92,134	87,724
Depreciation (and amortisation)	2	17,510	18,241
Net loss on sale of non-current assets	3	9,648	0
Total operating expenses		765,708	665,840
Revenues from Services			
Other operating revenue	5	137	0
Total revenues from services		137	0
Net Cost of Services	13	765,571	665,840
REVENUES FROM GOVERNMENT			
Hospital Fund - recurrent appropriation	4	851,000	725,000
Liabilities assumed by the Treasurer	6	31,606	27,132
Resources received free of charge	7	20,773	20,532
Total revenues from government		903,379	772,664
Change in net assets resulting from operations		137,808	106,824
ADD: Opening balance of accumulated surplus / (deficit)		36,408	(70,416)
Closing balance of accumulated surplus/deficit		174,216	36,408

Statement of Cash Flows

For the year ended 30th June 1999

	Note	1998/99 $ Inflows (Outflows)	1997/98 $ Inflows (Outflows)
CASH FLOWS FROM / TO GOVERNMENT			
Appropriations Capital and Recurrent	4	851,000	725,000
Net cash provided by government		851,000	725,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Payments to suppliers		(170,452)	(180,270)
Payments to employees		(482,476)	(539,426)
		(652,928)	(719,696)
Receipts			
Other Operating Receipts		137	0
		137	0
Net cash (used in) / from operating activities	13	(652,791)	(719,696)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	19	(28,690)	(15,760)
Proceeds from sale of non-current assets	20	4,600	0
Net cash (used in) / from investing activities		(24,090)	(15,760)
CASH FLOWS FROM FINANCING ACTIVITIES			
TOTAL CASH FLOWS FROM OPERATING, INVESTING AND FINANCING ACTIVITIES		**(676,881)**	**(735,456)**
Net increase (decrease) in cash held		**174,119**	**(10,456)**
Cash at the beginning of the reporting period		17,032	27,488
Cash at the end of the reporting period	**8**	**191,151**	**17,032**

Notes To The Financial Statements

For the year ended 30th June 1999

1 Statement of accounting policies

The following accounting policies have been adopted in the preparation of the financial statements. Unless otherwise stated these policies are consistent with those adopted in the preceding year.

a) General

i) The financial statements are prepared in accordance with the Financial Administration and Audit Act 1985.

ii) Subject to the exceptions noted in these accounting policies, the financial statements have been drawn up on the basis of historical cost principles.

iii) The accrual basis of accounting is being applied.

iv) The financial statements constitute a general purpose financial report which has been prepared in accordance with Australian Accounting Standards and UIG Consensus Views as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary the application, disclosure, format and wording. The Financial Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Australian Accounting Standards and UIG Consensus Views. The modifications are intended to fulfil the requirements of general application to the public sector together with the need for greater disclosure and also to satisfy accountability requirements.

If any such modification has a material or significant financial effect upon the reported results, details of that modification and where practicable, the resulting financial effect is disclosed in individual notes to these financial statements.

(b) Valuation of Non-current Assets

Certain non-current assets have been revalued from time to time as disclosed in the financial statements. Increments have been taken to the asset revaluation reserve. Decrements have been offset against previous increments (if any) relating to the same class of assets and the balance (if any) charged against profits. Other assets are recognised at cost.

(c) Leased Assets

The Accountable Authority has entered into a number of operating lease arrangements for buildings and office equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Operating Statement over the lease term, as this is representative of the pattern of benefits to be derived from the leased property.

The Accountable Authority has no contractual obligations for finance leases.

(d) Depreciation (and amortisation) of non-current assets

All non-current assets having a limited useful life are systematically depreciated over their useful lives in a manner which reflects the consumption of their service potential.

Depreciation is provided for using the reducing balance method, where rates which are reviewed annually. Useful lives for each class of depreciable asset are:

Computer equipment	5 years
Furniture and fittings	7 to 40 years
Other mobile plant	6 to 10 years
Other plant and equipment	7 to 30 years

(e) Investments

The Accountable Authority does not have investments with private companies, partnerships or sole traders.

(h) Employee Entitlements

i) Annual and Long Service Leave

These entitlements are calculated at current remuneration rates.

A liability for long service leave is recognised, and is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service.

