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Health Rights Commission

30 September 2003

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

Dear Minister

In accordance with the provisions of the *Health Rights Commission Act 1991* and the *Financial Administration and Audit Act 1977*, I am pleased to submit the Annual Report of the Health Rights Commission for the year ended 30 June 2003.

Yours sincerely

David Kerslake
Commissioner

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Foreword

The Health Rights Commission was established to provide an independent and impartial avenue for reviewing health service complaints; ensuring individual remedies where warranted, and also ensuring that the lessons learned from complaints result in systemic improvements that enhance the overall quality of health services in Queensland.

David Kerslake
Commissioner

This is my first Annual Report as Health Rights Commissioner for Queensland. My appointment took effect early in August 2002.

The period since then has contained some interesting challenges. At the time of my appointment the Commission had been in operation for 10 years and in that time had developed a range of processes and procedures with which I needed to make myself familiar. At the same time, a recent review of the Commission had recommended changes, endorsed by Cabinet, to a number of the ways we do business. The early part of my tenure has seen the confirmation of some approaches and changes to others. I first wish to express my gratitude to my staff for their patience, support and sheer hard work throughout this process. I should also acknowledge the contribution of previous Commissioners, not least for choosing staff wisely.

My overall impression since joining the Commission is that it is a very professional organisation whose staff are fully committed to the Commission's key roles of fairly reviewing individual complaints and providing feedback, where appropriate, to foster best practice in the health system. I have also been impressed by the high regard in which key stakeholders hold the Commission. I have set myself the goal of further strengthening relationships with these groups.

I am acutely aware that the effectiveness and credibility of statutory review agencies such as the Health Rights Commission also depends to a large degree on the extent to which the community as a whole is aware of their existence. The right to complain is of little use to people who are unaware a complaint agency exists. Equally, I am conscious of the fact that, individually, agencies have limited resources available to carry out community outreach activities. One of my early initiatives was to approach other review agencies to explore ways that, together, we might better promote public awareness of the services we offer. As a result, and with the assistance of Multicultural Affairs Queensland (a division of the Department of the Premier and Cabinet), a number of like agencies have embarked upon a combined project to promote access and awareness among groups from culturally and linguistically diverse backgrounds. By combining some of our resources, we hope to spread the message more widely than would otherwise be possible, with plans in place to broaden this approach to include Aboriginal and Torres Strait Islander communities. This initiative and some of the Commission's other awareness strategies are canvassed in more detail elsewhere in this report.

Since the Commission was first established in 1992, it has dealt with over 20,000 complaints and enquiries from members of the public. The Commission's track record in dealing with those complaints fairly and thoroughly is, in my view, second to none, as evidenced by the case studies that appear elsewhere in this report. It is perhaps worth noting that approximately 35% of the cases pursued by the Commission in the past year were partially or fully substantiated or, at least, resulted in outcomes sought by the complainant. This included apologies, negotiated settlements and policy/procedural changes. Arguably, many other complainants benefited from the assurance provided by an independent body that the service they had received was reasonable, although I acknowledge that not all would see it this way. I should also emphasise that it is not just health consumers who stand to benefit from the Commission's work. Individual health providers also benefit, either through the opportunity to agree on a remedy to a complaint, or through an independent body verifying that the treatment they provided was appropriate (potentially avoiding litigation either way). The community as a whole also stands to benefit from improvements to health practices and procedures that may stem from Commission investigations.

Having said that, where people make a complaint they also quite reasonably seek to have the matter dealt with as soon as possible. It is fair to say that over the years, and in common with many other review agencies, the Commission has struggled to keep up with the steady increase in the number and complexity of complaints it has received. This is reflected in the backlog of complaints at the time of my appointment, with a number of cases in various stages waiting to be dealt with, some of which were over two years old.

I am grateful to the Government for the temporary increase in funding given to the Commission in the past year to help address this backlog. It is not sufficient, however, for the Commission simply to ask for more money when the going gets tough. We also need to be constantly striving to "sharpen our focus", looking out for ways we can deal with cases more quickly. Over the past year we have spent considerable time looking inwards and reviewing our complaints handling procedures. One successful strategy has been to place increased emphasis on "direct resolution", providing complainants with advice and guidance to enable them to pursue their complaints directly with the health provider in the first instance. In our experience, if a complaint can be resolved without the need for external intervention there is less likelihood of the complaint escalating and a better prospect of maintaining the all-important relationship between patient and provider. So far this has led to a reduction in the number of formal complaints dealt with by the Commission. This in turn has enabled us to put more emphasis on cases where we may potentially make a real difference, such as those that reflect significant individual concerns or reveal systemic or system-wide problems.

To facilitate timeliness, our processes have been modified to keep to an absolute minimum the number of stages that each case goes through before it is finalised. The Commission has bolstered its intake area and if a complaint can be adequately dealt with at this initial stage, we leave it there. This reflects our desire to deal with complaints as informally and expeditiously as possible, with the added advantage of reducing the amount of double handling of complaints. On the other hand, where a complaint requires more formal processes or input from a more senior officer, every effort is made to identify this at the earliest opportunity and move the case on at that point. In the course of the year, formal investigations that were already underway were reviewed to determine if further work was warranted and, if so, what the focus of those enquiries should be.

It is pleasing to report that as a result of these initiatives, the Commission has reduced its backlog of outstanding cases awaiting allocation from approximately 340 to less than 25. It has been a very busy year for the Commission, but one where I feel we have laid some foundations that will stand us in good stead in the future.

