OFFICE OF HEALTH REVIEW

CLICK HERE
FOR CONTENTS

contents

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who we are

The Office of Health Review was formed in 1995, under the *Health Services (Conciliation and Review) Act 1995*. We are a statutory body with the responsibility of making health and disability services better, through impartial resolution of disputes.

what we do

We investigate complaints in an effort to conciliate between consumers and providers. Over the past five years, we have helped many people resolve their grievances with health providers. In November 1999, the Office of Health Review was also given responsibility for accepting and resolving complaints about disability services.

Apart from helping individual complainants, a significant achievement is the feedback that has been passed on to providers, resulting in improvements to health and disability services overall.

our mission

We are committed to making health and disability services better, through the impartial resolution of complaints.

statement of compliance

HON. JOHN DAY MLA
MINISTER FOR HEALTH

The *Financial Administration and Audit Act 1985* (FAA Act) and the *Health Services (Conciliation and Review) Act 1995* require me to submit an annual report on the activities of the Office of Health Review.

This is our fourth annual report and contains an account of our work for the year ending 30 June 2000. The report aims to provide a flavour of the matters dealt with by my office during the year and thus includes a cross-section of case studies as well as articles on matters of interest.

I draw your attention to section 69 of the FAA Act with regard to the tabling of this report.

David Kerslake
DIRECTOR

31 August 2000

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director's foreword

The past year was an eventful one for the Office of Health Review, with a major expansion of our jurisdiction and a continued increase in complaints received.

disability complaints

Until recently, the Office's jurisdiction has been confined to dealing with complaints about health services. With the passage of amendments to the Disability Services Act, however, the Office also became responsible for investigating complaints about disability services. It is still early days and, therefore, difficult to predict the likely impact of the amendments. Preparing for this new responsibility has nevertheless been a significant challenge and one that we have taken very seriously. At present the level of disability complaints is low, but on the other hand complaints received to date have generally been highly complex. Judging the outcome of such complaints also requires us to look at issues from a different angle.

Another significant challenge is the need to foster community awareness of the Office's new role. We anticipate that as community awareness grows, a higher proportion of complaints will be received about disability services. An article providing a more detailed outline of the Office's role in this area appears later in this report.

complaint numbers

Compared to last year, there was an overall increase of 15% in the total number of complaints received, and an increase of 138% in enquiries about matters outside our jurisdiction. Over 98% of cases were able to be closed during the year, with a high level of customer satisfaction in the process. We have endeavoured to provide a fair, impartial and timely service to both consumers and providers, and our customer feedback indicates that we have been successful in this regard. We have continued to improve our complaints system to ensure that both consumers and providers have confidence in our ability to act upon complaints and reach a fair outcome.

systemic issues

We have continued our strong focus on systemic issues. One of the outcomes most often sought by complainants is that they do not want an unfortunate experience to be repeated for someone else. Through dealing with individual complaints, we are well placed to identify areas of broader concern across the health and disabilities sectors. Through our feedback to providers, we are able to help improve practices and procedures and to encourage them to maintain high levels of service to their patients or clients. In this way, a complaint made by one person can help to improve the system for everyone.

All recommendations for systemic improvements in 1999-2000 were accepted by the providers concerned, indicating that this Office has a high level of credibility and the ability, where necessary, to facilitate change. The effectiveness of the complaints system is improved also by this holistic approach. We have been encouraged by the positive emphasis placed by provider organisations on the development of in-house complaints processes. The community today is very different from, say, 10 years ago and members of the public have a strong and legitimate expectation that health and disability providers will be held accountable for their actions. A high-profile, well-resourced internal complaints mechanism sends a very strong message in this regard, as well as providing the opportunity to improve quality through client feedback.

public awareness

In previous reports I have stressed the overriding importance of accessibility to the complaints process. Often, those most in need of our help are least likely to know of our existence. During the year we continued to expand our public awareness program, with outreach visits to Aboriginal communities and regional health services in Broome, Port Hedland, Karratha and Geraldton. A multicultural evening conducted by the Office enabled us to expand our contacts with ethnic communities and to get feedback on the most effective strategies for disseminating information about our role. Marketing of the Office to multicultural groups, seniors and remote Aboriginal communities, both directly and through various media outlets, will continue to raise the Office's profile, but ultimately the grapevine is our most effective communication tool.

Finally, I would like to pay tribute to the high level of commitment shown by my staff throughout the year. Together, we look forward to building on previous successes, and contributing to improved health and disability services in Western Australia. The challenges of such a role are considerable, but so too are the rewards.

David Kerslake
Director

David Kerslake,
Director, Office of Health Review

the year in review

The Office has experienced a continuation of the increasing volume of complaints and enquiries noted each year since we came into existence. The continuation of this trend has added significantly to the workload of staff and has caused us to look hard at how well placed the Office is to meet growing demand. The planned recruitment of two additional staff members to start in 2000/2001, is a response to the Office's increased workload in 1999-2000.

The Office has also faced the fact that our current accommodation in Albert Facey House is inadequate for our staff, our visitors and storage of almost four and a half thousand case files. We are in the process of arranging a move to more spacious offices, with room for our growing library of medical and other texts.

Despite the increase this year in the volume of both complaints (15%) and enquiries about matters outside our jurisdiction (138%), the Office has increased its outreach into the community. Of special note is the initiative of taking the Office's message to remote areas of the State, where health and disability services are of profound importance but choices are far more limited than in the metropolitan area or even rural centres, closer to Perth.

Outreach was also highlighted in our activities during Carer's Week and our celebration of Harmony Day. The Carer's Fayre was held over two days in October 1999 and attracted over eight hundred people. Four of our officers attended the Fayre, and staffed an information stall where consumers were able to make their complaints direct to staff.

With some 200,000 carers in the State, according to ABS figures, and the recent addition of disability services to our responsibilities, we envisage a regular presence at future Carer's Fayres.

Representatives of Western Australia's ethnic communities were the Office's guests in March 2000, as we celebrated Harmony Day. As a result of contacts made on this occasion, staff have been invited to address a number of community groups and arrangements are under way for presentations on radio programs in several other languages.

complaints and investigations

1427 complaints were received in 1999-2000, an increase of more than 15% over the previous year. 1396 (98%) of those cases were finalised. A further 227 enquiries were received about issues outside our jurisdiction, and were referred elsewhere. Overall, the level of complaints has increased by 154% since the Office's first full year of operation.

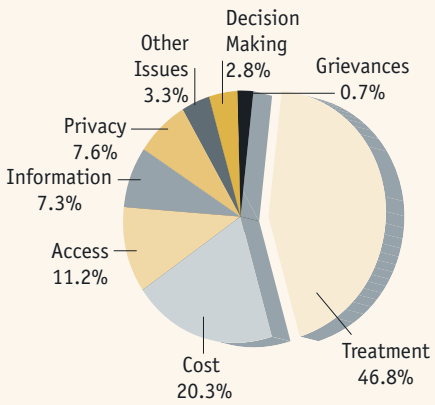
As with previous years, the bulk of complaints in 1999-2000 were against medical practitioners – some 42% of all complaints. This figure appears high at first glance, but is given perspective by the fact that medical practitioners provide more than half of all health services delivered in Western Australia each year.

The next largest category of complaints was public hospitals. These accounted for 24% of all complaints received in 1999-2000. Complaints about doctors in public hospitals are included in this category. Complaints about private hospitals accounted for 3.4% of all complaints. These figures, like those for complaints about dentists and other dental providers (12%) have hardly changed since last year.

what issues do people complain about?

As with previous years, most complaints centred on concerns about treatment and diagnosis. Treatment was either the only issue or the key issue in 47% of cases. 20% of complainants were unhappy about either the actual cost of services, or the adequacy of information provided about treatment costs. Access to services (11%) and alleged breaches of privacy or confidentiality (8%) accounted for the bulk of other complaints.

1999-2000 Issue Type



Issue	Complaints	% age
Access	160	11.2%
Cost	289	20.3%
Decision Making	39	2.8%
Grievances	11	0.7%
Information	104	7.3%
Other Issues	48	3.3%
Privacy	108	7.6%
Treatment	668	46.8%

outcomes of complaints

527 written cases proceeded to preliminary assessment, as per the current legislation. Of these, 123 were resolved completely or mainly in favour of the complainant, and a further 83 were resolved partly in favour of the complainant. In many cases, there were multiple outcomes.

