Office of Health Review

Annual Report 2001-2002

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HON BOB KUCERA APM MLA
MINISTER FOR HEALTH

In accordance with Section 66 of the Financial Administration and Audit Act 1985, we hereby submit for your information and presentation to Parliament, the Annual Report of the Office of Health Review for the financial year ending 30 June 2002.

The Annual Report has been prepared in accordance with the provisions of the:

Financial Administration and Audit Act 1985;
Disability Services Act 1993 ;
Electoral Act 1907 ;
Equal Opportunity Act 1984;
Freedom of Information Act 1992;
Public Sector Management Act 1994; and
Government and Ministerial Annual Reporting Policies.

Eamon Ryan
DIRECTOR

30 August 2002

Foreword

This is my final Annual Report as Director of the Office of Health Review, as I am relocating to Queensland to take up the position of Health Rights Commissioner. It therefore seems appropriate to reflect not only on the past year but also on the almost five years that I have been at the Office of Health Review. It is also an opportune moment to consider what lies ahead for the Office.

The past year has been as busy as ever, despite a slight reduction in the number of complaints. We received 1383 new complaints in 2001-2002, compared to 1496 in 2000-2001. Despite this slight reduction, the overall complexity of cases increased and the workload remains high. Unfortunately, even though there was an increase, the number of disability complaints remains low.

The level of complaints in 2001-2002 also represents an increase on the Office's first year of operation. Since the Office's inception, however, the staffing complement has increased only slightly. It is a credit to my hard working staff, both past and present, that this substantially increased workload has been able to be managed without any significant backlog of cases.

The ability to stay on top of caseloads is also a reflection of the flexible and relatively informal procedures that we adopt in investigating and assessing complaints, and the high level of cooperation that we receive from different groups and individuals. I have commented in the past on the invaluable assistance we receive from health practitioners who provide expert advice on some of the more complex cases with which we deal. Often such advice is given freely, but it is the thorough and reliable nature of such advice that is of most assistance. By obtaining advice on a de-identified basis we are more readily able to convince the provider complained against that a particular remedy is appropriate, or to reassure the complainant that the treatment they received was reasonable and appropriate. Not everyone is accepting of our conclusions and recommendations, but overall the system is highly effective both in resolving disputes and avoiding unnecessary litigation. In many cases the informal, non-adversarial approach we adopt also helps to preserve the relationship between consumer and service provider, something which invariably would be lost by a more adversarial approach.

Despite our past successes, there are always areas where we can do better or where people will remain disappointed, despite our best efforts. In each of my Annual Reports I have commented on the work we have done to promote public awareness of the Office. Despite that, I remain concerned that some community groups still do not have equitable access to the services we offer. Indigenous groups, ethnic communities and people with disabilities are those most disadvantaged in this regard. In part, this reflects the fact that we are not adequately resourced to carry out large scale promotional activities.

Another of the challenges we face, though, is that even where groups are aware of our Office, they may still be reluctant to complain. During the year I addressed a forum on public awareness at the WACOSS conference. By canvassing the views of people representing different ethnic and cultural groups I gained invaluable insight into the reasons why such groups are often reluctant to complain. These issues are explored in

more detail in an article elsewhere in this report entitled *Why those who should complain, don't.*

In my previous Annual Report I referred to a proposed review of the Office and the legislation under which we operate. Unfortunately, I have to report that the review has not yet commenced. No doubt a Government announcement on the commencement of the review of the Office and its Terms of Reference will be made in the near future and I encourage all stakeholders to make submissions.

The legislation under which the Office of Health Review operates – the *Health Services (Conciliation and Review) Act* 1995 – has a number of shortcomings that require attention. I alluded to these in my previous reports and therefore will not repeat them here.

I would nevertheless like to take this opportunity to reflect on some of the key ingredients of an effective health and disability complaints system. Looking around Australia there are many different models, but features common to most complaints mechanisms include:

- jurisdiction over the broad range of health services, public and private;
- discretionary power to determine which complaints to investigate, what conclusions to reach and whether to refer matters to another body;
- flexible procedures for dealing with cases, with the option of choosing between informal resolution, mediation, conciliation and investigation as appropriate;
- the power to access relevant records and the authority to compel people to cooperate with an investigation;
- the power to make recommendations and to criticise health providers whose practices fall short of reasonable expectations;
- responsibility for recommending improvements to health services; and
- the power to make public reports on the outcome of investigations.

Most of these characteristics already feature in the Western Australian system and should be retained.

There are two other features that I have deliberately kept to last: independence and impartiality – these are the foundation stones of any effective complaints mechanism. Fundamentally, it is not my role to take either the consumer's side or the provider's, but to make an objective assessment of what is fair and reasonable in each case. I thank my staff, once again, for their strong commitment to these principles and for the balanced approach they have brought to the work of our office.

David Kerslake
30 June 2002

Analysis of Health Complaints

In 2001-2002 the Office of Health Review (OHR) received 1359 health complaints and 24 disability complaints. This represents a small decrease in the number of complaints received over last financial year. 1440 cases were finalised, 1417 of which were health complaints, this includes a number of complaints carried over from the previous year. There is no significant backlog of cases.

What issues do people complain about?

The majority of complaints were again about treatment, which can include inappropriate treatment, wrong treatment and problems with diagnosis with 50% of closed complaints in that category. This is a decrease of 3% over the previous financial year.

The second most common complaint issue, both this year and last year, related to costs. This includes categories such as over-charging and inadequate information on costs. 15% of health complaints closed were in this category, compared with 16% in 2000-2001.

Other significant categories include access to services (12%), alleged breaches of privacy (8%) and inadequate information being given by providers, usually about the nature and risks of the proposed treatment, (6%). It is interesting to note that although the exact percentages change from year to year, the descending order of issues remains the same.

Which services do people complain about?

As with previous years, the largest number of complaints were against Medical Practitioners (30%). This category has shown a steady reduction over the last three years, which is an encouraging sign. A majority of these complaints were against General Practitioners (61%), with other specialities accounting for significantly fewer cases. This statistic reflects the larger number of services provided by General Practitioners each year. They are at the "front line" of health care and it is therefore hardly surprising that they have the most complaints. General Surgeons, Obstetricians/Gynaecologists, Anaesthetists and Psychiatrists each accounted for 5% of complaints against Medical Practitioners, and these were the next largest category after General Practitioners. Orthopaedic surgeons and Plastic/Cosmetic Surgeons each accounted for 4% of complaints against Medical Practitioners.

24% of complaints were against public hospitals, and this category includes complaints against doctors and nurses in public hospitals. This is a similar figure to 2000-2001 where this category accounted for 23% of complaints. Only 3.5% of complaints were about private hospitals. Although this comparison initially appears to show private hospitals in a more favourable light, it needs to be noted that a majority of complaints from patients at private hospitals relate to their treatment and the complaint is therefore lodged against the individual doctor rather than the hospital. On the other hand, complaints against public hospitals include complaints against doctors because they are actually employed by the hospital, even if only on a

sessional basis. Each public hospital is therefore responsible for treatment provided by medical staff.

Complaints against dentists accounted for 6% of complaints, which is the same figure as last year. Complaints against alternative providers including acupuncturists, naturopaths and osteopaths made up 1% of all health complaints.

Outcomes of complaints

Most complaints to this office begin with a telephone call. Staff are often able to resolve the matter quickly and informally by making some preliminary enquiries without requiring the complainant to put the complaint in writing. Sometimes, staff are able to provide the complainant with sufficient information and advice so that they may resolve the matter themselves. Where this does not happen, for example, where a complaint is complex or a complainant does not feel able to resolve the matter themselves, we send a complaint form. Sometimes the complainant chooses not to take the matter further and does not return the form.

We received 583 written health complaints and closed 670 written health complaints in 2001-2002. Of these closed health complaints, 97 were resolved mainly or completely in favour of the complainant and 106 were resolved partly in favour of the complainant. Of these 203 cases, 29% led to some systemic improvement such as a change in policy and or procedure. In 274 cases, or 47% of written complaints, the complaint was not upheld. In these cases, we assessed the issues and concluded that the provider did not act unreasonably. We always provide complainants with a detailed explanation of our conclusions. Most of the time, we are able to reassure them that the service they received was adequate and appropriate. Hopefully, this helps to restore their confidence in the practitioner. Only 25 cases, or 4% of written cases were unable to be determined. In other words, there was insufficient evidence to reach a decision one way or the other. This can be frustrating for all parties as well as for OHR staff, as they would like to be able to resolve each matter thoroughly. Nevertheless, it would be inappropriate for me or my staff to attempt to 'guess' the appropriate outcome in the absence of objective evidence.