Realistically, however, some major challenges lie ahead.

Firstly, although the Commission is required to invite providers to respond to complaints made against them, it has no power to compel them to do so. In many cases, this means that the Commission's capacity to deal with complaints quickly and efficiently will ultimately depend upon the willingness of health service providers to respond to complaints in a thorough and timely way. No one likes being criticised and I can therefore understand why some providers might react to complaints in a negative or defensive way. I also appreciate that we live in an increasingly litigious age. This is recognised in the Health Rights Commission Act, which provides that the Commission can refer complaints to a process of conciliation, a setting in which anything said or admitted by either party is protected and cannot be used in a court of law. While this may be appropriate in cases where compensation is a potential outcome, the vast majority of complaints made to the Commission simply do not fall into this category. Nevertheless, in the Commission's experience, providers (or, in many cases, their advisers) often decline to provide even the barest response to a complaint unless the matter can be dealt with in conciliation. Given that the Commission has a limited number of available, trained conciliators, and given that recent personal injuries legislation has in any event freed up access to this type of information, I hope that in future, providers can more easily be encouraged to respond to complaints at the outset. This will enable the Commission to take greater advantage of the revised complaints processes referred to above and, I have no doubt, enable complaints made to us to be resolved one way or the other with the minimum of fuss and delay.

Secondly, after 10 years of operation the Commission needs to consider carefully what its strategic priorities should be for future years. I have already referred to the need to do more to publicise the Commission and its activities. Another area where I feel we can do more, consistent with the objectives set down in our legislation, is the provision of advice to providers on their own complaints handling mechanisms and, better still, on how best to avoid complaints in the first place. For example, health complaints commissioners in Australia and elsewhere generally agree that 80% or more of the complaints they receive have some form of communication issue at the core. There would appear to be benefits in all health professionals undertaking ongoing training in this area. Appearing elsewhere in this report is an article on this topic I published in the Australian Medical Association Queensland journal that illustrates this point. I am keen to obtain input from all health professions on whether the Commission could make a worthwhile contribution in this area.

I would like to pay tribute to one of the Commission's long serving officers who retired during the year. Linda Morley joined the Commission as an Enquiry Officer in 1994 and was appointed Manager Complaints in 1998. She served with distinction under three different Commissioners and set a standard of commitment and integrity for others to follow. She has not really retired, but opted for a "sea change". We wish her well for the future.

Finally, considering the case studies that appear in this report, it is important to record that the Commission not only receives complaints, from time to time it also receives accolades about particular health services. At one of our recent community outreach activities we ran a competition asking participants to tell us in 50 words or less about "the best health service you received and why you felt it was so good". Responses included:

My Doctor would have to be the best. You feel comfortable and know that she is extremely caring. Good listener, good adviser and will send you straight away for tests - and best of all - rings to tell you the results. And doesn't look at the clock. Pleasure to visit her when I'm sick.

and

The best health service I got was from the charge nurse. She really cared for me. When I came to the hospital I was very ill and she called the consultant and arranged admission to ICU. She really listened to me. She saved my life.

That seems to be an appropriately positive note on which to finish.

David Kerslake
Commissioner

Analysis of Complaints

The Commission received 4,472 new complaints during the year, on top of an existing backlog of approximately 340 complaints awaiting allocation in different parts of the Commission.

4,840 complaints were closed during the year. Of these, 4,573 were resolved by the intake and assessment team. This reflects an increased emphasis on resolving complaints as quickly and informally as possible.

As well as managing an increased number of complaints, the Commission also made significant inroads into the backlog of complaints awaiting allocation, and finalised a number of older cases. The efforts of very committed and efficient staff cannot be too highly emphasised.

Given the Commission's limited resources, addressing the backlog of complaints awaiting assessment, investigation or conciliation also required a fresh approach. The following strategies were put in place during the reporting year.

Intake

The intake area is the initial point of contact for a person wishing to make a complaint. The Commission receives a considerable number of calls and correspondence from people either wishing to make a complaint or seeking advice in relation to a health service they or a family member have received. The intake staff obtain information at this stage and, where appropriate, provide advice to the caller to enable them to address their concerns. The efficiency of our processes at this stage is crucial to the Commission's ability to handle a high volume of complaints in a timely way.

The Commission finds that many complaints, especially those of a less serious nature, can be dealt with reasonably quickly by encouraging direct resolution between the parties concerned. In view of this, during the reporting period the Commission placed greater emphasis on assisting complainants to resolve their complaints by initially directing them to the health service provider. During the year, the Commission developed a Direct Resolution information sheet, which provided advice to complainants with a view to facilitating resolution of complaints between the parties involved, where this was appropriate.

In some cases, the Commission contacted the health service provider to encourage them to participate in this direct resolution process. Additionally, where a complainant had unsuccessfully tried to obtain an explanation from a provider the Commission contacted that provider to encourage them to respond. Some examples from cases dealt with in this manner are as follows:

A woman contacted the Commission stating she had taken her 15-year-old daughter to her General Practitioner (GP) for advice on contraception. She complained that the information the GP had given her daughter was minimal and he had told her daughter that she should not expect boys to wear condoms. The woman said that her daughter's blood pressure was not taken and she was dissatisfied with the whole consultation. The woman was not confident in approaching the GP to resolve matters so the Commission contacted him to see if a meeting to resolve matters was appropriate. The GP responded directly to the woman. She was satisfied with the response and the fact that the GP had acknowledged her views, and the matter was closed.