The methods of measurement of the liabilities are consistent with the requirements of Australian Accounting Standard AAS 30 "Accounting for Employee Entitlements".

ii) Superannuation

Staff may contribute to the Superannuation and Family Benefits Act Scheme, a defined benefits pension scheme now closed to new members, or to the Gold State Superannuation Scheme, a defined benefit and lump sum scheme now also closed to new members. All staff who do not contribute to either of these schemes become non-contributor members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992.

The liability for superannuation charges incurred under the Gold State Superannuation and Family Benefits Act pension scheme, together with the pre-transfer service liability for employees who transferred to the Gold State Superannuation Scheme, are provided for at reporting date.

The liabilities for superannuation charges under the Gold State Superannuation Scheme and West State Superannuation Scheme are extinguished by quarterly payment of employer contributions to the Government Employees Superannuation Board.

The note disclosure required by paragraph 51(e) of AAS30 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State Scheme deficiencies are recognised by the State in its whole of government reporting. The Government Employees Superannuation Board's records are not structured to provide the information for the Accountable Authority. Accordingly, deriving the information for the Accountable Authority is impracticable under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

The superannuation expense is comprised of the following elements:

- change in the unfunded employer's liability in respect of current employees who are members of the Superannuation and Family Benefits Act Scheme and current employees who accrued a benefit on transfer from that scheme to the Gold state Superannuation Scheme and;
- notional employer contributions which would have been paid to the Gold State Superannuation Scheme and West State Superannuation Scheme as if the Statutory Authority had made concurrent contributions to those schemes.

(i) Insurance

The Accountable Authority fully insures declared property and insurable risks under a managed fund known as "RiskCover". The fund is operated by the Insurance Commission of WA under the supervision of the Treasury Department.

Risks insured against have been divided into the following five areas:

* Property (including buildings, contents, portable equipment) at replacement cost;
* Liability (ie. public liability, professional indemnity, medical malpractice, and directors & officers);
* Motor Vehicle (material damage and third party property damage);
* Miscellaneous (ie. personal accident, fraud & dishonesty and marine); and
* Workers' compensation

The Accountable Authority has not undertaken any self insurance.

(i) Revenue

Revenue other than government appropriations includes charges for Freedom of Information costs

(k) Appropriations

Appropriations in the nature of revenue, whether recurrent or capital, are recognised as revenues in the period in which the Accountable Authority gains control of the appropriated funds. Appropriations which are repayable by the Accountable Authority to the Treasurer are recognised as liabilities.

(l) Accounts Receivable, Accounts Payable, Accrued Salaries and Borrowings

Accounts Receivable are recognised at the amounts receivable and are due for settlement no more than 30 days from the date of recognition.

The authority does not have debtors

Accounts Payable, including accruals not yet billed, are recognised when the economic entity becomes obliged to make future payments as a result of a purchase of assets or services. Accounts payable are generally settled within 30 days.

The authority does not have borrowings

Accrued salaries represent the amount due to staff but unpaid at the end of the financial year as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Accountable Authority considers the carrying amount approximates net fair value.

(m) Net Fair Values of Financial Assets and Liabilities

Net fair values of financial instruments are determined on the following bases:

* Monetary financial assets and liabilities not traded in an organised financial market - cost basis carrying amounts of accounts receivable, accounts payable and accruals (which approximates net market value);
* Fixed rate borrowings and leave liabilities - current risk adjusted market rates.

(n) Property, Plant and Equipment

The threshold for recognising an asset is $1,000.

(o) Comparative Figures

Comparative figures have been adjusted to conform with changes in the presentation of the financial statements.

		1998/99 $	1997/98 $
2	**Depreciation and amortisation**		
b)	Computer equipment / software	12,248	13,106
c)	Furniture & fittings	1,000	926
f)	Other plant & equipment	4,261	4,210
		17,510	18,241
3	**Net loss on disposal of non-current assets**		
c)	Computer equipment / software	9,648	0
		9,648	0
4	**Government appropriations**		
	The Accountable Authority is funded through the "Amount Provided To Fund Outputs For The Year From The Health Department WA Appropriations", on a recurrent basis.		
	Hospital Fund - recurrent appropriation	851,000	725,000
	Total appropriations revenue	851,000	725,000

Funding Arrangements

Government funding for the operational costs of the Accountable Authority is based on an annual level of funding for a specified level of activity. This funding is then advanced on a monthly basis as per an agreed cash payment schedule calculated on seasonal trends and scheduled activity. Adjustments to funding are made during the year based upon actual activity levels. Receipts (other than donations) are offset against recurrent funding. Major capital and other special purpose funding is determined annually and is mainly funded on a recoup basis, as per the operational funding methodology above or purchased directly by the Health Department on behalf of the Accountable Authority.