Sometimes, despite our best efforts, we are unable to resolve a case to the satisfaction of the complainant. It is open to either party to a complaint to take the matter up with the State Ombudsman. The Ombudsman has the power to review the process by which we undertook our enquiries and to assess whether our conclusions were based on relevant, objective evidence. Last year, none of the complaints made to the Ombudsman about the Office were upheld. This is nevertheless an important process to ensure the accountability of my office.

Articles

Informed consent

In previous annual reports I have emphasised the need for health practitioners to obtain informed consent for proposed treatment. The decision of the High Court in *Rogers v Whitaker* makes it clear that practitioners have a legal duty to warn their patients of any material risks inherent in proposed treatment. In the view of the Court, a risk would be material either (a) if a reasonable person in the position of the patient, if made aware of it, would attach significance to it, or (b) if the practitioner, having some knowledge of the patient, would be aware that the patient would attach some significance to it.

In *Rogers v Whitaker* the plaintiff, Mrs Whitaker, discussed with her doctor the possibility of surgery on one of her eyes. There was a risk, albeit slight, that the surgery could leave her blind in that eye. Since her vision in the other eye was already severely impaired, her doctor should have known that she would attach special significance to the particular risk. The court found that her doctor was negligent in failing to draw attention to the risk and, further, that had he done so, in all likelihood, Mrs Whitaker would have decided against the proposed surgery. As it turned out, she went ahead with the surgery without being made aware of the risk and ended up almost totally blind.

Given the publicity associated with this case and the many forums at which it would have been discussed I would expect that health providers, medical practitioners in particular, would be acutely aware of the importance of properly advising patients of the risks prior to treatment. Unfortunately, for a small group of practitioners the message still does not appear to have got through. I continue to have raised with me cases that indicate that some providers do not make as much effort as they should to ensure their patients are fully informed and that they consent to all procedures. Even setting aside the overriding importance of good patient care, I would have thought that current concern about rising insurance premiums was sufficient to bring this issue more sharply into focus than appears to be the case for some practitioners.

In one complaint, a woman complained that her four year old daughter had four teeth extracted without consent. The woman stated that she had given consent for her young daughter to have four teeth extracted under general anaesthetic but was told after the operation that another four teeth had been identified as being compromised and had also been extracted.

The provider advised that the other teeth had only been identified as requiring extraction when the child had been examined under the stronger lights in the theatre. They believed that because the teeth would have had to have been extracted eventually that it was better for the child to extract all eight teeth at the one time.

I obtained advice that confirmed the teeth concerned did require extraction. Even so, the mother's consent should still have been obtained to extract the additional teeth. It was difficult to understand why this did not occur, given that the mother was in the waiting room outside.

A common theme from gynaecology and obstetrics complaints received this year was that of informed consent. In this year we dealt with more cases than in previous years where it appeared that proper informed consent had not been obtained for gynaecological procedures.

Complaints about this issue arose mainly in situations where the surgeon made a decision to perform a procedure even though circumstances had changed, or because a procedure may have been required in the future. In some of these cases the women may have been able to delay such surgery for some time, or have alternative treatment.

At this stage I am unable to give specific case examples as all of the relevant cases are ongoing. Nevertheless, the issue is one of concern and one that I will continue to follow closely.

I raise these issues because they highlight the importance of obtaining informed consent. Of particular concern to me is the fact that consent forms for procedures typically require patients to give signed consent to the proposed treatment *and any other treatment that may be deemed necessary* in the course of the procedure. Thus, if excessive bleeding were to occur in the course of surgery and it became necessary to administer a blood transfusion, this would be covered. Consent forms are not intended, however, to provide authority for quite unrelated procedures. I accept that there will always be grey areas, but encourage all health professionals to make themselves conversant with the requirements of informed consent.

Informed Financial Consent

In addition to consent to the actual treatment, it is also necessary to obtain informed financial consent. Consumers are entitled to make informed financial decisions about their health care. Unfortunately, some providers still fail in their duty to provide sufficient information about the level of costs applicable to particular procedures.

This issue often arises in circumstances where a patient receives an initial course of treatment for which the costs are known, but then further treatment is required. Hospital charges (for example, where a patient anticipates day surgery but ends up having to stay overnight) and dentistry are situations where problems typically arise.

Other complaints arise from situations where providers work together in a team, such as a surgeon and an anaesthetist. For example, a surgeon may provide patients with an accurate estimate of their out of pocket costs (after Medicare and health fund rebates), but the patient may quite reasonably construe this to represent their costs all up, including hospital and anaesthetist charges. The end result can understandably be very upsetting for patients.

On the other hand, some providers use standard quotation forms outlining such things as the nature of the procedure; the specific item numbers involved; the likely costs; the possible health fund rebate (if applicable) and the out of pocket expenses which will remain the responsibility of the patient. Patients are advised in writing to check with the hospital or their private health fund about the full costs and any gap they have to meet, allowing them to make an informed decision about whether to proceed with the treatment. Rarely does my office receive a complaint where such an approach has been followed.

Anaesthetists' fees are one area where it is not always easy to give precise estimates, given that accounts are usually based on the duration of the procedure, which in turn may depend upon how the procedure goes. There is no reason, however, why anaesthetists cannot make this absolutely clear at the outset. By quoting a fee per unit of time, they also empower consumers to 'shop around' should they wish, and as is their right.

When one looks at the issues of consent to treatment, and informed financial consent, there are significant messages for both health consumers and providers. From a consumer's perspective it is everyone's right, if not their responsibility, to ask questions about the nature and risks of treatment, the options available, and the likely costs.

Providers, for their part, should openly recognise that their patients have the right to ask such questions and to have the final say about the nature of the treatment they may receive. From a provider's perspective, dealing with complaints and disputes can also be very stressful and time consuming. It makes sense, therefore, not only to ensure that patients are fully informed, but to document the discussions that have taken place. This prevents complaints and makes them easier to resolve if they are made.

Why those who should complain, don't

In previous annual reports I have drawn attention to the ongoing need to promote community awareness of the Office of Health Review and the work that it does. This problem is not unique to my office, however. In my experience all review or 'watchdog' agencies – health complaints bodies, Ombudsman's offices and so on – experience the same difficulties. Few are adequately resourced to carry out comprehensive public awareness programs.

I think it is fair to say that members of the community are now more likely to complain to such agencies than, say, 20 years ago. Generally, people are far more aware of their rights and of the agencies that they can complain to. The fact remains, however, that those who have most to complain about are often least likely to be aware of their right to complain, or to know who they can complain to if they choose to exercise that right.

Groups who appear to under-utilise the services provided by 'watchdog' agencies include indigenous groups, members of ethnic communities, people with disabilities, chronically or mentally ill people, aged people, young people and low-income earners. For example, it beggars belief that indigenous groups, especially those in more remote areas, have less to complain about in relation to their health and wellbeing than other groups in the community. Yet, out of approximately 1500 complaints my office receives each year, very few are made by indigenous people.

Recently, I had the opportunity to give a presentation on this issue at a conference hosted by the Western Australian Council of Social Services (WACOSS). I repeat the comments that I made then.

Firstly, a right of review is of absolutely no value to people who are not aware of that right. In this regard, 'watchdog' agencies such as the Office of Health Review still do not do enough to publicise their services. One of our major obstacles is the fact that we are not adequately resourced to do this task properly. Government therefore has an important role to play.

Even without additional resources, however, there is still much that we can do to address this issue imaginatively. For example, the Office of Health Review recently obtained some invaluable publicity through an article published in the *West Australian's* Health + Medicine section on Wednesday 3 July 2002 and *Yarranma* in March 2002. We have learned, through experience, that such opportunities do not usually come to you – you have to seek them out.

In addition, I believe there is much to be said for review agencies working together to promote public awareness of these offices. By combining our resources we can get the message to far more people that 'It's OK to complain' and who they can complain to. There is no reason why one 'watchdog' agency, in promoting its activities cannot spread the word about other agencies, or why the others can't reciprocate. I have already held productive discussions with the State Ombudsman on this issue.

The second point that I raised at the WACOSS conference is that expanding awareness of our services will not in itself guarantee equitable access to those

services. The concept of equity implies not just awareness, but actual participation. Even where people are aware of the existence of a service, they may still be denied equal access if there are other significant barriers to their use of such a service. These barriers may stem from cultural, geographical, historical or other factors. For example:

- Some groups may be reluctant to complain through fear of reprisals. This could be the case for people with disabilities or their families, who may have fought hard to obtain a service in the first place and may be loathe to complain about the quality of the service in case it is withdrawn altogether. Fear may also be a factor for members of some ethnic communities who have suffered from past victimisation.

  Most 'watchdog' agencies have provisions in their legislation which make victimisation of a complainant an offence, but the fact remains that these provisions are not well known and may not be particularly reassuring even if they were.