In another case, a woman complained that a nurse at her medical centre had given her an injection that had not been ordered by the doctor. The Commission suggested that she contact the doctor in the first instance to obtain an explanation. The woman later contacted the Commission stating she had spoken with her doctor who had satisfied her that there had been no error but a breakdown in communication. In view of this, the woman withdrew the complaint.

Even where the Commission accepts complaints for action, complainants are encouraged wherever possible to approach the provider for additional information, such as medical records, which would assist the Commission in addressing their complaint sooner. This helps the Commission to reduce the time spent in obtaining information relevant to each complaint and to move more quickly to identify and analyse issues raised by the complaint.

The intake area has traditionally been staffed by permanent part time staff, as experience has shown that full time staff tend to "burn out" from the sheer number of complaints dealt with each day. The Commission has now taken a different direction, moving to appoint more permanent staff in this area but ensuring that they only spend part of their time dealing directly with public enquiries. They spend the remainder of the time analysing and researching individual cases to maximise the number of cases able to be finalised at this stage. This has reduced the pressure on other areas of the Commission and, at the same time, ensured that complaints are progressed at the earliest possible opportunity.

Assessment

Complaints that are not able to be resolved informally or that are deemed unsuited to such an approach are assessed to determine what further action, if any, is necessary. During this assessment stage, the Commission seeks to gather sufficient information to enable it to make an informed decision. Typically, this may entail obtaining access to patient records and perhaps obtaining informal advice on clinical issues from independent experts.

Sometimes the information obtained at this stage enables the Commission to reassure the complainant that the health service they received was reasonable, and the case is closed at that point. Other cases may need to be referred for further statutory action, such as conciliation or investigation. It is important, however, that as far as possible cases are not referred on until the case has been thoroughly assessed and deemed suitable for further action.

At the beginning of the reporting period there were approximately 254 cases being assessed. This amounted to a caseload of between 45 and 50 for each officer in this section. A further 142 cases were awaiting allocation.

The amount of work involved with such heavy caseloads is obviously difficult to manage. In the past, this often meant that cases were unable to be finalised within the statutory timeframes for the preliminary assessment of complaints. Such cases were automatically referred to another stage (investigation or conciliation) merely because the time frame for assessment had run out, not because they had been deemed suitable for formal statutory action. The Commission's inability to complete assessments within the specified timeframe was often brought about by factors beyond its control, such as delays in receiving the provider's response. Cases that were automatically referred on then began to accumulate at the next stage, leading to backlogs and inevitable delays.

A recent external review of the Commission's operations, endorsed by Cabinet, suggested that the time restrictions on dealing with complaints at the initial assessment stage should be relaxed. In line with this recommendation, cases are now kept longer at the more informal assessment stage and only referred for more formal statutory action where justified by the nature or complexity of the complaint. This has enabled the Commission to deal with the majority of cases at the assessment stage. This in turn has afforded greater flexibility in juggling staff resources.

Through this less rigid approach to time restrictions the Commission has virtually eliminated the existing backlog of complaints. The success of this strategy has also seen more providers responding to complaints at an earlier stage as they realise that the Commission is taking a more pro-active approach to managing its complaint handling processes. With the benefit of both parties' views at an early stage, the Commission has often been able to obtain independent advice with the result that many cases have been resolved at an early stage when otherwise they would have been placed in a queue in a conciliation backlog.

Some examples of the success of this strategy are as follows:

A woman said that her son, who suffered from muscular dystrophy, had been referred to a public hospital for tests by his GP. She said her son had been kept in hospital for 24 - 26 hours having further tests done before being discharged home with a further follow-up appointment. She said her son died six days later. The woman said she sought an explanation from the hospital as to why her son had been discharged but had not received a response. The Commission contacted the hospital during assessment. Although it was initially reticent to meet with the woman and her family, an appointment was made. When the Commission later contacted the woman she said that the meeting had been a success and the family had received a satisfactory explanation. The hospital also thanked the Commission for facilitating a satisfactory outcome. In view of this the complaint was closed.

In another case, a woman said that her mother had been admitted to a public hospital following a heart attack. She said that her mother was put on blood thinning medication which had adverse side effects and she believed the standard of care her mother received was unsatisfactory. The Commission arranged for a meeting between the woman and the hospital and contacted the woman following the meeting. The woman advised the Commission the meeting had been much better than she expected. She said the hospital staff had been very welcoming and provided very honest explanations, admitting that the standard of care could have been better. She had received an apology and assurances that new procedures were being implemented to prevent the same problem from occurring again. As the complaint had been resolved to the satisfaction of the complainant, and the revised procedures were appropriate, the case could be closed without further action. The benefits of this approach were not only an earlier resolution for the complainant, but an earlier opportunity for the Commission to satisfy itself that procedures were in place to prevent the problem from recurring.

Having addressed the new complaints backlog, assessing officers' caseloads have been reduced to the point where they are now able to assist in the conciliation of the less complex complaints. This not only provides continuity for the complainant and provider who are dealing with the same case officer, but also provides case officers with opportunities to enhance their skills for future employment opportunities.

Conciliation

Conciliation provides a forum for dispute resolution that is both confidential and privileged under the Health Rights Commission Act.

105 cases were referred to conciliation during the reporting period, adding to a substantial backlog of cases that had previously been earmarked for conciliation but on which action had not yet commenced. Significant progress was made in reducing the backlog, however, with a total of 161 conciliation cases being finalised during the same period. At this time there are only 19 cases awaiting allocation to a conciliator. All of these cases are of recent origin.