5	**Other operating revenue**		
	Freedom of Information Act Fees	137	0
		137	0
6	**Liabilities assumed by the Treasurer**		
	Superannuation	31,606	27,132

	1998/99 $	1997/98 $
7 Resources received free of charge		
Total resources received free of charge	20,773	20,532
Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
Office of the Auditor General		
- Audit services	19,000	19,000
Crown Solicitor's Office		
- Legal Advice	1,773	1532
8 Cash resources		
a) Cash on Hand	400	400
b) Cash at Bank - General	190,751	16,632
Total	191,151	17,032
For the purpose of Statement of Cash Flows, cash includes cash on hand, cash advances and cash at bank. Statement of Cash Flows is reconciled to related items in the Statement of Financial Position as above.		
9 Property, plant, equipment and vehicles		
d) Computer equipment / software		
At cost	55,690	58,251
Less accumulated depreciation	(22,914)	(27,668)
	32,776	30,583
e) Furniture & fittings		
At cost	15,077	15,077
Less accumulated depreciation	(2,738)	(1,737)
	12,339	13,340
h) Other plant and equipment		
At cost	35,269	35,269
Less accumulated depreciation	(11,121)	(6,860)
	24,148	28,409
Total of property, plant, equipment and vehicles	69,262	72,331

	1998/99 $	1997/98 $
10 Accounts payable		
Accounts payable for goods and services received	4,829	0
The Authority considers the carrying amounts of accounts payable approximate their net fair values.		
11 Accrued salaries		
Amounts Owing for Accrued Salaries	8,036	6,058
8 Working Days From 21 June To 30 June 1999		
1998: 12 Working Days From 15 June To 30 June 1998		
3 Working Days From 28 June To 30 June 1999		
1998: 6 Working Days From 22 June To 30 June 1998		
Accrued salaries are settled within a few days of the end of the reporting period.		
The Accountable Authority considers that the carrying amount of accrued salaries is equivalent to the net fair value.		
12 Employee entitlements		
Current Liabilities:		
a) Liability for annual leave	30,822	22,382
b) Liability for long service leave	15,407	11,436
	46,229	33,818
Non-Current Liabilities:		
d) Liability for long service leave	27,103	13,079
	27,103	13,079
The authority considers the carrying amount of employee entitlements approximates fair value.		

	1998/99 $	1997/98 $
13 Reconciliation of net cash used in operating activities to net cost of services		
Net cash (used In) / provided by operating activities (Cash Flow Statement)	(652,791)	(719,696)
Depreciation	(17,511)	(18,241)
Profit / (Loss) On Sale Of Assets	(9,648)	0
Decrease / (increase) in Creditors	(4,829)	21,473
Decrease / (Increase) in Employee entitlements	(28,413)	98,293
Superannuation liabilities assumed by the Treasurer	(31,606)	(27,132)
Resources received free of charge	(20,773)	(20,532)
Net cost of services (Operating Statement)	(765,571)	(665,840)

14 Remuneration of Accountable Authority and Senior Officers

The total of fees, salaries and other benefits received or due and receivable for the reporting period by Senior Officers other than members of the Accountable Authority, from the statutory authority or any related body.	128,209	98,152

The number of Senior Officers (other than Senior Officers reported as members of the Accountable Authority), whose total of fees, salaries and other benefits received, or due and receivable, for the reporting period, falls within the following bands:

	1998/99	1997/98
$90,001 - $100,000	0	1
$100,001 - $110,000	0	0
$110,001 - $120,000	0	0
$120,001 - $130,000	1	0
Total	1	1

15 Retirement benefits

In respect of Senior Officers other than members of the Accountable Authority, the following amounts were paid or became payable for the reporting period:		
Contributions to Gold State Superannuation Scheme and West State Superannuation Scheme	8,384	7,738
	8,384	7,738

	1998/99 $	1997/98 $
16 Remuneration of auditor		
The total fees paid or due and payable to the Auditor General for the reporting period, are as follows:		
Fees for audit (Received free of charge - refer note 7)	19,000	19,000

17 Explanatory statement

(a) Comparison of Actual Results with those of the Preceding Year

Details and reasons for significant variations between actual revenue (income) and expenditure and the corresponding item of the preceding year are detailed below. Significant variations are considered to be those greater than 5% or $40,000.00.