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 have been developed. The outcomes are measurable, and provide valid comparisons for analysis. Outlined below are the categories, with a brief explanation.

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 types of remedies available to the complainant which could resolve the dispute are: an apology; 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; costs are refunded or waived, or 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 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 allegation of the complainant, but there is some aspect, or aspects, of the complaint that has been upheld. In such cases, the types of remedies available to the complainant that could resolve the dispute are the same as for Category a. above. However, those remedies will only apply to the portion of the complaint that has been upheld.

c. complaint not upheld

Sometimes no portion of the 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 is unable to determine the true version of events. These complaints are recorded on a database so that, if a pattern of conduct emerges from a particular provider, appropriate action can be taken.

e. complaint withdrawn or lapsed

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

f. referred to registration board

Under the Act, the Director may refer a complaint to a provider Registration Board where it is considered not suitable for conciliation or investigation, and it needs to be dealt with by the appropriate Board. For example, complaints that have substantiated claims of inappropriate sexual conduct are referred to the relevant 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 this Office. For example, the complaint may be out of time or a court, tribunal or Registration Board has already determined the issues.

h. referred elsewhere

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

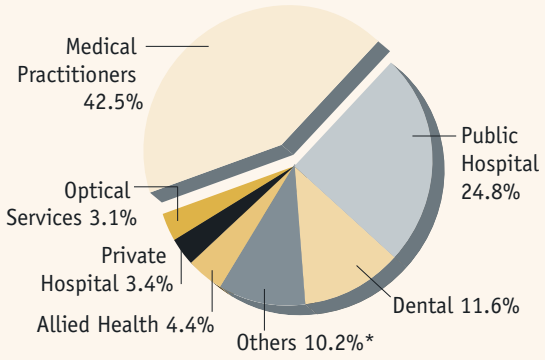
which services do people complain about?

The largest number of complaints was about medical practitioners (42.5% of all complaints). The following list shows the specialities about which a significant number of was complaints received. As expected, general practitioners, who provide the greatest number of medical services, head the list. The relatively high proportion of complaints about psychiatrists adds another dimension to the business of assessing complaints, as these are frequently complex and difficult cases.

providers	number of complaints
General Practitioners	308
Psychiatrists	92
Obstetricians/Gynaecologists	52
General Surgeons	49
Orthopaedic Surgeons	47
Anaesthetists	30
Plastic/Cosmetic Surgeons	26
Neurologists	19

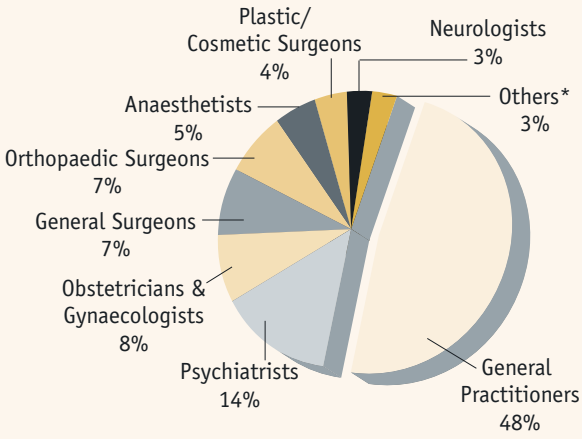
A very small number of complaints was received about providers in specialities such as cardiology, oncology, pain management, urology and radiology.

Which Service Providers did people complain about?



*Includes Aged Care, Ambulance Service, Alternative Health Services, Community Health Service (Public), Disability & Rehabilitation Services, Mental Health, Nursing, Pharmacists

Complaints about Medical Practitioners by Speciality



*Includes cardiologists, oncologists, pain management specialists, urologists and radiologists

legislative review

On the 18th November 1999 the State Parliament legislated to transfer the responsibility for handling complaints about disability services to the Office of Health Review.

The legislative changes mean that the Office of Health Review is currently operating under two different Acts, the Health Services (Conciliation and Review) Act and the Disability Services Act. Although the complaint processes outlined under these Acts are broadly similar, there are some important differences. Unfortunately, this means that for the time being, we are obliged to apply different rules to the two categories of complaints. The key differences are set out below.

time limits

Both Acts specify time limits within which a complaint must be lodged with this Office. Health complaints must be made within 12 months of the incident occurring. The time limit for disability complaints, on the other hand, is 2 years. In both categories, the Director has discretion to accept complaints that are out of time, if the circumstances so warrant. Even so, the difference between jurisdictions has the potential to create confusion among complainants particularly if they have concerns in both the health and disability areas. This could mean that some disability complaints are accepted under circumstances where health complaints are rejected.

The preference of this Office is to extend the 2-year time limit to health complaints.

written and oral complaints

Another key difference relates to oral and written complaints. Health complaints must be made in writing. Under the Disability Services Act, however, the Director has discretion to accept a complaint orally if he is satisfied that the complaint cannot be made in writing. Generally speaking, it is desirable for complaints to be made in writing, both to confirm the nature of the complainant's concerns and to afford the provider every opportunity to respond to those concerns. At the same time, however, both Acts need to recognise the fact that some people are unable to put their concerns in writing and that others may be dissuaded from lodging a legitimate complaint because of these requirements. This Office also needs to have the capacity to respond to complaints where time is of the essence - for example, where a person complains that they have been denied urgent treatment.

refusal of a service

With regard to health services, complaints may be made about a *public* provider unreasonably refusing to provide a service. It is not within our jurisdiction, however, to accept complaints about a *private* provider refusing a service. Disability complaints, however, can be about either public or private providers refusing to provide a service. This is an important inclusion for disability complaints as many of the service providers are private organisations but publicly funded. Clearly, there would be also be circumstances where it would be unreasonable for a private health provider to refuse a service.

In our view the emphasis should be on whether or not the refusal was unreasonable in the particular circumstances, not on the distinction between public and private providers.

name change

Apart from the legislative anomalies referred to above, this Office is in favour of changing its name to identify more clearly with both the health and disability fields. The name should also make clear our

primary function, which is to investigate complaints. Accordingly, we favour the title *Health and Disability Complaints Commissioner*, or *Health and Disability Ombudsman*.

This Office has consulted with key stakeholder groups in relation to these issues and has put in proposals for further amendments to make complaints processes more consistent. The time period for these changes is not yet known.

senate inquiry into childbirth procedures

In August 1999 the Office of Health Review wrote a submission to the Senate Inquiry into Childbirth Procedures. The submission was one of many considered by the Inquiry in collating the report "Rocking the Cradle", which was tabled in the Senate on 8 December 1999. In preparing our submission, we looked through the complaints relating to childbirth that the Office has received since opening in 1996. We identified four common themes in these cases.

theme 1: general practitioners treating pregnant patients

Often a pregnant woman sees a General Practitioner throughout her pregnancy, rather than an obstetrician. Complaints brought to this office suggest that GPs need to be particularly alert to the specific problems that a pregnant woman can face. We are not suggesting that GPs should not treat pregnant patients, or that pregnant women should elect to see an obstetrician for care prior to delivery. We do feel concerned, however, that there is insufficient knowledge among a small number of GPs about the complex and specific potential problems associated with pregnancy.

theme 2: lack of information about possible risks and the options available

Informed consent is an important factor in all health care. We have dealt with several cases where women have chosen a mode of delivery of their baby, without adequate information being given about potential risks and the options available to lessen these risks. Examples include large babies being delivered vaginally and suffering shoulder dystocia, because the mother was not adequately informed of the risks, and therefore not in a position to choose whether or not to deliver a baby vaginally. Other cases illustrate the problems faced by women who have previously had caesarean deliveries but subsequently attempt a normal vaginal delivery. Although this is usually successful, many expectant mothers are not adequately informed of the risks associated with having the subsequent vaginal delivery.

theme 3: problems with epidurals

Many patients request an epidural to assist with pain management during childbirth. Some women feel numb for an extended period after the delivery and other women have developed severe headaches as a consequence of being administered an epidural. Other cases have related to epidurals not working or only partially working. The key issue arising from such cases once again relates to adequate explanation of risks.

theme 4: care of the mother following birth

Many complaints focus attention on the care of the mother and child following delivery. There have been complaints relating to blood clots following a delivery and problems with the stitching and healing of episiotomies. Another example included a woman who had a vaginal pack left in for six days following suturing of a vaginal tear.