Two key strategies contributed to this improvement.

Firstly, the revised assessment procedures referred to earlier enabled many cases to be resolved at an earlier stage, without the need to refer them to conciliation. Quite a few of those cases would otherwise have been held in abeyance until conciliators were available to deal with them. This substantially reduced the pressure on the conciliation team.

Secondly, delegations were provided to less senior staff enabling them to conciliate less complex cases with support and guidance from more senior officers. This enabled more senior conciliators to focus their attention on the more complex or sensitive cases.

In the past 12 months there appears to have been an increase in the number of instances where hospitals or their insurers suggest a potential complainant should contact the Commission for the specific purpose of negotiating a settlement in conciliation. There have also been a number of cases where following the initial notification of a complaint, the provider has responded very quickly, acknowledging a problem with the care provided and requesting conciliation as a means of resolving the complaint.

This suggests that providers have quickly identified and analysed those adverse events that could leave them vulnerable to a legal claim, but also reinforces the confidence that parties have in the fairness and impartiality of the Commission's conciliation processes.

There are many possible outcomes in conciliation, including explanations, apologies, referral to the appropriate registration body or improvements in health care practices and procedures. Increasingly, however, complainants are seeking monetary compensation as an outcome of their complaint.

Compensation may be negotiated through conciliation as an alternative to court action, but with the same standard of proof as would apply in a court. The conciliator does not have an adjudicating role and does not make a decision about who is right or wrong as a judge might do. Often, however, expert advice obtained by the Commission can shed significant light on issues that may be in dispute between the parties, such as whether treatment was of an adequate standard or the degree of harm that resulted from treatment found to be inadequate. This may assist the parties to reach a voluntary agreement on compensation, or an understanding of why compensation is not warranted in the particular circumstances. The aims are to avoid unnecessary and costly litigation by helping the parties to reach a realistic appraisal of the issues involved and, as far as possible, to preserve goodwill between the parties.

In one case a woman complained that when she presented to a hospital with acute leg pain, the hospital made a diagnosis of cellulitis without ordering an x-ray or undertaking any other investigation. Some nine months later her GP referred her to a private orthopaedic surgeon who ordered x-rays that revealed a fracture of both the tibia and fibula.

The woman said she had been severely incapacitated during this entire period and felt the hospital was entirely responsible for failing to investigate thoroughly and diagnose the fracture.

The hospital agreed to explore the complaint further in conciliation. Subsequently, however, the hospital's solicitor questioned whether it could be established that the fracture had occurred at the time of the woman's initial presentation, or whether the fracture may have occurred at a later date. At the Commission's request, an independent radiologist agreed to review the x-rays taken of the woman's leg at the time the fracture was diagnosed. He confirmed that in all probability the fracture had occurred some nine months before the x-rays were taken and was, therefore, the likely cause of the severe pain the woman had experienced at the time of her presentation to hospital.

On the basis of this opinion, a settlement was successfully negotiated in conciliation.

Investigation

At the beginning of the reporting period there were approximately 60 cases open in investigation, with a backlog of 36 cases waiting to be actioned. 35 new cases were received and allocated for investigation during the year. Despite this heavy caseload, 53 investigations were completed in the same period. 56 cases remain open in investigation but there are no longer any cases waiting to be allocated.

One of the benefits of relaxing the time frames has been that a number of cases have been able to be finalised at the assessment stage that would otherwise have been allocated for investigation. The Commission expects this trend to continue over time, enabling the investigation team to concentrate on those more complex or sensitive cases that warrant more detailed analysis.

The Commission has also taken a conscious decision to deal with those cases that are referred for investigation, as informally as possible. Under the Health Rights Commission Act, the Commission can exercise formal powers to require parties to produce information such as patient records or other relevant documents. The Commission's preferred option, however, is to work in cooperation with the parties and to facilitate the provision of information in an informal setting wherever possible, regardless of the seriousness of the issues raised in the complaint. Co-operation from health providers enables the Commission to make inquiries in a timely manner without needing to invoke formal powers, and at the same time demonstrates the good faith of providers and their commitment to open disclosure.

Major issues that were the subject of investigations during the year included standards of mental health care for indigenous consumers with suicidal ideation, the review of hospital protocols for the risk assessment and management of pressure sores, and the review of protocols for monitoring intravenous sites.

In one case, the Commission found that a hospital had inadequate protocols for intravenous cannulation monitoring which led to a serious infection in a man with a cardiac condition. Following on from the Commission's recommendations, the hospital rewrote the protocols, establishing a system for recording relevant information and educating nursing and medical staff accordingly. The Commission subsequently received a complaint against a 2nd hospital which raised similar concerns. With permission, the Commission passed on the revised protocols developed by the first hospital. They were willingly adopted by the second hospital, resulting in improvements that stood to benefit patients in two different communities.

In accordance with the Health Practitioners (Professional Standards) Act and the Nursing Act, the Commission is responsible for monitoring investigations conducted by registration bodies. This responsibility falls primarily to the Commission's investigations team. During the year, 141 reports were reviewed. Following on from recommendations made by the recent review of the Commission, a conscious decision was taken to place greatest emphasis on those cases involving allegations of serious misconduct or significant competency issues.

Conclusion

The Commission has been very fortunate in the quality and dedication of its staff whose efforts have been recognised by complainants and providers alike for their efficient and unbiased approach to complaints.