- Another impediment to complaining is the fact that some groups do not have a reliable yardstick against which to measure the quality of the services they receive. This could be the case, for example, for indigenous groups in remote areas who may believe that the level of service they receive is 'as good as it gets' anywhere else.

- Even though agencies usually have in place procedures for the use of translators and interpreters, language difficulties are still a major obstacle for some people. This difficulty is generally well recognised for ethnic groups but far less so for indigenous groups.

There may also be major barriers inherent in the complaint systems themselves: cultural insensitivity, inflexible processes or legislation, and so on. For example, I never cease to be amazed by the number of agencies – mine included – whose legislation requires that complaints be in writing. This not only makes it more difficult to complain, but tends to send the message that complaints are not particularly welcome.

Where to from here?

Although 'watchdog' agencies have done a lot of work to improve access and equity, there is much more that remains to be done.

I have acknowledged that such agencies, mine included, still do not do enough to publicise their services. Government also has an important role to play, not only through funding, but also through the use of regional offices to both publicise services and receive complaints.

Governments also need to give priority to amending any legislation that still requires complaints to be in writing. Such provisions effectively disempower many people.

There is a range of marketing tools we could use – newspapers, radio and television, brochures and posters, giving presentations to community groups, establishing networks with other organisations, and so on – but which one?

To answer this question, in the forthcoming year we will be liaising with different sections of the community to reinforce that it is everyone's right to complain; to get advice on how we can most effectively publicise our services; and to obtain ideas on what the real barriers are and how those barriers can best be removed. We also need to ensure that our staff are culturally aware and sensitive to the barriers to access.

If we fail to do this, we will continue to deny people their right to have their complaints heard. By failing to hear their concerns, we will also miss out on the opportunity to feed information back into the system to help improve practices and procedures in a way that will benefit everyone.

Transfer of Medical Records

Recent changes to the Federal Privacy Act and the accompanying publicity have increased patients' awareness of their rights to access their medical records held by private health service providers, such as general practitioners. This has contributed to an increasing number of complaints being made to me not only about access to medical records but also about the transfer of patients' medical records from one practitioner to another.

Legally, medical records belong to the individual practitioner or practice, not the patient. Nevertheless, if a patient chooses (for whatever reason) to move to a different practice they are entitled to expect that a copy or at least an adequate summary of their records will be transferred to the doctor of their choice. This is important to ensure continuity of care and appropriate treatment taking into account the patient's past medical history. At the same time, patients need to recognise that practitioners have the right to charge a reasonable fee to recover their administrative costs for the transfer.

In response to complaints received, I formulated some basic principles that I feel should apply when patients ask to have their records transferred between practitioners.

The underlying principle should be good patient care.

Recognising this:

- Patients have a right to request the transfer of their records between practitioners and should not be disadvantaged by exercising choice.

- Patients' ongoing health care should not be placed at risk by unreasonable restrictions on the transfer of medical records from one practitioner to another. The importance of this principle is to ensure continuity of care, reasonable access to past medical history, and appropriate current treatment taking into account the patients' past medical history.

- The information transferred needs to be adequate. It is reasonable for patients to expect that copies or an adequate summary of their medical records would be transferred to the practitioner of their choice.

- Timely transfer of records in keeping with the patient's treatment regime or special needs is essential.

- On the other hand, patients need to recognise that practitioners have a right to charge patients a reasonable amount for the transfer or a summary of their medical records. Such charges should only be levied to defray actual administrative costs incurred and should be capped at a reasonable limit. They should not be viewed as a source of general revenue or be used to discourage the transfer of or access to the records.

- Recognising the impost on the transferring practitioner, there is a need for both practitioners to work together to ensure a smooth process and that patients are not disadvantaged.

Medical practitioners and their patients will benefit from these principles by having a clear understanding of how records can be transferred between practices. It should also reduce the number of disputes and subsequent complaints to this Office.

Health Case Studies

In some situations, we find that a provider has clearly acted unreasonably. One option is to negotiate a financial outcome for that patient.

Case One
A man attended a dentist as his crown dislodged on four occasions.

In response to the complaint, the dentist advised that the patient had poor oral hygiene which caused recurrent decay and gingival growth making treatment difficult. The dentist advised that in such a situation any form of restorative treatment is bound to fail.

I asked an independent dentist to review the patient's dental records. He found no reference to caries or poor oral hygiene. The independent dentist advised that if the patient's oral hygiene was poor then a record should have been made in the treatment notes and the patient should have been referred to a periodontist before attempting any treatment.

On my recommendation the treating dentist agreed to refund the total cost of treatment, $1047.00.

Case Two
A man's teeth became sensitive to heat and cold following bridgework. Food also lodged under the bridge making it difficult to keep clean, and his surrounding gums became inflamed and swollen.

Concerned about the status of his teeth, the man attended another dentist for a second opinion. He was advised that the design of the bridge was inadequate and would need replacing. On the basis of this advice the consumer complained to my office seeking a refund for the money outlaid for the original dental work.

I sought advice from an independent dentist who confirmed that the bridge was inadequate and would need to be replaced.

In response to my recommendations the dentist refunded the consumer the proportion he had paid towards the total costs of the bridge, $3,400.00. In addition, a contribution of $355.00 was paid towards the cost of having the bridge removed and a temporary bridge fitted. The dentist also reimbursed the consumer's private health fund the proportion it paid towards the total cost of the bridge.

Sometimes a provider can appear at first glance to have acted unreasonably, but investigation reveals that this is not the case. In these instances, we always ensure the complainant is provided with a detailed explanation.

Case One
A woman complained that a GP failed to diagnose her sixteen year-old son's spinal tumour before it became an emergency situation.

The mother said that she had taken her son to the GP three times over a two week period with worsening back symptoms but that it was not until she asked for a specialist referral that the GP took any action. The mother said that by the time the GP provided a referral her son was unable to walk and had to have emergency surgery as the tumour had developed to a stage where it could have caused paralysis.

The GP's records showed that the boy had not attended as often as the mother had stated and that his symptoms initially could have been due to a number of other causes. From the GP's notes it appeared that the boy's condition had deteriorated rapidly between visits and that when he presented with clear signs of paralysis the doctor referred the boy for emergency treatment.

An independent opinion concluded that the treatment provided by the GP was reasonable and that because of the rare occurrence of spinal tumours in children it was not unreasonable for the GP to consider other possible causes first.

The boy's mother also complained that the GP prescribed the wrong dose of a medication for her son following his surgery. My investigation found that the GP had prescribed the dose written on the hospital discharge summary and that it was clearly the hospital which had made the error in entering the medication dose incorrectly onto the discharge form.

I explained the outcome to the mother and drew the Hospital's attention to the prescription error on the discharge summary so that it could take appropriate action.

Case Two

A woman consulted a Gynaecologist. In the course of the examination the receptionist entered the room and handed the doctor a mobile phone. He proceeded to take the call. The woman felt humiliated because of the interruption and the lack of privacy (there was no curtain around the examination bed) and was also concerned that the phone call did not seem urgent enough for the interruption to take place.

The provider explained in his response that it was sometimes necessary to take phone calls because he was on call during his normal consulting hours. This is not an unusual practice for a specialist. His reception staff usually screened the phone calls and only calls that were deemed to be urgent would be put through to him during a consultation. This had been the case on this occasion. He nevertheless apologised to the complainant for any discomfort or humiliation she felt and undertook to explain to patients the urgency of such calls if the situation arose again in future.

Although the complainant clearly would have preferred for the consultation to proceed uninterrupted, she understood the urgency of the situation and accepted the provider's apology. This is another instance where, with a little more thought and better communication the complaint could have been avoided.

Where complaints raise issues of professional standards or inappropriate conduct, it is open to my Office to refer the matter for consideration by the appropriate registration board. Once such a referral is made, the Board must investigate the matter.

Case One

A woman complained of breach of confidentiality. The complainant stated that she had undergone a particular treatment about which she felt quite sensitive and had no wish for all the world to know. It transpired that an acquaintance visited the same practitioner who mentioned the complainant's name, in effect as a recommendation for this type of treatment.

The complainant felt devastated by this and lodged a complaint about the breach of confidentiality.

The complainant stated that she subsequently received a telephone call from the provider offering her a financial incentive to withdraw the complaint. She felt quite upset and intimidated by the provider's actions.

With the complainant's permission, I referred the matter to the relevant registration board and the matter proceeded to a formal inquiry. The Board ultimately imposed a reprimand and fine for the breach of confidentiality and a further fine for improper conduct in attempting to induce the patient to retract her complaint.

The financial penalties and associated costs were substantial. In addition, the provider was ordered to undertake a remedial communication course.