These complaints again raise issues about the information and support provided to new mothers. In some instances, the demands on hospitals can mean that the needs of the new mother are overlooked, when this time can be distressing and the experiences unfamiliar. It is important that hospitals ensure new mothers are provided with adequate information and support, as well as medical care, after the delivery of their child.

Our submission also noted that, because of the role of the Office of Health Review, we only ever receive complaints, not praise for obstetricians, midwives and hospitals involved in the delivery of a child.

sexual harassment

The Office of Health Review has received a number of sexual harassment complaints in the last financial year.

Surprisingly, a number of complaints involved what had previously been considered good relationships, for instance between long standing patients and their GP. A common theme that emerged in these complaints was that the health provider, perhaps through familiarity, failed to maintain professional boundaries. Some of our investigations revealed that the health providers concerned seemed to be unable to distinguish between informality or friendliness and unprofessional conduct. Often a patient will develop a close and trusting relationship with their health provider. They may refer to themselves as friends. Ultimately though, no matter how open or friendly the interaction between the consumer and provider, it is a *professional* relationship that has boundaries that must be observed.

The following cases illustrate the types of complaints received by the Office:

The consumer was a female resident at a hostel. Most of the residents are patients of a GP who has a practice nearby and who makes regular visits to the hostel. She was concerned about the manner in which the GP would examine her – for example, he would pull down her blouse without warning when checking her heartbeat. He would joke with residents and nurses and often would put his arm around them. She said that she generally had a good relationship with the doctor and that they did like to share a joke together. However, she was particularly offended by what she considered to be overly familiar comments.

In response to the complaint, the GP said that the hostel had a casual, 'homely' atmosphere and he tried to put patients at ease. Sometimes he would try to comfort patients by putting his arm around them. There was no suggestion that he was deliberately making sexual advances, rather that he had failed to observe professional boundaries.

Following this complaint, the GP undertook to ensure that future consultations would be conducted on a more professional basis.

In another example, the complainant was a new patient of a GP. During a consultation where more than one issue was discussed, the GP made inappropriate remarks, as well as pulling the patient's clothes aside without warning. The patient was concerned about such unprofessional comments. When the GP was made aware of the complaint, he was surprised that she had taken his 'joke' seriously. He said that he was an 'informal' type of doctor, and he did not intend to change the way he practised even if some patients took it the wrong way.

It appeared that this doctor was not able to distinguish between informality or friendliness and an inappropriate transgression of boundaries.

Disturbingly, another patient of the same doctor made a similar complaint. She was a long-standing patient. The GP jokingly suggested to her that he should be rewarded with a present since he worked so hard for her. When the patient replied that she could not even afford to buy her husband a present,the GP commented on other steps that may please her husband. His comments were of an overtly sexual nature. When the patient pointed out that her sexuality was none of his business, he responded that he had the right to know if she had sex or not.

In response to the complaint, the GP told this Office that he could not remember exactly what he said, but he did remember mentioning that the patient would be a good present for her husband. He confirmed that he believed he had the right, as her GP, to know about her sex life. The GP also stressed that he treated his long-standing patients as friends and he did not like a 'stuffed-shirt' approach to medicine.

Again, it was apparent that the GP was unable to distinguish between informality and unprofessional conduct. He did not recognise that his comments would be considered offensive in any circumstances, let alone in a professional situation. Rather, the GP felt that if a patient took offence to his manner, it was a reflection of the patient's problems. His statement that he had "the right" to know about issues (such as sexuality) that were not relevant to the consultation, indicated a rather disparaging view of patient's rights.

Both complaints against this doctor were referred to the Medical Board.

In another example, a male psychiatric nurse telephoned a female patient at home following her discharge from the nurse's place of employment, to discuss an employment opportunity. They met socially and, according to the consumer, they had sexual intercourse at the nurse's home. The following day, she was admitted to hospital and became (once again) a patient of the nurse concerned.

While the nurse denied being sexually intimate with the consumer, he admitted to making an error in judgement by contacting her at home and inviting her to his home. He knew that the patient's medical conditions made her particularly vulnerable and that she was likely to require further periods of hospitalisation.

The case was referred to the Nurses' Board for disciplinary action.

consent

A fundamental aspect of good patient care is the patient's right to make an informed choice about medical treatment. While consent is essential to good medical practice, the need to gain consent for all but the most minor procedures is also reinforced by the law.

Consent can be written (as for surgery), or implied (as in holding one's arm out to receive an injection). The more 'major' a treatment is, the more information must be given to the patient prior to asking for their consent.

Consent must be informed, voluntary and must cover the act or treatment to be performed. Each of these components of consent will be explored briefly, together

with the implications arising from allegations of lack of consent, which are made to this Office.

1. informed consent

The patient must be told of a) the risk of an adverse event occurring from the treatment and b) the potential level of harm, which may arise from that adverse event.

2. consent must be voluntary

Where an adult has the capacity to give concent, it must be done voluntarily.

The situation becomes more complicated where the patient is a child or where the patient is an incapacitated adult (for instance, someone who has an intellectual disability).

Normally a guardian or next of kin would be able to give consent for medical treatments in these circumstances, and so a consent form should have a brief clause stating in what capacity the person is consenting (as 'self', 'guardian', 'next of kin', for instance).

3. consent must cover the proposed treatment

A patient should not be asked to consent to one treatment, and then receive a different treatment. In such a case, the patient would be deemed to have not given their consent to the procedure which was undertaken, thereby exposing the provider (and their employer) to legal liability, or to a finding by this Office that their conduct was unreasonable.

consent and the office of health review

The Office of Health Review recently dealt with a case that highlights the complexity inherent in the above points. A man presented to a hospital with a bowel hernia, which threatened the viability of his bowel. His condition was serious. The

risks of non-treatment were gangrene, septic shock and death.

The man refused to give consent for an operation. The treating doctor consulted the Duty Psychiatrist by telephone. The Duty Psychiatrist advised that as the patient's life was at risk, it was appropriate to proceed without the consent of the patient, and advised that the man could be treated as an involuntary patient under the Mental Health Act. The wife's consent was accepted, even though the Duty Psychiatrist did not review the man personally.

The Office of Health Review found that, as the man had not been personally assessed, the treating doctor did not have a proper basis under the Mental Health Act to accept the wife's consent.

By proceeding with the surgery without the man's consent, the hospital had left itself open to an action in battery. The fact that medical staff had acted with the very best of intentions did not alter the fact that consent had not been given.

Our Office consulted Crown Law for advice on the likely quantum of damages in such a situation. Crown Law's response highlighted the difficulty in assessing damages. The complainant declined to proceed with conciliation through our Office and we were unable to take the case further.

We pointed out to the hospital, however, the potential legal repercussions of their actions and the fact that damages would

have been very high had the man suffered an adverse outcome from surgery conducted without his consent. We also pointed to the inappropriate reliance on the Mental Health Act in these circumstances.

complaints from indigenous consumers

Aboriginal and Torres Strait Islander people are a small proportion of the population as a whole, although they are frequent users of health services. As noted in last year's Annual Report, indigenous consumers rarely complain about health services, and for that reason, they are among several groups of people in the community that the Office of Health Review tried to reach in 1999-2000.

In August 1999, the Director visited health services and facilities at a number of centres in the Pilbara and Kimberley. He also took the Office of Health Review's message to Aboriginal communities at Tjukaborda and Bidyadanga. As well as visiting mainstream services in these regions, the Director visited the Kimberley Aboriginal Medical Service Council in Broome and the Wirraka Maya Aboriginal Health Service in Port Hedland. He met with Aboriginal health outreach workers from Jarndu Yawru Women's Resource Centre in Broome.

The Director's visit generated considerable interest and led to an undertaking that he would visit more remote communities – including Kalumburu, Kununurra, Fitzroy Crossing, Halls Creek and Warmun, in 2000-2001. The Office's role was explained in radio and local press interviews and the Director spoke on Aboriginal radio about how the Office uses complaints about health services to feed back information that will improve the system as a whole.

Representatives from various health and medical services discuss issues with David Kerslake, Director of the Office of Health Review.

Fourteen complaints to the Office of Health Review in 1999-2000 were from Aboriginal complainants. This is equal to the total number of complaints received from people identifying themselves as indigenous in the previous three years of the Office's existence. Issues this reporting year included inadequate treatment, failure or refusal to provide treatment, unsatisfactory billing practices, unreasonable (rude) behaviour by practice staff, access to medical records and delay in diagnosis.