In one case, a surgeon wrote to the Commission about the way it had assessed a complaint against him.

"The officer's dealings with myself, though probing and thorough, were most professional.... The Commission's handling of the matter inspires an all too rare confidence in the wider medico-legal arena in current times".

In another case, the Commission had no jurisdiction to deal with a particular complaint and referred the matter to another agency. The complainant wrote to the Commission about the assistance he had received.

"I have never experienced anyone who has spent so much valuable time towards one in need. You are a much valued staff member of the Health Rights Commission and your professionalism is beyond dispute".

Of course, in any "watchdog" agency it is never possible to meet the expectations of every client, given that there are at least two sides to every story. It is nevertheless refreshing to see that the Commission receives fewer brickbats than it does bouquets.

Complaints Liaison Officer

The primary role of the Complaints Liaison Officer is to provide support to persons who allege that they have been victims of sexual misconduct by health care providers, or in other cases where the complainant is particularly distressed. This support can include referral to, and liaison with counselling services and other agencies. The Complaints Liaison Officer can also accompany the complainant to court, the Health Practitioners Tribunal or Professional Conduct Committee appearances, or to have statements taken by the Queensland Police Service.

During the year, a total of 68 new complaints of alleged sexual misconduct were received by the Commission, an increase of 18 over the previous year. Of these, 24 were confirmed in writing and the complainants received ongoing support. An additional 24 complainants whose matters had commenced in the previous year continued to receive support. Many of these were serious complaints where criminal charges had been laid or where a provider was facing a disciplinary hearing. During the sometimes lengthy period between the committal hearing and the trial, or in the course of investigations conducted by Health Practitioner Registration Bodies, the Complaints Liaison Officer provides an important point of contact for complainants.

Support networks continued to be maintained throughout the year with sexual assault support services and other relevant agencies throughout the State. These included the Sexual Crimes Investigation Unit of the Queensland Police Service and the Office of the Adult Guardian. This enabled the Commission to provide complainants with the most-up-todate and relevant information about other areas that could provide additional assistance.

In addition to this support function, the Complaints Liaison Officer assists the Commission with broader policy development. For example, in the latter part of 2002, the Complaints Liaison Officer was a member of the Process Committee engaged by the Commissioner to examine the processing of complaints, with a view to reducing backlogs and identifying areas for improvement. A comprehensive audit of workflow practices was undertaken and consultations with staff and stakeholders were performed in which the Complaints Liaison Officer played a large part.

Other policy work undertaken by the Complaints Liaison Officer included submissions made to the following:

- Office of the Federal Privacy Commissioner - Public Interest Determination under the *Privacy Act 1988*.
- Queensland Health - Review of Public Patient Charter.
- NSW Health Care Complaints Commission - Using Consumer Complaints to make Health Services Safer and Better.
- Comments on Discussion Paper about the establishment of an Australian Council of Complementary Medicine.
- Standards Australia International - Draft Open Disclosure Standard.
- NADRAC - Alternative Dispute Resolution Terminology Discussion Paper.
- National Herbalists Association of Australia - Response to Discussion Paper.
- Health and Disability Commissioner New Zealand - response to survey.
- University of Queensland - Review of the School of Medicine in 2003.

Sexual misconduct

The Commission's Complaints Liaison Officer has reported an increase in complaints of alleged sexual misconduct being made to the Commission. This is particularly where the provision of a health service might entail "hands on" contact or require the removal of clothing. For example, complaints have been received where inappropriate and unwelcome sexual touching has occurred and/or suggestive comments have been made during consultations.

In the case of one massage therapist, the Commission received complaints from five separate women who alleged sexual assault. The cases were referred to the Queensland Police Service and the Complaints Liaison Officer continued to provide support to the women involved during the police investigation process, thereby attempting to minimise the trauma they had suffered. Assistance was provided via liaison with the police, providing referrals to counselling services and accompanying the women to give police statements. This support was welcomed by the women, given that the legalistic environment can be another distressing experience following the alleged incident. The practitioner was recently convicted and sentenced to six years jail.

Consumers and providers should be aware that there are certain steps they can take to safeguard against the likelihood of such incidents occurring, or to avoid possible misconceptions. For consumers these steps should include the following:

- Check the provider's experience and qualifications before the treatment, including membership of professional associations (if relevant).
- Inform the provider about the type of treatment that is desired, including what areas of the body are to be treated and what clothing (if any) is to be removed. Check that the provider performs the kind of treatment that is required.
- If the provider suggests removal of all clothing or massage in the genital regions, the consumer should not proceed.
- If during the session anything occurs that the consumer considers inappropriate, cease the consultation and tell the provider that the conduct is not acceptable.
- Tell someone as soon as possible if sexual misconduct occurs. This could be a trusted family member or friend. It is strongly encouraged that complaints be reported to the Commission, the police or a sexual assault support agency.

Providers should ensure that the following steps are taken:

- Provide information to the consumer about qualifications and experience as well as the proposed treatment. Questions should be asked of the consumer to determine their expectations.
- Give information to the consumer such as what clothing may need to be removed.
- Check that the consumer consents to the treatment after having been given the information ("informed consent").
- If clothing is to be removed during the procedure, obtain the consumer's consent again. Consumers should be asked to remove their own clothing wherever possible. The underpants should not be removed by either gender.
- Ensure that the consumer is adequately covered, with only areas to be treated left exposed.
- Massage near the genital regions should never be performed.