Case Two

A complaint was made by a woman whose baby had died in utero during the last weeks of her pregnancy. She expressed concern that the weight of the baby when delivered was much less than it should have been at that stage of her pregnancy. Her doctor was a GP whose practice had a significant obstetrics component.

My investigation established that the doctor had relied heavily upon ultrasounds he had taken during the pregnancy but that his interpretation of the ultrasounds had been inaccurate. He had therefore failed to recognise that the baby was suffering from intrauterine growth retardation (not growing adequately).

Because this complaint involved not only a serious outcome but also raised concern about the doctor's skills the matter was referred to the Medical Board. The Board considered the information provided and decided to hold an inquiry. As a result of the inquiry the doctor was reprimanded and required to complete an ultrasound training course at a teaching hospital. The doctor will also have his obstetrics practice reviewed on a quarterly basis for the next two years, and had to meet the costs of the Board's inquiry.

The complainant has since come back to me and the matter is being considered further with a view to conciliation.

An important part of my role is to recommend changes or improvements where a complaint reveals deficiencies in systems or procedures. It is always reassuring to see changes implemented, as this means that the complainant has assisted in improving services for future patients.

Case One

In 2001-2002 we identified an important systemic issue relating to complaints received from people with intellectual disabilities who also have a psychiatric illness, where consumers were either denied assessment or admission when they sought assistance from psychiatric or mental health units. This denial of treatment was because the consumer had an intellectual disability.

In the first case, the parents' attempts to have their adult son assessed for admission were unsuccessful because the psychiatric unit had a policy which excluded "…individuals whose primary problem is an intellectual disability." The young man's general practitioner and his private psychiatrist both contacted the unit seeking an assessment and received the same advice regarding policy. Following the parents' complaint, the young man was subsequently assessed. There remained a question, however, of the appropriateness of the policy at the hospital. The unit has now revised its policy to make it clear that the exclusion applies to people who *only* have an intellectual disability without a treatable mental illness and that it does not exclude people with an intellectual disability who also have a psychiatric illness.

In the second case, the parents of a boy with autism sought to have their son admitted to a mental health unit for his and their protection as he was exhibiting violent and uncontrollable behaviour. Following an initial assessment they were advised that his behaviour was characteristic of his autism and was not symptomatic of a psychiatric illness. The family sought a second opinion from a private psychiatrist who confirmed that their son did indeed have a psychiatric illness. He was subsequently admitted to the mental health unit.

We drew these cases to the attention of the Health Department who advised that Mental Health Services and the Disability Services Commission were developing a Memorandum of Understanding regarding treatment of people with an intellectual disability who also have a psychiatric illness.

A copy of *The Protocol between the Disability Services Commission and the Department of Health - People with Intellectual Disabilities and Mental Health Disorders*, was subsequently forwarded to me in April 2002. This Protocol should address the issues raised by the above complaints to prevent their experiences being repeated in the future.

Case Two

A woman complained that she had been charged for a specialist appointment for her young baby at a public hospital.

The appointment had been arranged by the woman's paediatrician in the eastern states in anticipation of her moving to WA. However, the doctor in the eastern states was not aware that the clinic to which he had referred her was actually a private clinic operating out of a public hospital.

Because of a lack of paediatric services in the area the public hospital had agreed to rent space in its outpatient clinic to a private specialist. Unfortunately, no signs or other information were placed in the area to advise patients that it was a private clinic.

In addition, the letter the provider sent to the woman confirming her appointment made no mention that the clinic was private or of any fees.

On my recommendation, the specialist concerned agreed to refund the woman the amount she had paid above the Medicare scheduled fee. He also arranged for the hospital to put up signs identifying the clinic as private, to avoid similar confusion in future.

Case Three
A woman complained that the clasps on her upper partial denture broke and she was unable to wear her denture. She advised that she had tried to resolve the matter with the dental prosthetist directly but an agreement could not be reached, as the prosthetist wanted to charge for the repair.

At my request, an independent dentist reviewed the manufacture and fit of the denture and advised that the design was unreasonable and a new denture would be required.

Despite my recommendation that he refund the full cost of the denture ($700), the prosthetist agreed to refund only $400. Although I was prepared to take the matter further, the complainant decided to accept the amount offered and the matter was finalised at that point.

Sometimes providers respond quickly and generously to a complaint, in recognition of the difficulty faced by the complainant. We find that complainants often respond very positively to gestures of goodwill, especially those made early in the complaints process.

Case One
A man was having hair replacement treatment at a hair clinic. He initially undertook the treatment over a period of 13 months but for a number of reasons stopped having the treatment. He was not happy with the results after he stopped because of a reversal of some of the hair regrowth.

The provider responded by explaining that the complainant had been aware that the progress of the hair regrowth would not continue if treatment ceased. He nevertheless offered to refund the money that the complainant had already paid. Although this was done as a gesture of goodwill rather than an acknowledgment of any wrongdoing, it very effectively resolved the matter.

Case Two
A woman had chest pain over a period of time and consulted a cardiologist. She was unhappy with the consultation and complained that she had to wait over an hour to see the doctor and was not told the fee prior to the consultation. She was also dissatisfied with the consultation and claimed that the doctor did not spend enough time with her and that the only advice he gave her was to lose weight.

Upon receiving a copy of the complaint, the specialist contacted the complainant. He expressed regret that she was not satisfied with his service and apologised for keeping her waiting. He said that in retrospect he should have spent more time discussing her condition with her and apologised for not doing so. He waived the outstanding account.

Case Three
A non-resident of WA, whose first language was not English, was treated in a public hospital for a minor ailment. She complained that the information she had received about fees was confusing and that she had received an account for services which she had not expected. While it was reasonable in the circumstances to levy a charge, the hospital acknowledged the confusion that had arisen. As a gesture of goodwill they agreed to waive the outstanding fee.

Ideally, some complaints would not be raised with this office in the first place, if the provider took a little more care with the situation originally.

Case One
A woman contacted a public hospital to locate some radiological films dating back to November 1996. She suffered from a serious medical condition and wished to obtain the films to assess the benefits of new treatment that had just become available. Her specialist had advised her that the hospital kept films for 5 years. She contacted the hospital in May 2001 and was advised by staff that the films had been destroyed. My enquiries revealed that the films were actually in archives. The hospital agreed to provide a copy of the films to the consumer, at no cost to her. These were couriered to her home, again at no expense to her, and the hospital apologised for any distress caused. Clearly, however, the complaint need not have arisen had more care been taken in responding to her initial request.

Case Two
A man was referred to an outpatients clinic for treatment for an eye condition. He went for one appointment and was told to return the following week for medication. He did so, only to be told that his medication had been used for an emergency and he could not have treatment that day. He would need to come back at another time. He was concerned that there was not enough medication at the hospital to cover all eventualities.

My enquiries established that the complainant should not have had to wait at all. Even allowing for the emergency, staff could have obtained a further supply at short notice from the hospital pharmacy. At worst, this should have resulted in a slight delay in the appointment, not a rescheduling. The hospital apologised for its error and reinforced with all staff the appropriate procedure in such cases.

The complainant was happy that the hospital had at least acknowledged its mistake, but again this is a complaint that could easily have been avoided.

Analysis of Disability Complaints

24 disability complaints were received in 2001/2002 and 23 complaints were closed including 5 from the previous financial year. 7 complaints have been carried forward into the next financial year.

What issues and services do people complaint about?

71% of new complaints were about non-government service providers, 21% were about the Disability Services Commission and 8% about public authorities. The largest single category of complaint was about accommodation 46%, with therapy next at 25%, respite 13%, education 8% and in-home support and recreation 4% each.

The majority of the complaints 71%, were about the manner of providing services, 21% about non-provision of services, 4% about the DSC not granting funds and 4% about the provision of services (this was where another provider was preferred).

Outcomes

Only 9 % of complaints were resolved partly in favour of the complainant. This figure is misleading, however, since the majority of complaints (87%) were allowed to lapse or were withdrawn by the complainant either at enquiry stage or during the enquiry period. In many of these cases the complainant obtained a benefit without the need for us to pursue the matter further. Seven complaints are still under investigation.

Disability in Review

Although the number of disability complaints have increased over the past twelve months (24 compared with 15 in 2000/01), overall the numbers remain relatively low. Whether they are disappointingly low is a different question. A review of the *Disability Services Act 1993* was undertaken during the past year, which provided an opportunity to consider this question.

There is a distinction to be made between people's awareness of a complaints service and their need or preparedness to access it. This office has noted that disability service providers, in general, have well developed internal complaints procedures which are backed up, in the case of funded agencies, by standards monitoring by the Disability Services Commission. Specialist advocacy organisations also play an important role in facilitating resolution of complaints. Together these systems seem to have been quite successful in resolving complaints without recourse to an external complaints mechanism such as that offered by this office. Therefore, although it is still important to have an external complaints mechanism that is independent and impartial in its handling of complaints, it may not be so surprising that the number of complaints brought to the office is not high.