We are aware that there is still a lot to be done in this area. We hope that, ultimately, complaints from indigenous consumers will reflect their proportion within the wider community as well as their use of health services. Future directions for us to take include a conscious strategy to raise awareness of our Office and of consumers' right to complain, and the appointment of an Aboriginal Liaison Officer, as a first point of contact for indigenous people lodging a complaint.

exercise of formal powers

A key component of the Office's function is the conciliation element of our work. We approach all of our cases from an independent and conciliatory perspective, with an emphasis on resolving disputes through informal negotiation. Our powers of persuasion and persistence usually mean that, if we arrive at a conclusion and make a recommendation in a case, the recommendation will be accepted by the provider. However, we do not have the power to enforce our recommendations. Sometimes this leads to the misconception that we are a "toothless tiger". Most assuredly, this is not the case.

It is worth noting that we have the power to undertake a formal investigation and to report to Parliament on any issues that we feel are in the public interest. Formal investigative powers enable us to access medical records and other documents relevant to an investigation. Reports to Parliament provide an opportunity to highlight matters of public interest and concern. Cases that raise serious questions about the competence or propriety of a health provider can also be referred to the appropriate Registration Board and that Board is then required to investigate the matter.

The Director made a report to Parliament in March 2000 regarding a formal investigation that involved sterilisation without lawful consent. The complaint involved a man with Down Syndrome who had developed a relationship with a woman in his group home. His parents were concerned that the couple were, or were likely to become, sexually active and that they lacked the capacity to care for a child born into the relationship. The man's parents took him to a general surgeon who performed a vasectomy. Both the man and his mother signed the consent form. The man's brother lodged the complaint because he felt that his brother lacked the capacity to make an informed decision on the procedure. He was concerned that the surgeon had not complied with the requirements of the Guardianship Act.

Our investigation confirmed that the consumer lacked the capacity to understand the sterilisation procedure. We also found that the surgeon had failed in his legal obligation to satisfy himself that the man was capable of consenting to the

procedure. He should not have performed the procedure if the consumer was unable to understand its nature and ramifications.

The purpose of the report to Parliament was to encourage awareness of the law and to draw attention to certain limitations in the Guardianship Act as it is presently drafted. We felt that the legal framework was too narrow to provide adequate protection to consumers in these circumstances. The consumer in this instance does not have an appointed Guardian, and, accordingly, the surgery could not be sanctioned under the provisions of the Guardianship Act, as those provisions only apply to "represented persons". The Director alerted Parliament to the need to expand the existing law in this area. This matter was reported on in the press and the Director is still working with the Medical Board, the Australian Medical Association and the Medical Defence Association on informing providers of their responsibilities in this area.

In cases where we feel that a medical provider has acted unreasonably and that disciplinary action might be appropriate, we obtain the consent of the complainant and refer the matter to the Medical Board, with the recommendation that they investigate the matter.

In 1999-2000, 7 complaints against doctors were referred on to the Medical Board. Of these, some doctors were counselled, and other cases are still being investigated. In one such case the doctor, Mr John Schulz, was found to have been grossly careless in the treatment of one patient, and grossly careless and negligent in the treatment of another patient. The outcome was that he was excluded from all forms of medical practice, other than that undertaken as part of a training program in a teaching hospital, and was required to undertake training that was acceptable to the Board.

The opportunity that the Office of Health Review has to identify and refer appropriate cases to Registration Boards is beneficial to the overall health system. This is particularly so where there are multiple complaints about a provider, as the relevant Board can review the practitioner's professional competency if necessary.

case studies

The Office of Health Review satisfactorily resolved almost 1400 cases in the last year. In many cases, consumers' concerns have resulted in changes to policies and procedures, costs refunded or accounts waived, compensation awarded or additional services obtained. There were also numerous occasions where an apology or explanation was given to the consumer, and in some cases, a compromise was reached between the consumer and the health service provider. The following case studies are representative of the broad range of complaints received by the Office this reporting year.

compensation granted

Conciliation can often resolve matters without consumers having to take legal action.

In one case, a young woman complained that she attended emergency surgery and was diagnosed with an inflamed gall bladder that required surgery. She was admitted for laparoscopic surgery and advised that she might have surgery the next day, so she was fasted. The following day, surgery was cancelled as the hospital ran out of theatre time. She was kept in hospital and treated for pain during the following day (day three). The next day she was again fasted, but surgery was again cancelled. On the fifth day, her surgery was again cancelled. She continued to be managed for pain and underwent some investigation. She was discharged on day nine and placed on the waiting list for surgery. One week post discharge, she presented to the Emergency Department and was again admitted for surgery, but no date was fixed. On the fifth day after this admission, she developed pancreatitis and underwent open surgery.

Complete healing took several months and the woman suffered ongoing internal pain.

Our investigation revealed that at the first presentation to Emergency, the woman's condition was considered serious enough by the medical officer to warrant admission and surgery. The hospital suggested that the surgery did not take place as more urgent cases were given the theatre time available, but they could not provide any evidence to support this decision.

Given the initial decision that the woman required surgery, and that the hospital could not substantiate their decision making process, their patient management regarding the surgery was considered unreasonable. The outcome, in addition to the ongoing medical management, was a payment to recoup her costs and compensate for the pain and suffering.

Another woman lodged a complaint with this office alleging the failure of a hospital Emergency Department to diagnose her husband's condition. He was taken to the hospital by ambulance, after a collapse at home. He had also been experiencing severe headaches for days.

The man was examined at the hospital and some hours later his wife was advised that the headache was due to a neck problem and anti-inflammatories with paracetamol would be sufficient treatment. Her husband was discharged and after two hours at home, he again collapsed and was taken by ambulance to another hospital where he was diagnosed with a brain tumour and admitted for surgery.

Following our investigation, it was acknowledged that other possibilities should have been considered. The treating doctor had not taken the appropriate steps of referral that would have enabled the man to be observed in a hospital environment for a period of time which would have led to a diagnosis of his pathology slightly earlier. It would also have made the second ambulance trip unnecessary.

The treating doctor also acknowledged that he should have listened to what the family told about the patient's symptoms. In addition to this action, the hospital agreed to reimburse the patient's medical fund for the cost of the second ambulance trip.

referral to registration boards

Sometimes there is a need to refer matters for further investigation. For example, a man had kidney stones and was admitted to hospital for treatment. He was under the care of an urologist. He passed two stones and underwent surgery. Following the surgery he was discharged. Some days later the urologist's rooms called the man and asked him to come in to have his stent removed. He told the receptionist that he did not have a stent. The urologist told his receptionist that the man did have a stent inserted and that he needed to come in to have it removed.

When the patient came in for the appointment, he restated to the urologist that a stent had not been inserted. The urologist was adamant and went ahead with the procedure to remove the stent, which involved inserting an implement into the man's urethra. The urologist did not locate a stent and continued to search using the implement for some time. The patient became uncomfortable. The urologist then sent the patient to have an x-ray to determine where the stent was. The x-ray clearly showed that no stent had been inserted. The patient was concerned that the urologist did not listen to him when he insisted that no stent had been inserted. He was concerned that he underwent a painful procedure unnecessarily.

The urologist informed this office that he always inserts a stent when a patient has passed a kidney stone. He notes this and asks the patient to return to have the stent removed. In this instance the stent was not noted in the medical record. However, because the urologist "always" inserts a stent, he went ahead with the attempted removal anyway.

We obtained an opinion from another urologist. The advice we received was that a stent is not required in all cases, so the urologist did not err by not inserting a stent in this instance. The urologist did advise, however, that the procedure to search for and remove a stent can be very intrusive and uncomfortable. A more appropriate and less obtrusive way to determine whether or not a stent had been inserted would have been to arrange an x-ray for the patient first.

We felt that the urologist acted unreasonably in not listening to the patient and in not recording that a stent had not been inserted. The matter was referred to the Medical Board of Western Australia.

systemic complaints

As referred to in the Director's foreword, an effective complaints system not only deals with individual complaints but also identifies problems or issues at an organisational level and feeds this information back through the organisation concerned to ensure continuous improvement of service delivery.

When systemic issues are identified it is the role of this Office to recommend, to the appropriate body or organisation, changes to remedy the problem so that the health or disability service can be improved. The examples below show the benefits of identifying systemic issues.