Professional bodies, associations and tertiary institutions can be useful sources of information for both providers and consumers.

Tables

Table 1: Complaints Resolved by Stage in 2002/2003

Stage of Complaint Process	Number of Complaints
Intake	4,045
Pre-Assessment	29
Assessment	499
Conciliation	161
Investigation	52
Ministerial Investigation	1
Multiple Action	13
Referred to Registration Bodies	40
Total	**4,840**

Table 2: Complaints Open as at 30 June 2003

Current Case Stage	Number of Cases in Stage
Intake	93
Pre-Assessment	2
Assessment	86
Conciliation	163
Investigation	53
Ministerial Investigation	3
Multiple Action	36
Referred to Another Entity	4
Referred to Registration Bodies	160
Total	600

Table 3: Respondents to Complaints Received

Provider	Number of Complaints
Aboriginal Health Service	1
Aged Care Facility - Commonwealth	17
Aged Care Facility - Private	22
AIDS / HIV Service	1
Alcohol & Drug Service	10
Ambulance Service	16
Audiologist	2
Breast & Cervical Service	7
Child Community Health Service	1
Chiropractor	23
Community Health Service	14
Community Mental Health Service	13
Complementary (Alternative)	27
Corrections Health	8
Cosmetic Practitioner	3
Counsellor	10
Day Respite	4
Dental Technician / Prosthetist	14
Dentist (Public/Private)	238
Dietician	5
Disability Adult Day Service	1
Family Planning	3
Fertility Clinic	2
Hospice	3
Hospital Private	163
Hospital Psychiatric	23
Hospital Public - Queensland Health	969
Insurance	3
Integrated Mental Health Service	158
Medical Centre	139
Medical Practitioner	1,412
Not Recorded	843
Nurse	19
Nursing Service	6
Occupational Therapist	1
Optometrist	22
Osteopath	2
Other Health Service	76
Pathology Service	24
Pharmacist	44
Physiotherapist	13
Podiatrist	5
Prosthetist / Orthotist	1
Psychiatrist	15
Psychologist	22
Radiographer	10
Radiology Service	23
Residential Care Worker	1
Respite Care	3
Sexual Health Service	10
Social Worker / Welfare Officer	2
Supported Accommodation Facilities	18
Total	4,472

Table 4: Primary Issues in Complaints Received

Treatment	
Coordination of treatment	63
Diagnosis	418
Inadequate treatment	506
Infection control	41
Medication	284
Negligent treatment	169
Rough/painful treatment	85
Treatment withdrawn/denied	42
Wrong/inappropriate treatment	166
Unskilful treatment	16
Total	**1,790**

Rights	
Access to records	211
Discrimination	15
Inconsiderate service	13
Privacy/confidentiality	99
Accuracy/inadequacy of records	31
Assault	26
Certificates/reports	36
Competence	54
Financial fraud	8
Illegal practices	22
Impairment	6
Sexual misconduct	68
Assault	1
Other code breach	1
Unprofessional conduct	1
Total	**592**

Communication	
Attitude	282
Consent issues	59
Inadequate information	294
Interpreter/special needs services	4
Involuntary admission	39
Other	1
Wrong or misleading information	32
Total	**711**

Access	
Attendance	6
Delay in admission or treatment	91
Discharge/transfer arrangements	19
No/inadequate service	1
Referral	16
Refusal to admit/treat	187
Service unavailable	69
Transport	7
Waiting lists	46
Total	**442**

Administration	
General administration	90
Hygiene/environmental standards	34
Inadequate/no response to complaint	21
Other	458
Reprisal/retaliation	4
Total	**607**

Cost	
Billing practices	263
Government subsidies	8
Inadequate information on costs	28
Overcharging	24
Private health insurance	4
Public/private election	3
Total	**330**
TOTAL OF ALL ISSUES -	**4,472**

Feature Articles

Effective complaints management - take the time to save the time

An important part of the Commission's complaint resolution function is to assist health providers and patients to resolve issues between themselves. The Health Rights Commission Act specifically provides that health consumers should make reasonable attempts to resolve their concerns directly with the service provider in the first instance. The following is based on an article published by the Commissioner during the year. It reinforces the fact that the ideal place to resolve any complaint is in the practitioner's rooms, not at the Health Rights Commission. Intervention by the Commission should be very much the last resort.

Sometimes direct resolution can prove to be difficult. On the one hand, health providers may react defensively when they receive a complaint. This is understandable. Being the subject of a complaint is never a pleasant experience, especially if the person complained against feels that they have done nothing wrong.

On the other hand, some complainants have somewhat unrealistic expectations or, in some instances, may not be confident in their ability to make their concerns known and understood.

In spite of these difficulties, health providers should take all complaints seriously and make every effort to resolve them at the first available opportunity. There are two very good reasons for this.

Firstly, complaints provide a valuable opportunity to reassess the quality of services. Without complaints, systemic problems go unnoticed and the level of dissatisfaction with services can then only increase.

Secondly, complaints rarely go away of their own accord and, if ignored, are likely to escalate. In this regard, it is important that health providers recognise that when dealing with patients' concerns, they may only get one opportunity to set things right. Complainants are generally far more receptive when they first make their complaint than they are likely to be at any later stage. They are far more likely to accept the eventual outcome if they see that the provider concerned has taken their complaint seriously from the outset. They are invariably far less receptive if they get the impression that the service provider is simply trying to avoid the issue.