An analysis of the outcome of complaints closed this year revealed that the majority are either withdrawn or allowed to lapse by the complainants at an early stage in the enquiry process. There are various possible explanations for this. We are often able to make enquiries about the issues raised in the complaint, which satisfies their concerns, or to suggest alternative and more appropriate avenues for resolution of the complaint.

In addition, it is recognised that because of their greater vulnerability and reliance on services, people with disabilities may be more reluctant to pursue a complaint than other members of the community. They may have fought very hard over a long period of time to obtain a service and may feel that to complain may threaten the continuance of that service. Although there is a penalty of $2,500 in the *Disability Services Act 1993* to protect complainants from threats or intimidation, reluctance to complain is still an issue that requires further attention.

This office has continued our efforts to raise public awareness among the disability community about our role as an independent, impartial complaints body and the increase in the numbers of complaints point towards some success in this regard. The most effective way to disseminate information is by word of mouth and in this, we rely on disability service providers and particularly the Disability Services Commission to assist by informing their clients about our services.

During the recently completed review of the *Disability Services Act 1993*, discussion occurred over the desirability of disability and health complaints being dealt with by the same body. Our experience over the past two years of dealing with disability and health complaints, is that there are often occasions in the early stages of a complaint where the precise jurisdiction is unclear. This is increasingly the case as non-government service providers diversify and provide both health and disability services some of which are funded by the Disability Services Commission and others by the Health Department.

If amendments to the Disability Services Act are to achieve changes that will improve service delivery for people with disabilities, the inherent disadvantages in separating disability and health complaints should be understood. Being referred from one complaints body to another when jurisdiction is uncertain, and the added frustration this can cause for people seeking a timely response to their concerns are likely outcomes of a separation of jurisdictions.

In an ideal world, there would be sufficient resources available to establish a specialist independent body to deal with disability complaints. However, the inevitable consequence of limited resources is the co-location of disability complaints with another complaints body. The Options Paper released by the Review Committee has recommended the State Ombudsman as the complaints mechanism of preference. This may however, be based on some misconceptions of the role and powers of the Office of Health Review and the State Ombudsman. The Ombudsman's office offers no greater powers or avenues of redress. If anything, transferring jurisdiction to the Ombudsman would effectively reduce the avenues available to people with disabilities, bearing in mind that they currently have the option of seeking a review by the Ombudsman if they are dissatisfied with the way the Office of Health Review has dealt with their complaint.

This office will, over the next twelve months, survey consumers who have made complaints to this office only to allow them to lapse or who have made a decision not to pursue a formal complaint. This should assist us to identify and address any shortcomings, from a consumer's point of view, in the legislation or the complaints process.

Disability Case Studies

Disclosure of confidential information

A woman complained on behalf of her teenage son who has autism, that his counsellor revealed information given in confidence at a counselling session, to another person. She complained about unprofessional behaviour and a breach of confidentiality. In this case the same counsellor was counselling the two parties involved in the incident.

The provider claimed that there was no breach of confidentiality and that the information was appropriately shared in the best interests of both parties.

Enquiries with the Psychologists Board of WA and the Psychotherapy and Counselling Federation of Australia revealed that as a general guide, psychologists and counsellors should not consult with both parties to a dispute unless specific written informed consent is obtained. Both bodies agreed that although it is not necessarily unethical or clinically inappropriate, it is preferable, due to possible conflicts of interest or breaches of confidentiality, that a counsellor not consult with both parties.

In this case, neither of the parties involved was clear about the role of the counsellor or about how much information would be shared at counselling sessions. The complainant reasonably believed that the information gained at the counselling sessions would be treated as confidential.

The counsellor continued to support the position that the counselling of both parties in this case was the best therapeutic option, but conceded that the rationale and the policies and procedures had not been adequately explained to the complainant. An apology was made to the complainant and clear written policies and procedures were developed, which included obtaining written informed consent from the clients before commencing therapeutic intervention.

Inadequate therapy services

A father complained that his daughter, who has a developmental disability, did not receive the level of therapy services for which she was funded.

The service provider received government funding for provision of a therapy service to the child. The service agreement did not, however, specify how many hours of therapy should be provided for the funds paid. The service provider informed the parents that a certain number of therapy sessions would be provided over a set number of weeks. For various reasons, some of which were beyond its control, the provider was unable to meet the original timetable with the agreed therapist. This resulted in fewer hours of therapy at a higher charge out rate.

Although the disability service provider was able to justify the expenditure of the funds, they agreed that it was unsatisfactory for the client to have received fewer hours of therapy than originally planned. Because this was largely beyond the

provider's control we were unable to find that they had acted unreasonably. However, we recommended that in future a written treatment plan be agreed and signed by both parties prior to the commencement of the service to reduce the likelihood of misunderstandings arising about the level or quantity of service.

Standard of care in a group home

A mother of a young man with a disability complained about services provided by a non-government organisation to her son in his group home. She expressed concern about the management of her son's money, his clothing, the development of his independent living skills, his diet, his recreational activities, his privacy and a number of other issues including her ability to become involved in her son's life.

The service provider was aware of the mother's concerns and had already taken steps to address these before the complaint was made. On receipt of the complaint the service provider wrote a detailed report on actions taken and outlined proposals to address any outstanding concerns including changes to house procedures and staff rosters. We held a meeting with the mother to determine the outstanding issues and as a result an agreement was reached for the service provider to engage a dietician to design a menu that ensured the young man had a healthy diet.

Unfortunately, the mother was not satisfied with the response to her complaint and as a result she decided to pursue her concerns through another avenue.

This complaint is an example of the difficulties that can arise when a parent's expectations of the standard of care and lifestyle of an adult child living in a group home are beyond that which a service provider can be reasonably expected to meet.

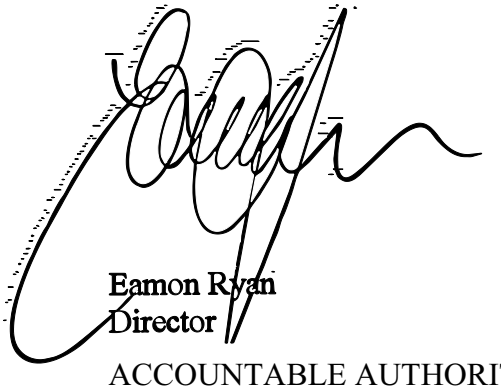
Director's Position

The Director, David Kerslake, resigned his position on 4th August 2002.

Mr Eamon Ryan was appointed as Director for an interim period of six months.

Certification of Performance Indicators

I hereby certify that the Performance Indicators contained in the Operational Report of this Annual Report are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Office of Health Review and fairly represent the performance of the Office of Health Review in the financial year ending June 30 2002.



Eamon Ryan
Director

ACCOUNTABLE AUTHORITY

30 August 2002

AUDITOR **GENERAL**

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2002

Matters Relating to the Electronic Presentation of the Audited Performance Indicators
This audit opinion relates to the performance indicators of the Office of Health Review for the year ended June 30, 2002 included on the Office of Health Review's web site. The Director is responsible for the integrity of the Office of Health Review's web site. I have not been engaged to report on the integrity of this web site. The audit opinion refers only to the performance indicators named below. It does not provide an opinion on any other information which may have been hyperlinked to or from these performance indicators. If users of this opinion are concerned with the inherent risks arising from electronic data communications, they are advised to refer to the hard copy of the audited performance indicators to confirm the information included in the audited performance indicators presented on this web site.

Scope
I have audited the key effectiveness and efficiency performance indicators of the Office of Health Review for the year ended June 30, 2002 under the provisions of the Financial Administration and Audit Act 1985. The indicators are set out in the performance indicator section of the annual report.

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, 2002.

K O O'NEIL
ACTING AUDITOR GENERAL
November 22, 2002

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

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 disability 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		**2001-2002**	**2000-2001**
a)	Cost per finalised complaint (based on the accrual costs for the period 1 July 2001 to 30 June 2002)	$697	$646
b)	Number of days taken to finalise a complaint (taken from the date of receipt of the complaint form to the date of closure of the file)	118 days	118 days
Effectiveness Indicators			
a)	Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations	59	42
b)	Percentage of complaints finalised this year (The percentage of complaints closed reflects the overall effectiveness of the OHR in dealing with a complaint)	104%	99%

Enabling legislation

The Office of Health Review exists by virtue of the *Health Services (Conciliation and Review) Act 1995.* We operate under this Act and also under the *Disability Services Act 1993,* which was amended in 1999 to bring complaints about disability services under our jurisdiction.