A woman complained on behalf of her father, who had passed away. The man had presented to the Emergency Department of a large public hospital with blood in his urine. He was assessed and diagnosed with bladder cancer and referred for urgent radiotherapy. He was told he would receive an appointment time in the mail and that the treatment should start within a week of discharge. The man never received an appointment time and the radiotherapy never took place. He tried to contact the hospital several times. When he returned to the hospital one month later for a urology check-up, they noted that the radiology appointment had not been made and arranged another urgent referral. The man suffered a heart attack and died while waiting for this appointment.

The hospital explained that the first referral for radiotherapy had been made, but it did not reach the radiation oncology department because of a breakdown in communication. They acknowledged that they should also have made a specific appointment time with the patient when it was discovered after a month that he had received no radiotherapy.

As it turned out, the delay in treatment had made no difference to the man's prognosis. We were concerned, however, that the referral system was inadequate. The hospital explained that a referral is written and pinned to the front of a patient's file, which is then forwarded to the appropriate department. They acknowledged that the referral could be misplaced at any stage in the process, as it passes through so many departments.

We spoke to other hospitals about their referral systems. One hospital makes referrals by telephone, which means that the referring department is reassured that the other department is aware of the patient. Another hospital had a policy of telephoning the department in addition to making a written referral. The Emergency Department can also arrange an appointment "on the spot" for a patient by telephoning the other department.

We contacted the Metropolitan Health Services Board and recommended that they review procedures across the board to ensure a fail-safe referral process. The Board is currently looking into this matter.

In another case, a woman complained about the proposed transport for her baby and herself from a maternity hospital to a smaller hospital to which she was returning after the birth. She was initially asked to drive herself and the baby in her own car. She had had a caesarean section two weeks previously and, as the baby was still less than 2 kg, it was too small to be safely strapped into the baby capsule. She was advised by the hospital that there was no hospital transport available and it was not permissible for a staff member to travel in her car in the back seat to look after the baby while she drove.

The woman said that staff advised her it is common practice for babies to be transported by a parent when being

transferred to other hospitals, provided that the treating doctor gives explicit permission.

Information from other hospitals did not support this practice. Although there was some variation across the three hospitals that were consulted, it was apparent that transport by a parent in a private car is not the norm in such circumstances. The hospital agreed to our recommendation that the policy be revised.

Another woman complained that she had taken her 4-year-old son to her GP following a fall. The GP referred her to the Emergency Department of a large hospital. The child was sent to have x-rays. The specialist advised there were no fractures and the child had a 'pulled elbow'. The mother questioned the specialist, who had another look at the x-rays and again stated there was no fracture. The specialist then attempted to 'reduce' the child's elbow. This was extremely painful for the child. The specialist left and returned a little later to try to 'reduce' the elbow again. The child was again screaming and the procedure was unsuccessful. The parents again questioned if there was a fracture and the specialist looked at the x-ray a third time and again said there were no fractures. The child's arm was placed in a sling and they were sent home.

The child continued to cry all night despite analgesia. The woman made an appointment for her child to see the GP the next day and rang the hospital to arrange to collect the x-rays. At the hospital she read the report of the x-rays that stated there was a fracture and slight deformity. The woman then arranged to speak with the Director of Emergency Medicine. He arranged for the same specialist to come down and set the arm. This was upsetting to the woman and the child. The specialist did not apologise and the woman felt he made inappropriate comments about his error. The woman talked her child into letting the specialist treat the arm. The child is now afraid of doctors.

We sought the opinion of a paediatric orthopaedic surgeon. He advised that the history and symptoms did not fit that of a pulled elbow, but clearly suggested a fracture. The appropriate treatment was a collar and cuff or sling to immobilise the elbow. No attempt should have been made to manipulate the elbow as this would not have affected the outcome and would have exacerbated the child's pain.

These findings were communicated to the hospital and strongly reinforced with the staff involved. The x-ray process was reviewed, as there were concerns within the hospital about existing procedures. This Office was provided a copy of their new procedures.

case studies

incorrect diagnosis

The importance of a correct diagnosis is highlighted in the following case. A woman complained to this office as she felt that her son was not assessed and managed appropriately after a motor vehicle accident. The boy was taken to the hospital by ambulance and treated for a possible broken shoulder and elbow, as well as abrasions. He was discharged the same day. That evening the boy showed signs of concussion, no memory of the event and ongoing memory loss. This was confirmed by the GP the next day. The woman was concerned that her son was discharged after only 2 hours at the hospital, that she had to ask the nurse to clean his wounds and that they could not diagnose the fracture.

The ambulance and hospital records showed no gross neurological deficit. An x-ray indicated a fracture. It was noted the boy had been wearing a helmet and that he had hit the windscreen of the car. The possibility of head injury was considered but on discharge the mother was not given any information about signs to watch out for.

The hospital responded that the boy did not lose consciousness and was fully lucid and orientated. The combination of no loss of consciousness, no obvious head injury and the fact that he did not exhibit any alteration in his conscious state, or any neurological disturbance, indicated there was no need to keep the boy under observation. The hospital did misread the x-ray. The boy did have a fracture but in a different area from that diagnosed.

Our investigation confirmed that suspected head injury cases should be carefully observed for a minimum of twenty-four hours. Where there is known concussion, i.e. where the head injury has resulted in a transient loss of consciousness, the patient should be observed in hospital. We also found that the hospital had failed to check the boy's memory of the event. If amnesia had been detected a CT scan should have been done and the mother given head injury advice. We recommended that the hospital's neurological assessment procedures be revised and that the lessons from this case be drawn to the attention of Emergency Department medical staff.

the role of the office of health review as 'honest broker'

Negotiations with providers on behalf of the consumer can achieve positive outcomes for everyone. In one case, a man came home late at night, in an intoxicated state, and fell asleep outside his house. A neighbour called an ambulance. Ambulance officers woke the complainant and took him inside the house. The ambulance service sent an account for $315 to the man. On appeal, the account was reduced to $215. The man still felt he should not have to pay because he did not require or receive any service from the staff who attended him. He was seeking to have the account waived.

During the assessment of this case, the complainant said he was prepared to make a $50 donation to the ambulance service in lieu of payment of the account. The ambulance service accepted this offer and the case was closed. In closing the case, we thanked the consumer and the provider for the conciliatory approach they took to the case.

Another man complained to the Office about an account he received from an anaesthetist. The man was privately insured and required a particular procedure at yearly intervals. The man, who was in his 50s, had had the procedure every year for almost thirty years. He had been

treated by the same surgeon and anaesthetist for the last several years, and as a result was charged a minimal amount above the gap, after the Medicare and private health insurance rebates. In 1999, his regular anaesthetist was not available so his surgeon arranged for a different anaesthetist to be involved. This anaesthetist charged the man the AMA recommended fee and the gap payment required was much larger than the complainant expected.

In his defence, the complainant argued that he had tried to contact the anaesthetist prior to the procedure, to ask about fees, and said that if he had known how large the gap was, he would have picked a different anaesthetist.

The anaesthetist responded in a positive manner and checked with his receptionist to see if any inquiry calls from the man had been noted. No calls had been noted, but the anaesthetist said he was part of a large office with ten practitioners and therefore he appreciated that is was possible the man may have spoken to a different receptionist, and as a result was not given the information he was seeking. Although his fee was reasonable, and he did not feel that he was in the wrong, the anaesthetist said he thought the complainant's manner was also reasonable, and he was therefore quite willing to negotiate a compromise. An officer from the Office of Health Review facilitated a mutually satisfactory outcome in which the patient paid a reduced gap to finalise the account.

communication

Communication issues lie at the heart of many complaints. An Aboriginal family complained about the inadequacy of information provided to patients about hospital admissions. The patient – the wife – was sent a letter advising of an 'admission' date and time. When she

arrived at the hospital she was sent to a hostel for accommodation and saw the doctor the next day. The hostel charged a nominal amount for accommodation and meals, but this was not explained to patients. In this particular case, the woman did not have enough money with her to pay the hostel. If the hospital had advised of the charge earlier, accommodation could have been arranged with other family members.

The hospital advised that the reason they use the hostel is to save patients the trouble of finding their own accommodation, and so that patients are available for any pre-admission treatment that may be required. In this case they accepted the amount of money she had at the time and did not pursue the matter. The fact remained, however, that the patient had been denied the right to make decisions for herself.