		1998/99	1997/98	Increase/ (Decrease)
i)	REVENUE	851,000	725,000	126,000
	Consolidated Fund Recurrent			
	The Consolidated Fund Contribution increased by $126,000 in 1998/99 in anticipation of covering expenditure to fill the 5 vacant FTE positions.			
	EXPENDITURE			
	Salary and Wages:	508,160	422,290	85,870
	Increase in 1998/99 was due to the filling of 4 FTEs on a fulltime basis and 1 FTE on a temporary basis.			
	Workers compensation insurance:	2,744	14,688	(11,944)
	Decrease due to a refund from overcharging for workers compensation premium. The original premium was charged at the hospital rate but subsequently changed to the government department rate.			
	Communications:	14,591	22,307	(7,716)
	Decrease in communication expenditure can be attributed to the major purchase of a new telephone system during the 1997/98 year.			
	Repairs and Maintenance:	63,145	40,726	22,419
	The following factors contribute to the increase when compared to 1997/98:			

1. An annual increase of approximately $12,000 in the amount of rent and outgoings for the office in Albert Facey House.
2. The Office also employs the services of the Health Departments' Information Technology branch for which it was charged $6,000 per annum starting October 1998.

(b) Comparison of Estimates and Actual Results

Section 42 of the Financial Administration and Audit Act requires statutory authorities to prepare annual budget estimates. Treasurer's Instruction 945 requires an explanation of significant variations between these estimates and actual results. Significant variations are considered to be greater than 10% of total operating expenses or $86,000

		1998/99 Actual	***1998/99 Estimate***	***Variation***
i)	Net Cost of Services	765,707	863,000	(97,293)
	The anticipation of filling the 5 new FTE positions contributed to an inflated figure for Salary and Wages and associated administrative costs for the 1998/99 estimate.			

	1998/99 $	***1997/98 $***
18 Lease commitments		
a) Non-cancellable operating lease commitments		
Payable no later than one year	33,093	21,391
Payable later than one, not later than two years	7,952	7,141
Payable later than two, not later than five years	0	6,248
	41,045	34,780
The above represents the net fair value of non-cancellable operating lease commitments.		

19 Payments made for non-current assets

During the reporting period the Accountable Authority paid consideration on purchase of non-current assets as follows:-

Paid as cash	28,690	15,760
Gross payments for non-current assets	28,690	15,760

20 Consideration on sale of non-current assets

During the reporting period the Accountable Authority received consideration on sale of non-current assets as follows:-

Received as cash	4,600	0
Gross proceeds sale of non-current assets	4,600	0

21 Additional financial instruments disclosures

	Weighted average effective interest rate %	Floating interest rate $'000		Fixed interest rate maturities 1 year or less $'000		1 to 5 years $'000		Over 5 years $'000		Non interest bearing $'000		Total $'000	
		1999	1998	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
As at 30th June 1999													
Financial Assets													
Cash resources	0.00%	190.8	16.6	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4	191.2	17.0
Accounts receivable		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total financial assets		190.8	16.6	0.0	0.0	0.0	0.4	0.0	0.0	0.4	0.4	191.2	17.0
Financial Liabilities		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Accounts payable		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.8	0.0	4.8	0.0
Accrued salaries		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.0	6.1	8.0	6.1
Employee entitlements		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	73.3	46.8	73.3	46.8
Total financial liabilities		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	86.2	52.9	86.2	52.9
Net financial assets (liabilities)		190.8	16.6	0.0	0.0	0.0	0.0	0.0	0.0	(85.8)	(52.5)	105.0	(35.9)

Credit risk exposure

All financial assets are unsecured

Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts.

In respect of other financial assets the carrying amounts represent the Accountable Authority's maximum exposure to credit risk in relation to those assets

The Authority does not enter into foreign currency hedging contracts

21 Reporting on operations

The operations of the Office of Health Review cannot be segmented as it has one operation which is the finalisation of complaints about health services and providers. The results of this operation are presented in the financial statements.

Estimates of Expenditure for 1999/2000

The following Estimates of Expenditure for the year 1999/2000 are prepared on an acrual accounting basis. The estimates are required under Section 42 of the *Financial Administration and Audit Act* and by instruction from the Treasury Department of Western Australia.

The following Estimates of Expenditure for the year 1999/2000 do not form part of the preceding audited financial statements.

Revenue	**1999/2000**
Consolidated Fund	$890,000

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