Mission statement

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

General 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.

Operations

My functions as Director of the Office as specified in s10 of the *Health Services (Conciliation and Review) Act* 1995 are –

- To undertake the receipt, conciliation and investigation of complaints and to perform any other function vested in me by this Act or another written law;
- To review and identify the causes of complaints, and to suggest ways of removing and minimising those causes and bringing 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 the Act and in particular –
  - (i) advice to users on the making of complaints to registration boards; and
  - (ii) advice to users as to other avenues available for dealing with complaints.

Ministerial and parliamentary directives

Under s11 and s45 of the *Health Services (Conciliation and Review) Act* 1995, the Minister for Health may give directions to me as Director of the Office of Health Review for complaint matters to be investigated. No directions were given during the year ending 30 June 2002.

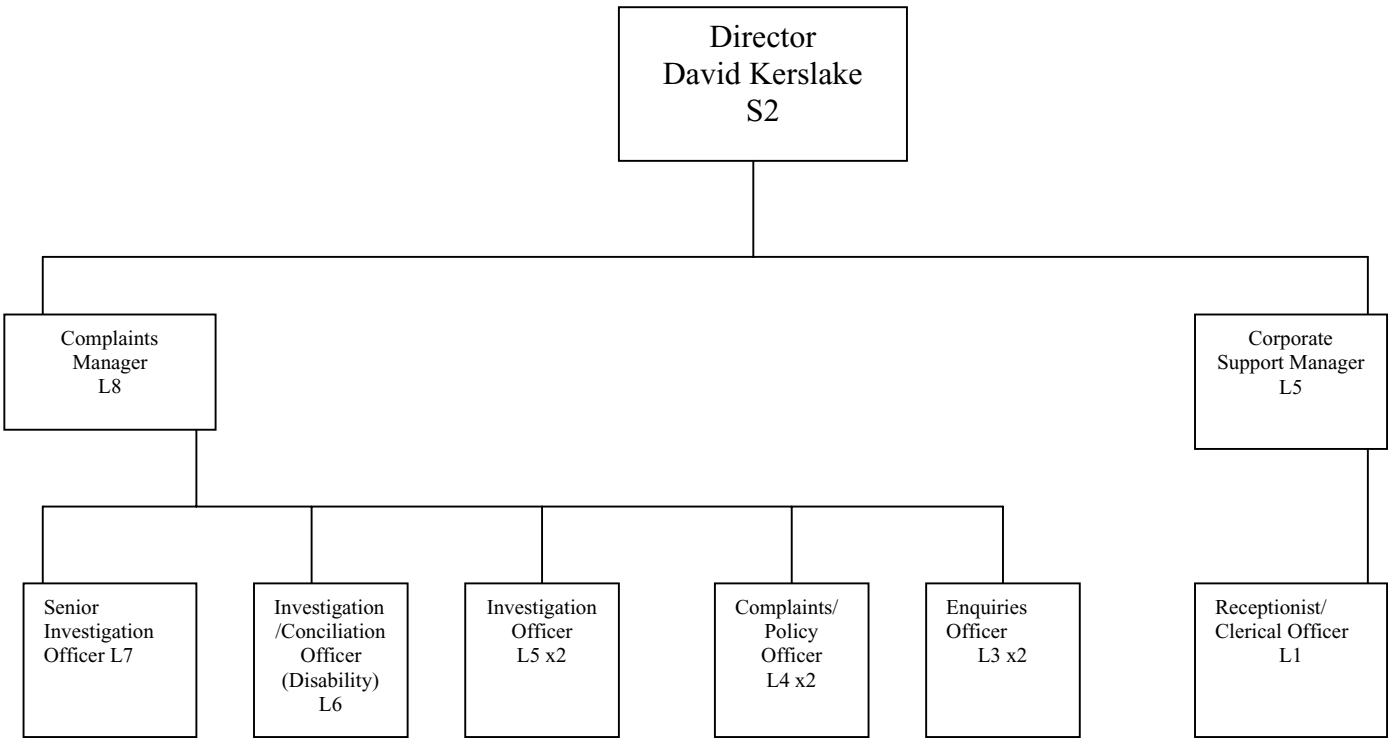
Under s57 of the Act, I may make reports to Parliament, or at the request of Parliament. No reports were requested or made during the year ending 30 June 2002.

Administrative

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

The Office of Health Review staff numbered 12 at 30 June 2002. There were 11 staff at the same time last year.

Organisational Chart as of 30 June 2002.



Promotions, publications and research

The Office of Health Review has not been involved in any formal research activities in 2001-2002. We promote our office through brochures and complaint forms that are distributed widely and are available on request. Staff also attend various forums and courses to promote awareness of the Office of Health Review.

Declaration of Interest

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 those contracts.

Subsequent events

As stated earlier, the Director, David Kerslake resigned his position on 4 August and Mr Eamon Ryan was appointed as Director for an interim period of 6 months.

No other events have occurred that may significantly effect the operations of the Office of Health Review since 30 June 2002.

Customer Feedback

At the conclusion of each complaint, an evaluation survey form is sent to both complainants and providers by the Office of Health Review for the purpose of reviewing the effectiveness of the processes used to resolve a complaint.

Complainant responses

74% of complainants who responded agreed that staff were prompt to respond to letters and phone calls. 91% agreed that staff were polite in dealing with them, and 84% agreed that the staff listened to what they had to say. 71% said that the complaint was dealt with in an unbiased way. Overall, 77% indicated that the reasons for the decisions were clearly explained. In addition, 90% found that the written information provided was easy to understand, which is a positive reflection on the reviews that our written information underwent during this financial year.

Approximately 74% of complainants who responded to the survey form indicated they had special needs, which did not tally with those who indicated they had special needs on the complaint form. This has highlighted an area where the form can be improved for the next financial year.

Some comments from complainants indicating the level of satisfaction with processes used by the Office of Health Review are:

"I am happy with the way the complaint was handled by your Office but obviously not with the outcome. My glasses remain unsuitable for the requested purpose – a problem I have not had in the past. But thank you for your courteous help".

"The service I received was excellent. This was my first experience with this sort of procedure so I needed to be guided and informed and that was done in an understanding but professional way. Thank you".

"I really appreciate what you have done for me. Thank you very much for helping me, for your time and for showing me that it's possible to write a complaint and be listened to".

"I do not agree with the findings but praise (case officer) for all the work she carried out…".

Provider responses

82% of providers who responded agreed that staff were prompt in responding to letters and phone calls. 97% agreed that staff were polite in dealing with them and 95% agreed that staff listened to what they had to say. 93% said that the complaint was dealt with in an unbiased way and overall, 91% felt that the reasons for the decisions were clearly explained. Similarly to complainants, 89% found that the written information provided was easy to understand, again a positive reflection on the written information now used by this Office which had been reviewed throughout this financial year.

Some of the comments from providers include:

"Difficult case, tactfully and efficiently handled".

" I was impressed with the research undertaken".

"I believe the issue has been handled in a caring and comprehensive manner".

"I think the Office of Health Review fulfils a useful role".

Outcomes

Feedback on how satisfied complainants were with the outcome indicated that 54% felt the issues in the complaint had been resolved, which is an increase from last financial year.

91% of providers felt the issues in the complaint had been resolved, which again was an increase from the last financial year, suggesting that satisfaction levels of both parties had increased.

When looking at provider and consumer responses combined, 77% were satisfied that the Office had resolved the issues in the complaint.

Statutory Report

Workers compensation

No workers compensation claims were made in 2001-2002.

Occupational Health and Safety

An Occupational Physiotherapist has assessed all office furniture and advised staff in relation to their specific ergonomic needs.

Statement of compliance with Public Sector Standards

The Office of Health Review has complied with the Public Sector Standards in Human Resource Management, the WA Public Sector Code of Ethics and our Code of Conduct. No applications were made for breach of standards review in 2001-2002.

Advertising and sponsorship

The Office of Health Review did not produce any written material in excess of $1500 in 2001-2002.

Waste Paper Recycling

The Office of Health Review uses a free paper recycling service provided by the building managers. The paper is collected once a week and recycled. We also have a shredder for the purposes of recycling waste paper that contains confidential information.

Information statement

The Office operates under strict confidentiality requirements, reflecting the type of work we undertake. People who are directly involved in a case can access the information on their file by applying to the office.

The Office has brochures, complaint forms and annual reports available to the public at no cost. Members of the public can request these by telephoning or visiting the office. No documents are available for purchase.

For operational work, the office holds files for each case handled. These contain information used to resolve the complaint, including responses from other parties and copies of records from health providers. In addition, the office has administrative files to store information relating to other functions of the office.