The hospital agreed to incorporate more information in letters to patients. The individual case was resolved at a meeting arranged between the hospital and the family.

explanation given

In some instances, reassuring the consumer that the treatment provided was appropriate can lead to a satisfactory resolution. A consumer complained to this Office that she had been admitted as an involuntary patient to a rural public hospital, and that she had been transferred to a hospital in Perth via Royal Flying Doctor Service, against her will.

We obtained all relevant medical records and sought independent advice on the medical issues raised by the complaint. Medical evidence suggested that the consumer had been assessed as an 'at risk' patient and that was the reason for the involuntary admission and transfer. An independent psychiatrist advised this Office that there was sufficient information for the doctor to make the clinical decision that the consumer was at risk. Our advice also suggested that being in a rural and remote area brought with it particular difficulties, as the nearest mental health facility for such patients was often in Perth, thereby necessitating a transfer of the patient to appropriate facilities.

The transfer and medication were found to be appropriate in all the circumstances and the complainant was reassured by these findings.

disability complaints

We have noticed in working on disability complaints that there is a stronger emphasis on policy issues than we find in health complaints. Following are some examples of the disability service complaints we have dealt with.

A man complained on behalf of his brother who required a wheelchair. The brother had received funding for the wheelchair, but had ordered accessories, such as a conversion kit and a programmer that are not considered essential. For that reason, he was left with an account from the wheelchair manufacturer for these accessories that amounted to $1500. The man felt that the funding program should cover these accessories.

We confirmed that the funding program has finite resources and demand always exceeds supply. Because the program has so many clients, they can only allocate funds for wheelchairs and standard, essential accessories. We concluded that the program's approach was reasonable in the circumstances and that, unfortunately, the client was responsible for purchase of additional items.

A further complaint involved a woman with a disability who required care to enable her to continue living in her own home. Her husband, who also had a disability, provided some of this care. Funding from two agencies provided the rest of the care. The first agency gave the complainant funding with which she purchased care from private individuals. The second agency provided direct care, in the sense that staff from that agency attended at the complainant's home.

A variety of difficulties led the second agency to withdraw the services of its staff, and to provide its funded hours to the first agency. This funding was then provided to the complainant, so that she could negotiate directly with private individuals for those hours.

The complainant was concerned that the delegation of these funded hours was due to expire on 30 June 2000, and that there did not appear to have been any alternative put in place. She would therefore lose those hours of care, which she could not physically or emotionally afford to do. In addition, this would put extra strain on her partner, to provide that extra care.

A representative from this Office met with both agencies to discuss the complainant's concerns. The second agency provided us with a copy of correspondence between themselves and the complainant and her husband, outlining the difficulties in providing services and the reasons for withdrawing services.

Our investigation revealed that the first agency had organised for the complainant's husband to be assessed separately and that an application for funded hours solely for him was proceeding. In addition, that agency undertook to develop a professional care plan, with input from the complainant and her husband, which could be kept on file and then reviewed each year, or as needs changed. The complainant was reassured that the funding arrangement would continue at the current level (that is with no drop in funding hours on 30 June). Finally, the second agency undertook to consider reviewing whether their staff could provide services directly to the complainant, and what would need to occur for this to happen. This Office agreed to follow up with the agencies at an appropriate later date to ensure that the promised arrangements had been put in place.

operational report

outcome

To resolve complaints about health and disability services by providing systems for dealing with complaints and improving practices and actions of health and service providers.

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	1999/2000	1998/1999
a) Cost per finalised complaint (based on the accrual costs for the period 1 July 1999 to 30 June 2000.	**$565**	**$682**
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).	**103 days**	**85 days**
effectiveness indicators		
a) Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendation.	**46**	**57**
b) Percentage of complaints finalised this financial year. (The percentage of complaints closed reflects the overall effectiveness of the OHR in dealing with a complaint).	**98%**	**91%**

national health complaints information project

As discussed in the Director's foreword, this Office has continued to contribute to the National Health Complaints Information Project (NHCIP) through its membership of the Data Reference Group. The ongoing compilation of data, and a National Workshop "Achieving Change in Practice" has led to substantial progress being made in identifying national issues, categories and individual provider classifications. The ongoing role of this Office in this Project will be vital in improving health services throughout Western Australia.

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.

complainants

Complainants who responded were very happy with the service provided by the Office of Health Review. 80% of complainants who responded said that staff were very prompt in responding to letters and phone calls, 93% said that staff were very polite in dealing with them, 88% said that the staff listened very well to what they had to say, and 85% said that staff explained the complaints handling process very clearly. Overall, 78% indicated that they were satisfied or very satisfied with the Office of Health Review.

Some comments from complainants:

"I was very happy with the whole complaints procedure."

"The service you provide is excellent. At no time did I feel embarrassed, considering the nature of the complaint."

"Just keep up the good work that you are doing. It's nice to know people still care and understand."

"I was really amazed with the help and service I received from the Office of Health Review. I can't see any way to improve it – it's an excellent organisation."

providers

Provider responses were also very positive. 81% of providers who responded indicated that they were satisfied or very satisfied with the outcome of the complaint. This is an upward trend from last year where 77% of providers responded this way. 90% said that the staff were very prompt in responding to letters and telephone calls, 97% indicated that staff were very polite in dealing with them and 88% said that staff listened very well to their comments and explanations.

Over 85% of providers felt that staff dealt with the complaint efficiently, and overall, 87% of providers were satisfied with the manner in which the complaint was handled. 82% of the providers said they would feel comfortable about undertaking the process again.

Here are some comments that indicate the level of satisfaction with the Office that providers have:

"*Thank you for your most professional, efficient and fair handling of the case to all concerned"*

"I thank you for your help and "professionally nice" manner.

Your staff have the patience of saints and I think you do a very good job."

"Thank you for applying the basic principles of common sense and fair play."

"I was very impressed with your patience and trouble taken to explain details to the patient."

outcomes

Feedback on how satisfied complainants were with the outcome indicated that 50% of complainants were satisfied or very satisfied. This appears to be linked to whether the complainants achieved the outcome they were seeking. Only 31% of complainants were dissatisfied with the outcome. 19% of the respondents chose not to comment on the outcome. As the Office of Health Review has the legislative role of improving the health system, by the impartial resolution of complaints, the feedback from both providers and complainants indicates that the Office is very effective in achieving its objectives.

The overall satisfaction levels have increased this financial year, which confirms that client comments are acted upon, and ongoing monitoring ensures that the Office of Health Review continues to provide an efficient service for complainants and providers.

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 health and disability services better, through the impartial resolution of complaints.

objectives

To resolve complaints about health and disability 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.

In the 1999-2000 financial year, the Disability Services Act was amended to bring complaints about disability services under the jurisdiction of the Office of Health Review. The Equal Opportunity Commission had previously dealt with these matters.

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 2000.

Under s.56 of the Act, the Director may make reports to Parliament or at the request of Parliament. No reports were requested by Parliament. The Director did report to Parliament on a case relating to the sterilisation of a man with an intellectual disability. A copy of this report is available on request.

administrative

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

The Office of Health Review staff numbered 10 as at 30 June 2000. There were 10 staff at the same time last year.

The position of Assistant Enquiries Officer was appointed as was the position of Receptionist/Clerical Officer.

workers compensation

No workers compensation claims were made in 1999-2000.

occupational health and safety

An Occupational Physiotherapist visited the Office of Health Review in the financial year 1999-2000 and discussed physical requirements of staff. She made recommendations and suggestions to staff in relation to ergonomic needs. This action was taken in an effort to increase safety for staff in the workplace and thereby reduce the potential for workers compensation claims.

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 was 1 claim lodged against our Office for breach of Public Sector Standards in 1999-2000. However, the review outcome was that no breach was found.