Given the number of cases we deal with, the Commission is well placed to see what works well and what doesn't, when providers respond to complaints. Complainants are rarely motivated by malice. Many start out with no intention whatsoever of seeking financial compensation or disciplinary action against the provider concerned. More commonly, they seek to have their concerns acknowledged, for others to know what it is like for them, some assurance that the same thing will not happen to someone else and, above all, a full explanation of what happened and why, expressed in terms that they can understand.

Importantly, even in those cases where compensation is sought, this issue will not be avoided simply by the provider ignoring the problem.

The article published by the Commissioner made the following suggestions to health providers.

Listen to and acknowledge the patient's concerns.

Depending upon the circumstances, it may be appropriate to invite the patient to come in to the practice to discuss their concerns in person. But whether responding in person or in writing, do so promptly. This shows that the matter is being taken seriously.

Address issues openly and sincerely, in simple language, avoiding complex medical terms as far as possible.

Ensure that all of the issues raised by the patient are addressed, not just the ones that may seem important to the provider. Double-check the accuracy of the information provided and confirm the patient's understanding of that information.

Be sensitive and show that you do care. It can make a huge difference if the response to a complaint is courteous, friendly and sincere. The aim should always be to preserve the relationship with the patient wherever possible, not just to get them to go away.

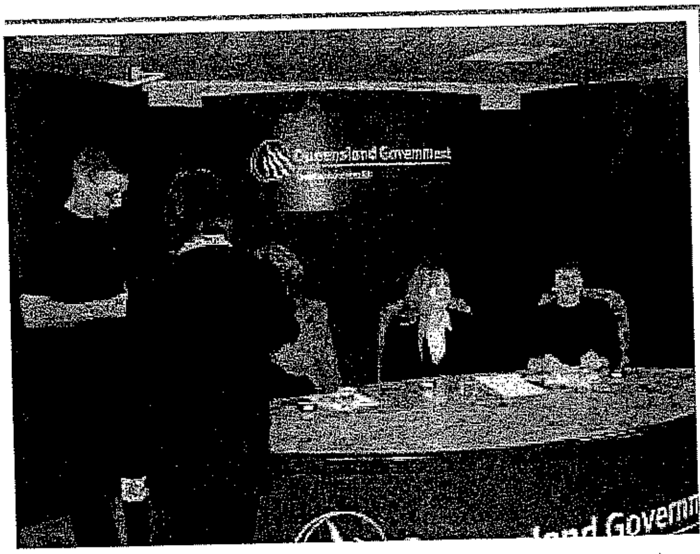
Don't be afraid to say sorry. Expressing regret that a particular outcome occurred or the fact that the patient is upset may go a long way towards resolving the matter, but does not constitute an admission of liability.

Above all, avoid the temptation to respond to the complaint in an emotional or defensive way.

There are lessons for health consumers as well. Even where a patient suffers an adverse outcome, this doesn't necessarily mean it was somebody's fault. All procedures involve some degree of risk. And even if the outcome could have been avoided, it is not as if problems with treatment are intended. All areas of health care are difficult and challenging.

It is understandable that patients and their families react to an adverse outcome in an emotive way, but the problem is more likely to be resolved if they also approach complaints in a constructive way.

Based on an article previously published in the AMAQ journal



Conciliators providing an information session as part of a Quality Improvement and Patient Satisfaction Satellite Broadcast to Queensland Health Complaint Co-ordinators

Improving access and awareness for Multicultural Queensland - Your Rights are our Business

NAIDOC Week - an opportunity to display the joint Commissions - Ombudsman project Banner"Your Rights are Our Business"

"Your Rights are Our Business" has become the message for a collaborative partnership of independent statutory agencies seeking to enhance community awareness of and access to complaint mechanisms in Queensland.

During the year the Commission approached the Community Engagement Division, Department of the Premier and Cabinet, with a proposal to initiate meetings with other statutory agencies seeking to engage and raise awareness with culturally and linguistically diverse communities in Queensland.

The initial meeting of this project was held in February 2003 and included the Anti-Discrimination Commission, Health Rights Commission, Crime and Misconduct Commission, Commission for Children and Young People, State Ombudsman and Legal Ombudsman. As a result, a range of issues and strategies have been identified to promote equal access to complaint services, raise awareness, identify opportunities for joint promotion and ensure that complaints handling processes reflect cultural sensitivity.

MAQ Interchange speakers: (L-R) Darryl Briskey MP, Parliamentary Secretary to the Premier; Susan Booth, Commissioner, Anti-Discrimination Commission; Robin Sullivan, Commissioner, Commission for Children and Young People; Frank King, Deputy Ombudsman, Office of the Queensland Ombudsman; David Kerslake, Commissioner, Health Rights Commission, Brendan Butler, Chairperson, Crime and Misconduct Commission and Jack Nimmo, Legal Ombudsman

Since the commencement of this project the group has participated in joint awareness raising activities, such as participation in an Interchange Forum organised earlier this year by Multicultural Affairs Queensland to deliver information to representatives from a range of ethnic groups. The banner "Your Rights are Our Business", developed as part of the project, has already been used in joint promotions at public events such as NAIDOC Week.

This project is a key demonstration of collaborative practice across government agencies. Its message is not only about people exercising their rights, but also acknowledges that members of the multicultural community experience barriers which limit their awareness of services and the ability to raise concerns and complaints. The project promotes the messages that "It's OK to complain" and that one person's complaint can serve to improve the level of services available to the entire community.