There were seven Freedom of Information requests in the 2001-2002 financial year, all of which related to personal information. Two of these were granted full access and five were granted edited access. There were no reviews and no amendments. No one was charged for access. The average time to process an application was 19 days.

Enquiries about Freedom of Information are lodged with the Complaints Manager, at the Office of Health Review, Level 17, 44 St Georges Tce, Perth, 6000.

Evaluations

There were no evaluations undertaken by the Office of Health Review in 2001-2002.

Report on Customer Group Outcomes

Disability Service Plan

In the 2001-2002 financial year, we continued to implement the policies outlined in our Disability Service Plan. We have made our publications available in braille and on audio tape and have made it clear to consumers that these are available in these formats. We continue to liaise with the building managers if an issue relating to access arises. The officer responsible for investigating disability complaints has also assisted in ensuring all staff are aware of the issues facing clients with disabilities.

Equal Employment Opportunity Outcomes

Of the 12 staff employed at the Office on 30 June 2002, 10 were women and women occupy 50% of senior positions in the office. Two main ethnic groups are represented in the staff.

Cultural Diversity and Language Services Outcomes

The Office has a Language Services Strategy and we continued to implement the policies from that strategy in 2001-2002. We continue to work with interpreters and translators and we have signage to advise of the availability of these services. The Multicultural Access Contact Officers network coordinated by the Department of Health, includes a representative from the OHR and the members of that network have been advised of our Multilingual guides.

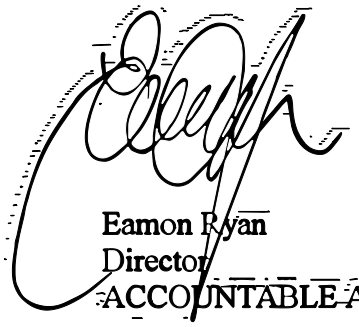
Youth Outcomes

The Office of Health Review investigates complaints from all health consumers, including children, whose parents can complain on their behalf, and young adults. We have one staff member in the age bracket of 12-25.

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 2002 and the financial position as at 30 June 2002.

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.



Eamon Ryan
Director
ACCOUNTABLE AUTHORITY

30 August 2002

Charles Spadaro
PRINCIPAL ACCOUNTING OFFICER

30 August 2002

AUDITOR **GENERAL**

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2002

Matters Relating to the Electronic Presentation of the Audited Financial Statements
This audit opinion relates to the financial statements of the Office of Health Review for the year ended June 30, 2002 included on the Office of Health Review's web site. The Director is responsible for the integrity of the Office of Health Review's web site. I have not been engaged to report on the integrity of this web site. The audit opinion refers only to the statements named below. It does not provide an opinion on any other information which may have been hyperlinked to or from these statements. If users of this opinion are concerned with the inherent risks arising from electronic data communications, they are advised to refer to the hard copy of the audited financial statements to confirm the information included in the audited financial statements presented on this web site.

Scope
I have audited the accounts and financial statements of the Office of Health Review for the year ended June 30, 2002 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 and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions so as to present a view which is consistent with my understanding of the Office's financial position, its financial performance and its cash flows.

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

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Office of Health Review
Financial statements for the year ended June 30, 2002

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 Statement of Financial Performance, 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 and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Office at June 30, 2002 and its financial performance and its cash flows for the year then ended.

K O O'NEIL
ACTING AUDITOR GENERAL
November 22, 2002

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Office of Health Review

Statement of Financial Position

As at 30th June 2002

	Note	2002 $	2001 $
CURRENT ASSETS			
Cash assets	9	453,144	388,512
Total current assets		453,144	388,512
NON-CURRENT ASSETS			
Property, plant and equipment	10	53,221	63,078
Total non-current assets		53,221	63,078
Total assets		**506,365**	**451,590**
CURRENT LIABILITIES			
Payables		17,552	2,991
Accrued salaries	11	18,234	15,781
Provisions	12	79,310	61,428
Total current liabilities		115,096	80,200
NON-CURRENT LIABILITIES			
Provisions	12	62,358	41,652
Total non-current liabilities		62,358	41,652
Total liabilities		**177,454**	**121,852**
Net Assets		**328,911**	**329,738**
EQUITY			
Accumulated surplus / (deficiency)	13	328,911	329,738
Total Equity		**328,911**	**329,738**

The Statement of Financial Position should be read in conjunction with the notes to the financial statements.

Office of Health Review

Statement of Cash Flows

For the year ended 30th June 2002

	Note	2001/02 $ Inflows (Outflows)	2000/01 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Government appropriations		983,000	900,000
Net cash provided by Government		983,000	900,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(307,794)	(324,082)
Employee costs		(594,823)	(530,822)
Receipts			
GST receipts on sales		(1,350)	1,467
Other receipts		(7,200)	4,340
Net cash (used in) / provided by operating activities	14(b)	(911,167)	(849,097)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	10	(7,201)	(22,005)
Proceeds from sale of non-current assets	3	-	2,215
Net cash (used in) / provided by investing activities		(7,201)	(19,790)
Net increase / (decrease) in cash held		64,632	31,113
Cash assets at the beginning of the reporting period		388,512	357,399
Cash assets at the end of the reporting period	14(a)	453,144	388,512

The Statement of Cash Flows should be read in conjunction with the notes to the financial statements.

Office of Health Review

Statement of Financial Performance

For the year ended 30th June 2002

	Note	2001/02 $	2000/01 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses		635,747	546,160
Superannuation expense		53,519	47,862
Supplies and Service Expense		32,056	18,475
Repairs, maintenance and consumable equipment expense		111,982	130,334
Depreciation expense	2	17,058	17,668
Net loss on disposal of non-current assets	3	-	3,447
Other expenses from ordinary activities	4	153,548	190,878
Total cost of services		1,003,910	954,824
Revenues from Ordinary Activities			
Other revenues from ordinary activities	5	-	4,340
Total revenues from ordinary activities		-	4,340
NET COST OF SERVICES		**1,003,910**	**950,484**
Revenues from Government			
Output appropriations	6	983,000	900,000
Liabilities assumed by the Treasurer	7	-	46,403
Resources received free of charge	8	20,083	19,204
Total revenues from government		1,003,083	965,607
Change in net assets before extraordinary items		(827)	15,123
Extraordinary revenue / (expense)		-	-
Change in net assets		**(827)**	**15,123**
Net increase / (decrease) in asset revaluation reserve		-	-
Total revenues, expenses and valuation adjustments recognised directly in equity		-	-
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(827)**	**15,123**

The Statement of Financial Performance should be read in conjunction with the notes to the financial statements.

Note 1 SIGNIFICANT 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 Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Australian Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, 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, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, 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, except for certain assets and liabilities which, as noted, are measured at valuation.

(b) Acquisition of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration are initially recognised at their fair value at the date of acquisition.

(c) Depreciation of Non-current Asset

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

Computer equipment	5 to 15 years
Furniture and fittings	5 to 50 years
Other mobile plant	10 to 20 years

(d) Leases

The Office of Health Review has entered into a number of operating lease arrangements for the rent of buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Statement of Financial Performance over the lease term as this is representative of the pattern of benefits to be derived from the leased items.

The Office of Health Review has no contractual obligations under finance leases.

(e) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets. These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(f) Receivables

Receivables are recognised at the amounts receivable, as they are due for settlement no more than 30 days from the date of recognition.

Collectability of receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised where some doubts as to collection exist.

(g) Payables

Payables, including accruals not yet billed, are recognised when the Office of Health Review becomes obliged to make future payments as a result of a purchase of assets or services. Payables are generally settled within 30 days.

(h) 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. The Office of Health Review considers the carrying amount approximates net fair value.

(i) Provisions

Employee Entitlements

(i) Annual and Long Service Leave

The liability for annual leave represents the amount which the Office of Health Review 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 is recognised, and is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, 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 on national government securities to obtain the estimated future cash outflows.

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 Pension Scheme, a defined benefits pension scheme now closed to new members, or 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 either of these schemes become non-contributory members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

The liability for future payments under the Pension Scheme is provided for at reporting date.

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. A revenue "Liabilities assumed by the Treasurer" equivalent to the change in this unfunded liability is recognised in the Statement of Financial Performance.

From 1 July 2001 employer contributions were paid to the GESB in respect of the Gold State Superannuation Scheme and West State Superannuation Scheme. Prior to 1 July 2001, the unfunded liability in respect of these schemes was assumed by the Treasurer. An amount equivalent to the employer contributions which would have been paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme if the Office of Health Review had made concurrent employer contributions to those schemes, was included in superannuation expense. This amount was also included in the revenue item "Liabilities 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 GESB's records are not structured to provide the information for the Office of Health Review. Accordingly, deriving the information for the Office of Health Review is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

(j) Revenue Recognition

Revenue from the sale of goods, disposal of other assets and the rendering of services, is recognised when the Office of Health Review has passed control of the goods or other assets or has delivered the services to the customer.