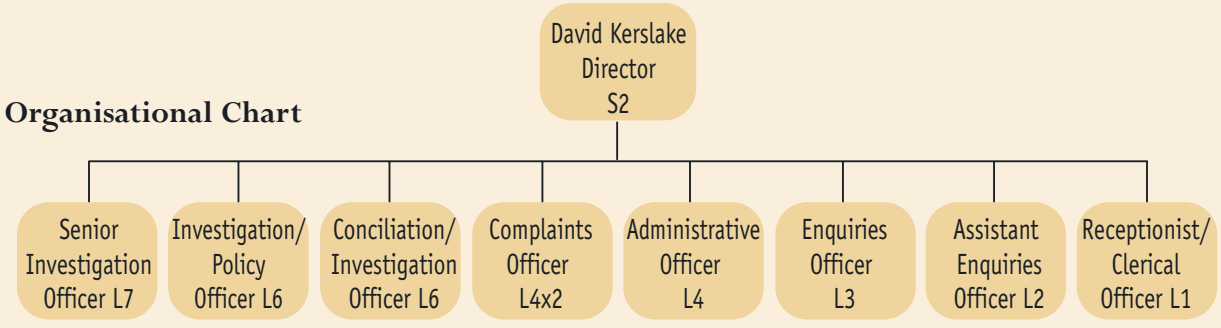
promotions, publications and research

(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 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

Organisational Chart



of promotional activities during the 1999-2000 financial year. These included a multicultural evening, a stall at the Carers' Fayre, run by the Carers' Association of Western Australia, articles about our office in provider and consumer publications and several presentations to provider, consumer and community 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 2000.

advertising and sponsorship

The Office of Health Review did not produce any advertising material in excess of $1500 in the 1999-2000 financial year. We placed an advertisement in the "Market Place" section of the Carers' Association newsletter for which we paid $100 to the Carers' Association of WA.

anti-corruption commission

There was no matter which required reporting to the Commission in 1999-2000.

report on equity, access and customer focus

disability services plan

The office has a Disability Services Plan that has been approved by the Disability Services Commission. The staff of the Office of Health Review are aware of the potential problems facing clients with a disability in terms of accessing the office and information about the office. The staff have been encouraged to be flexible with regard to the needs of these clients.

In line with our new responsibilities for disability services complaints, the Office has adopted a policy of making all publications available in audio, large print and braille, on request.

evaluations

There were no evaluations undertaken by the Office of Health Review in 1999-2000.

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 1999-2000 financial year, the Office received 9 Freedom of Information requests, all of which were for personal information. Of the nine requests, eight received edited access and one application received access in full. There were no internal reviews and no amendments.

The average time to process applications was 30 days.

customer focus outcomes

In the last financial year, the office has taken several steps to increase awareness of our existence. In association with the Library and Information Service of WA, there are now posters promoting the Office in all public libraries. The Director visited the Pilbara and Kimberley regions last financial year and met with representatives from Aboriginal communities in the area. He also featured on ABC and Aboriginal radio in remote areas.

The Office held a Harmony Day function in an effort to increase awareness of the office with multicultural communities. As a consequence of this function, overtures have been made to ethnic radio stations to promote our work.

The Office had a stall at the Carers' Fayre held in November 1999, which helped inform people with disabilities and their carers of the existence and function of the Office.

Several staff members participated in Panel discussions at the Health Consumers' Council conference in August 1999.

family and domestic violence plan outcomes

The Office has nothing to report against this requirement.

plan for women outcomes

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

equal employment opportunities outcome

Staff at the Office of Health Review numbered 10 on 30 June 2000. There were nine women and one man. Two main ethnic groups are represented in the staff, with one member of a minority ethnic group.

language services outcome

The Language Services strategy has been implemented in the Office and we have signage to advise of the availability of translation services. Several staff members have used interpreters in dealing with people from culturally and linguistically diverse backgrounds.

training

Staff have attended a number of training sessions in the last financial year, including courses on dealing with difficult people, workplace relations, career management for middle managers, administrative law, issues in insurance litigation, legal professional privilege, no fault liability schemes, conciliation, women in public sector management and how to chair a meeting.

Staff also attended seminars and conferences on Equal Employment Opportunity, Mental Health Services, the Guardianship and Administration Act, Strategies for Youth at Risk, Freedom of Information, GST, Y2K Contingency Planning and various computer courses.

certification of performance indicators

I hereby certify that the Performance Indicators on page 24 are based on proper records and fairly represent the performance of the Office of Health Review for the financial year ending 30 June 2000.

David Kerslake
Director
Accountable Officer
30 August 2000

opinion of the auditor general

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2000

Scope

I have audited the key effectiveness and efficiency performance indicators of the Office of Health Review for the year ended June 30, 2000 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 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, 2000.

D D R PEARSON
AUDITOR GENERAL
November 3, 2000

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 2000 and the financial position as at 30 June 2000.

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
Director
Accountable Officer

30 August 2000

Wade Starkie
Principal Accountable Officer

30 August 2000

opinion of the auditor general

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2000

Scope

I have audited the accounts and financial statements of the Office of Health Review for the year ended June 30, 2000 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 so as to present a view which is consistent with my understanding of the Office's financial position, the results of its operations and its cash flows.

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 and expenditure of moneys 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 financial position of the Office at June 30, 2000 and the results of its operations and its cash flows for the year then ended.

D D R PEARSON
AUDITOR GENERAL
November 3, 2000

statement of financial position

As at 30th June 2000

	Note	2000 $	1999 $
CURRENT ASSETS			
Cash resources	8	357,399	191,151
Total current assets		357,399	191,151
NON-CURRENT ASSETS			
Plant and equipment	9	64,403	69,262
Total non-current assets		64,403	69,262
Total assets		**421,802**	**260,413**
CURRENT LIABILITIES			
Accounts payable	10	3,664	4,829
Accrued salaries	11	11,546	8,036
Employee entitlements	12	46,592	46,229
Total current liabilities		61,802	59,094
NON-CURRENT LIABILITIES			
Employee entitlements	12	45,385	27,103
Total non-current liabilities		45,385	27,103
Total liabilities		**107,187**	**86,197**
Net assets		**314,615**	**174,216**
EQUITY			
Accumulated surplus		314,615	174,216
Total equity		**314,615**	**174,216**

statement of cash flows

For the year 30th June 2000

	Note	2000 $ Inflows (Outflows)	1999 $ Inflows (Outflows)
CASH FLOWS FROM / (TO) GOVERNMENT			
Recurrent appropriations	5	872,000	851,000
Net cash provided by government		872,000	851,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Payments to suppliers		(192,383)	(170,452)
Payments to employees		(500,763)	(482,476)
		(693,146)	(652,928)
Receipts			
Other receipts		0	137
		0	137
Net cash used in operating activities	13	(693,146)	(652,791)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	9	(12,606)	(28,690)
Proceeds from sale of non-current assets	3	0	4,600
Net cash used in investing activities		(12,606)	(24,090)
TOTAL CASH FLOWS FROM OPERATING AND INVESTING ACTIVITIES		**(705,751)**	**(676,881)**
Net increase in cash held		**166,249**	**174,119**
Cash at the beginning of the reporting period		191,151	17,032
Cash at the end of the reporting period	8	357,399	191,151

operating statement

For the year 30th June 2000

	Note	2000 $	1999 $
COST OF SERVICES			
Operating Expenses			
Salaries and wages		522,917	508,161
Superannuation		35,827	32,989
Workers compensation insurance		9,016	2,744
Supplies and services		30,104	24,786
Communications		16,709	14,591
Repairs, maintenance and consumable equipment		52,564	63,145
Other administrative expenses		104,715	92,134
Depreciation	2	17,465	17,510
Net loss on disposal of non-current assets	3	0	9,648
Total operating expenses		789,317	765,708
Revenues from Services			
Other operating revenue	4	0	137
Total revenues from services		0	137
Net cost of services	13	789,317	765,571
REVENUES FROM GOVERNMENT			
Recurrent appropriation	5	872,000	851,000
Liabilities assumed by the Treasurer	6	35,827	31,606
Resources received free of charge	7	21,889	20,773
Total revenues from government		929,716	903,379
Change in net assets resulting from operations		140,399	137,808
ADD: Opening balance of accumulated surplus		174,216	36,408
Closing balance of accumulated surplus		314,615	174,216

notes to the financial statements

For the year 30th June 2000

Note 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 previous year.

(a) General

The financial statements constitute a general purpose financial report which has been prepared in accordance with Australian Accounting Standards and Urgent Issues Group (UIG) Consensus Views as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary 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 are disclosed in individual notes to these financial statements.

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention.

(b) Acquisition of Non-current Assets

Items have been included as property, plant and equipment if the cost of acquisition is $1,000 or more and the useful life is expected to be two years or more.

(c) Leases

The Authority has entered into a number of operating lease arrangements for the rent of motor vehicles where the lessors effectively retain all of the risks and benefits incident to ownership of the items. 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 items.

The Authority has no contractual obligations under finance leases.

(d) Depreciation of Non-current Assets

All non-current assets having a limited useful life are systematically depreciated over their useful lives in a manner that reflects the consumption of their future economic benefits.

Depreciation is provided for on the reducing balance basis, using rates which are reviewed annually. Useful lives for each class of depreciable assets are:

Computer equipment	5 years
Furniture and fittings	7 to 40 years
Other plant and equipment	5 to 25 years

(e) Accounts Payable

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

(f) Accrued Salaries

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.

(g) Employee Entitlements

i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Authority has a present obligation to pay resulting from employees' services up to the reporting date. The liability has been calculated on current remuneration rates and includes related on-costs.

The liability for long service leave represents 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, when assessing expected future payments, to expected future wage and salary levels including related on-costs, experience of employee departures and periods of service. Expected future payments are discounted using interest rates attaching to national government securities to obtain the estimated future cash flows.

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 Gold State Superannuation Scheme, a defined benefit lump sum scheme now also closed to new members. All staff who do not contribute to this scheme become non-contributory members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992.

The liabilities for superannuation charges under the Gold State Superannuation Scheme and West State Superannuation Scheme are assumed by the Treasurer.

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 Authority. Accordingly, deriving the information for the Authority is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

(h) Recognition of Revenue

Revenue from the disposal of assets and the rendering of services, is recognised when the Authority has passed control of the assets or has delivered the services to the customer.

(i) Appropriations

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

(j) Resources Received Free of Charge or For Nominal Value

Resources received free of charge or for nominal value which can be reliably measured are recognised as revenues and as assets or expenses as appropriate at fair value.

(k) 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).

(l) Comparative Figures

Comparative figures are, where appropriate, reclassified so as to be comparable with the figures presented in the current reporting period.

	2000 $	1999 $
Note 2 Depreciation		
Computer equipment and software	12,918	12,248
Furniture and fittings	925	1,000
Other plant and equipment	3,622	4,261
	17,465	17,510
Note 3 Net loss on disposal of non-current assets		
a) Proceeds on sale of non-current assets		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash	0	4,600
Gross proceeds on sale of non-current assets	0	4,600
b) Loss on disposal of non-current assets:		
Computer equipment and software	0	9,648
	0	9,648
Note 4 Other operating revenue		
Freedom of Information Act Fees	0	137
	0	137
Note 5 Government appropriations		
Recurrent appropriation	872,000	851,000
Total appropriation revenue	872,000	851,000
Note 6 Liabilities assumed by the Treasurer		
Superannuation	35,827	31,606
Note 7 Resources received free of charge		
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	15,000	19,000
Crown Solicitor's Office		
- Legal services	6,889	1,773
	21,889	20,773

	2000 $	1999 $
Note 8 Cash resources		
Cash on hand	400	400
Cash at bank - general	356,999	190,751
	357,399	191,151

For the purpose of the Statement of Cash Flows, cash includes cash on hand, cash advances and cash at bank. Cash at the end of the reporting period as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as above.

Note 9 Plant and equipment		
Computer equipment and software		
At cost	63,282	55,690
Less accumulated depreciation	(35,832)	(22,914)
	27,450	32,776
Furniture and fittings		
At cost	20,091	15,077
Less accumulated depreciation	(3,663)	(2,738)
	16,428	12,339
Other plant and equipment		
At cost	35,269	35,269
Less accumulated depreciation	(14,743)	(11,121)
	20,526	24,148
Total of plant and equipment	64,403	69,262
Payments for non-current assets		
Payments were made for purchases of non-current assets during the reporting period as follows:		
Paid as cash	12,606	28,690
Gross payments for purchases of non-current assets	12,606	28,690

Note 10 Accounts payable		
Accounts payable for goods and services received	3,664	4,829

The Authority considers the carrying amounts of accounts payable approximate their net fair values.

	2000 $	1999 $
Note 11 Accrued salaries		
Amounts owing for:	11,546	8,036
6 working days from 23 June to 30 June 2000		
(1999: 4 working days from 25 June to 30 June 1999)		
Accrued salaries are settled within a few days of the end of the reporting period. The Authority considers that the carrying amount of accrued salaries is equivalent to the net fair value.		
Note 12 Employee entitlements		
Current liabilities:		
Liability for annual leave	45,644	30,822
Liability for long service leave	948	15,407
	46,592	46,229
Non-current liabilities:		
Liability for long service leave	45,385	27,103
	45,385	27,103
Total employee entitlements	91,977	73,332
The Authority considers the carrying amount of employee entitlements approximates the net fair value.		
Note 13 Reconciliation of net cash flows used in operating activities to net cost of services		
Net cash used in operating activities (Cash Flow Statement)	(693,146)	(652,791)
Decrease / (increase) in accounts payable	1,166	(4,829)
Decrease / (increase) in accrued salaries	(3,510)	0
Decrease / (increase) in employee entitlements	(18,645)	(28,413)
Non-cash items:		
Depreciation	(17,465)	(17,511)
Loss on disposal of non-current assets	0	(9,648)
Superannuation liabilities assumed by the Treasurer	(35,827)	(31,606)
Resources received free of charge	(21,889)	(20,773)
Net cost of services (Operating Statement)	(789,317)	(765,571)

	2000 $	1999 $

Note 14 Remuneration of accountable authority and senior officers

The total fees, salaries and other benefits received or due and receivable for the reporting period by Senior Officers and members of the Accountable Authority, from the statutory authority or any related body. 136,445 128,209

The number of Senior Officers and 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:

	1999/00	1998/99
$120,001 - $130,000	0	1
$130,001 - $140,000	1	0
Total	1	1

Note 15 Retirement benefits

In respect of Senior Officers and members of the Accountable Authority, the following amounts were paid or became payable for the reporting period:

Notional contributions to Gold State Superannuation Scheme and West State Superannuation Scheme 8,466 8,384

Note 16 Remuneration of auditor

Notional fees for external audit services provided by the Auditor General are: 15,000 19,000

(Refer note 7)

Note 17 Explanatory statement

a) Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.

Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10% or $40,000.

Note 17 Explanatory statement continued

	1999/00 $	1998/99 $	Increase/ (Decrease) $
EXPENDITURE			
Workers Compensation Insurance:	9,016	2,744	6,272
A refund from overcharging for workers compensation premium was received in 1998/99 year. The original premium was charged at the hospital rate but was subsequently changed to the government department rate.			
Supplies and Services:	30,104	24,786	5,318
Increase mainly due to additional administrative and clerical services contracted to provide relief for vacant positions.			
Repairs, Maintenance and Consumable Equipment:	52,564	63,145	(10,581)
Decreased costs for building leases and motor vehicle leases.			
Net Loss on Disposal of Non-Current Assets:	0	9,648	(9,648)
There were no disposals of assets during the year.			

b) Significant variations between estimates and actual results for the financial year.

Section 42 of the Financial Administration and Audit Act requires the Authority 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 those greater than 10% of budget or $89,000.

	1999/00 Actual $	1999/00 Estimate $	Variation $
Net Cost of Services	789,317	890,000	(100,683)

Salaries and wages are lower than the estimates due to delay in filling vacant positions.

Note 18 Expenditure commitments

	2000 $	1999 $
Operating lease commitments:		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	8,753	33,093
Later than one year, and not later than five years	0	7,952
	8,753	41,045

Note 19 Output information

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.

Note 20 Additional financial instruments disclosures

a) Interest rate risk exposure

The following table details the Authority's exposure to interest rate risk as at the reporting date:

As at 30th June 2000	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
Financial Assets							
Cash resources	0.00%	357					357
		357	0	0	0	0	357
Financial Liabilities							
Accounts payable						4	4
		0	0	0	0	4	4
Net financial assets (liabilities)		357	0	0	0	(4)	353
As at 30th June 1999							
Financial Assets							
Cash resources	0.00%	191				0	191
		191	0	0	0	0	191
Financial Liabilities							
Accounts payable						5	5
		0	0	0	0	5	5
Net financial assets (liabilities)		191	0	0	0	(5)	186

b) 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 agency's maximum exposure to credit risk in relation to those assets.

Estimates of Expenditure for 2000/2001

The following Estimates of Expenditure for the year 2000/2001 are prepared on an accrual 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 2000/2001 do not form part of the preceding audited financial statements.

Revenue	**2000/2001**
Consolidated Fund	$918,000

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