(k) 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.

(l) Comparative Figures

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

Note 2 Depreciation expense

	2001/02 $	2000/01 $
Computer equipment and software	12,846	12,993
Furniture and fittings	1,137	1,459
Other plant and equipment	3,075	3,216
	17,058	17,668

Note 3 Net profit / (loss) on disposal of non-current assets

	2001/02 $	2000/01 $
a) Proceeds from sale of non-current assets		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash by the Authority	-	2,215
Gross proceeds from sale of non-current assets	-	2,215
b) Profit / (Loss) on disposal of non-current assets:		
Computer equipment and software	-	(138)
Furniture and fittings	-	(5,524)
Other plant and equipment	-	2,215
		(3,447)

Note 4 Other expenses from ordinary activities

	2001/02 $	2000/01 $
Workers compensation insurance	6,006	7,762
Other employee expenses	25,759	19,691
Motor vehicle expenses	4,753	2,187
Insurance	7,478	6,157
Communications	19,512	23,204
Printing and stationery	14,402	21,770
Rental of property	-	2,479
Audit fees - external	11,000	11,000
Other	64,638	96,628
	153,548	190,878

Note 5 Other revenues from ordinary activities

	2001/02 $	2000/01 $
Other - Sale of Sundry Items	-	4,340
	-	4,340

		2001/02 $	2000/01 $
Note 6	**Government appropriations**		
	Cash appropriations (I)	983,000	900,000
		983,000	900,000

		2001/02 $	2000/01 $
Note 7	**Liabilities assumed by the Treasurer**		
	Superannuation	-	46,403

		2001/02 $	2000/01 $
Note 8	**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	11,000	11,000
	Other		
	- Crown Solicitors Office	9,083	8,204
		20,083	19,204

Where assets or services have been received free of charge or for nominal consideration, the Office of Health Review recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.

		2001/02 $	2000/01 $
Note 9	**Cash assets**		
	Cash on hand	400	400
	Cash at bank – general	452,744	388,112
		453,144	388,512

		2001/02 $	2000/01 $
Note 10	**Property, plant and equipment**		
	Computer equipment and software		
	At cost	76,711	69,511
	Accumulated depreciation	(51,808)	(38,963)
		24,903	30,548
	Furniture and fittings		
	At cost	18,074	18,074
	Accumulated depreciation	(3,990)	(2,854)
		14,084	15,220
	Other plant and equipment		
	At cost	35,269	35,269
	Accumulated depreciation	(21,035)	(17,959)
		14,234	17,310
	Total of property, plant and equipment	53,221	63,078

Payments for non-current assets	**2001/02 $**	**2000-01 $**
Payments were made for purchases of non-current assets during the reporting period as follows:		
Paid as cash by the Authority from output appropriations	7,201	22,005
Gross payments for purchases of non-current assets	7,201	22,005

	Computer Equipment and Software $	**Furniture and fittings $**	**Other plant and equipment $**	**Total $**
2001/02				
Carrying amount at start of year	30,548	15,220	17,310	63,078
Additions	7,201	1	-	7,202
Disposals -	-	-	(1)	(1)
Revaluation increments / (decrements)	-	-	-	-
Depreciation	(12,846)	(1,137)	(3,075)	(17,058)
Write-off of assets	-	-	-	-
Carrying amount at end of year	24,903	14,084	14,234	53,221

		2001-02 $	**2000-01 $**
Note 11	**Accrued salaries**		
Amounts owing for: Office of Health Review Staff 10 days from 21 June to 30 June 2002		18,234	15,781

		2001-02 $	**2000-01 $**
Note 12	**Provisions**		
Current liabilities:			
	Annual leave	64,794	47,000
	Long service leave	14,516	14,428
		79,310	61,428
Non-current liabilities:			
	Long service leave	62,358	41,652
		62,358	41,652
Total employee entitlements		141,668	103,080

The Office of Health Review considers the carrying amount of employee entitlements approximate the net fair value.

		2001-02 $	2000-01 $
Note 13	**Accumulated surplus / (deficiency)**		
	Balance at beginning of the year	329,738	314,615
	Change in net assets	(827)	15,123
	Balance at end of the year	328,911	329,738

		2001-02 $	2000-01 $
Note 14	**Notes to the statement of cash flows**		
	a) Reconciliation of cash		
	Cash assets 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 follows:		
	Cash assets (Refer note 9)	453,144	388,512
		453,144	388,512
	b) Reconciliation of net cash flows used in operating activities to net cost of services		
	Net cash used in operating activities (Statement of Cash Flows)	(911,167)	(849,097)
	Increase / (decrease) in assets:		
	Decrease / (increase) in liabilities:		
	Payables	(14,561)	673
	Accrued salaries	(2,453)	(4,235)
	Provisions	(38,588)	(11,103)
	Non-cash items:		
	Depreciation expense	(17,058)	(17,668)
	Profit / (loss) from disposal of non-current assets	-	(3,447)
	Superannuation liabilities assumed by the Treasurer		- (46,403)
	Resources received free of charge	(20,083)	(19,204)
	Net cost of services (Statement of Financial Performance)	(1,003,910)	(950,484)

		2001-02	2000-01
Note 15	**Remuneration of members of the accountable authority and senior officers**		
	Remuneration of senior officers		
	The number of Senior Officers (other than members of the Accountable Authority), whose total of fees, salaries, superannuation and other benefits for the reporting period, fall within the following bands are:		
	$150,001 - $160,000	1	1
	Total	1	1

	2001-02 $	2000-01 $
The total remuneration of senior officers is:	158,866	143,245

The superannuation included here represents the superannuation expense incurred by the Office of Health Review in respect of Senior Officers (other than members of the Accountable Authority).

Note 16 Explanatory statement

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

	2001/02 $	2000/01 $	Variation $
Superannuation Expense Variance due to increase of FTE by 1 to 12	53,519	47,862	5,657
Employee Expenses Variance due partly to increase of FTE by 1 to 12 and redundancy payout to one FTE towards end of financial year	635,747	546,160	89,587
Supplies & Services Expense The variance is due to increase in cost of purchasing independent medical reports from medical advisers, plus there were 3 months of free rental charges in the 2000-2001.	32,056	18,475	13,581
Repairs, Maintenance and Consumable Equipment Expense This variance is due to decreased costs for this financial year. Expense in previous years was inflated for one off set up costs.	111,982	130,334	(18,352)
Output Appropriation Revenue The variance is due to increased appropriation to allow for superannuation costs previously assumed by the Treasurer.	983,000	900,000	83,000
Liabilities assumed by Treasurer The variance is due to superannuation expense being paid by the Office of Health Review. Appropriation allowed for this payment.	-	46,403	(46,403)

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.

There are no significant variations between estimates and actuals results.

Note 17 Commitments for Expenditure

	2001/02 $	2000/01 $
Operating lease commitments:		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	121,036	106,385
Later than one year, and not later than five years	472,061	408,100
Later than five years	-	111,798
	593,097	626,283

Note 18 Contingent liabilities

At the reporting date, the Office of Health Review is not aware of any contingent liabilities.

Note 19 Events occurring after reporting date

There were no events occurring after the reporting date, which have a significant effect on these financial statements.

Note 20 Related bodies

The Office of Health Review had no related bodies during the reporting period.

Note 21 Affiliated bodies

The Office of Health Review had no affiliated bodies during the reporting period.

Note 22 Financial instruments

a) Interest rate risk exposure

The following table details the Office of Health Review's exposure to interest rate risk as at the reporting date:

	Weighted Average Effective Interest rate %	Non-interest bearing $000	Total $000
As at 30th June 2002			
Financial Assets			
Cash assets	0.0%	453,144	453,144
		453,144	453,144
Financial Liabilities			
Payables		17,552	17,552
Accrued Expenses		18,234	18,234
		35,786	35,786
Net financial assets / (liabilities)		417,358	417,358
As at 30th June 2001			
Financial Assets			
Cash assets	0.0%	388,512	388,512
		388,512	388,512
Financial Liabilities			
Payables		2,991	2,991
Accrued Expenses		15,781	15,781
		18,772	18,772
Net financial assets / (liabilities)		369,740	369,740

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 Office of Health Review's maximum exposure to credit risk in relation to those assets.

c) Net fair values

The carrying amount of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in note 1 to the financial statements.

Estimates of Expenditure for 2002/2003

The following Estimates of Expenditure for the year 2002/2003 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 2002/2003 do not form part of the preceding audited financial statements.

Revenue	**2002/2003**
Consolidated Fund	$1 026 058