Increasing Public Awareness

2002/2003 has seen the Commission make a strong commitment to the importance of education and awareness to the community of Queensland.

This year the Commission has participated in 53 education and information activities. While targeting consumers of health services, there has also been a particular focus on health provider organisations, tertiary facilities, Queensland wide conferences and public events.

With an emphasis on direct resolution as a driver, the Commission's major focus was not only in raising awareness, but also in the education and provision of information to assist the early resolution of complaints and concerns.

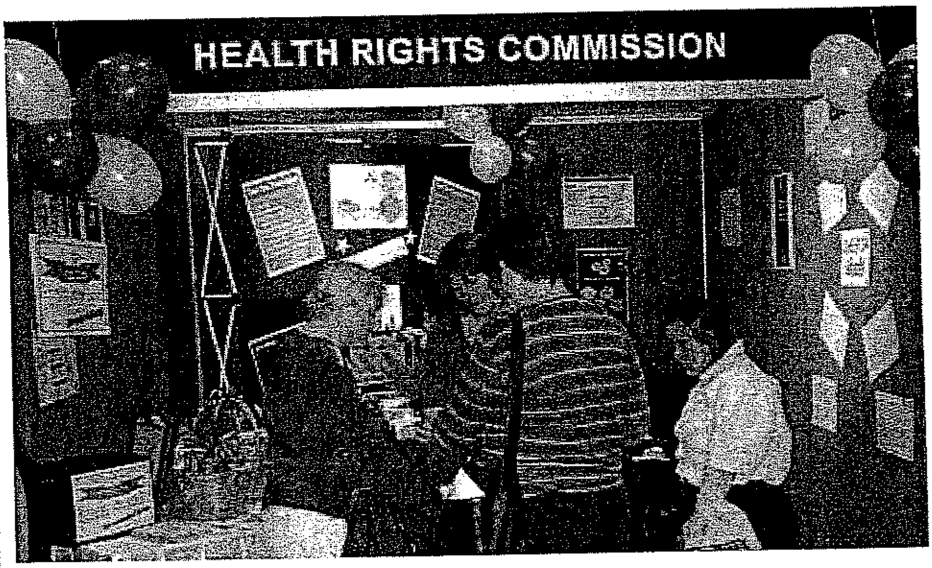
This included the development of new information materials such as Consumers - A Guide to Help You Resolve your Concerns/Complaint, and also targeting health providers to improve the management of complaints to enhance the resolution process. The development of provider specific information materials is a current project and will aim to provide health practitioners and services with information and tips in handling and managing complaints.

Increased participation in public events has given the Commission an opportunity to interface directly with consumers and providers and to raise its profile in the eyes of the Queensland public. Examples of activities have included attendance at Mental Health Week activities, NAIDOC Week, the AMAQ Health Expo, Ethnic Communities Council Youth Health Expo and the "Look Good Feel Good" Expos.

These opportunities not only provided a forum for distribution of information and promotional material, but also enabled Commission staff to engage directly with the public.

Networking opportunities have also been a highlight of participation in public events, meetings and conferences resulting in further educational activities and project work.

The Commission acknowledges that community outreach, education and awareness strategies are integral and complementary to effective and proactive complaints management.



Providing Information at the AMAQ International Health Expo

Case Studies

Good communication is an essential part of any health practice

Inadequate communication is a recurring theme in complaints to the Commission and often causes a great deal of distress to patients and their families. A number of welcome initiatives have been taken to improve the communication skills of health service providers, including the increased emphasis placed on this area in the training of recent graduates. Despite this, failures in communication continue to be the root cause of many complaints made to the Commission.

In one case, a patient experienced a particularly poor outcome following a fall in which she fractured her elbow. Although the elbow was treated and pinned following the accident, the complainant felt the hospital's orthopaedic surgeon had been remiss in failing to carry out a routine follow-up x-ray to check that the fracture had healed. As it turned out, there had not been a union of the fracture and the pins had come loose, but this went unobserved for approximately six months. She said that she had asked on a number of occasions for an x-ray to be performed but the surgeon had rudely dismissed her requests.

Subsequent efforts to repair the elbow had not been successful. At the time of the conciliation the complainant's arm was still badly damaged and her muscle strength and tone was severely diminished.

An independent opinion obtained in conciliation stated that ultimately the delay in detecting the non-union was unlikely to have contributed to the poor outcome. The original injury had been quite severe and, combined with a number of other predisposing factors, meant that a poor outcome was always highly likely. The independent adviser commented on the poor communication with the patient.

The medical superintendent offered to meet with the complainant to discuss her situation and to assure her of access to hospital services. A small ex-gratia payment was made in acknowledgement of the difficulties the complainant had experienced in the hospital system.

Failure to obtain informed consent is another recurring problem. Patients need to have sufficient information to make informed decisions and it is the responsibility of health practitioners to provide it, in a form that is easy to understand. This requires proper discussion, adequate information and genuine choices, not just the patient's signature on a consent form.

Complaints are a key factor in quality improvement

One of the Commission's key functions is to identify systemic issues arising out of complaints and to work with providers on the implementation of system improvements. In this way, one person's complaint has the potential to benefit the entire community.

The Minister for Health may refer public interest concerns to the Commission for investigation.

The Commission undertook a ministerial investigation concerning the suicide of an indigenous man who had been admitted to a *mental health service. The Commission concluded that the service should have involved the man's family in planning his care and that the risk of suicide should have been monitored more closely in the circumstances. The Commission recommended that the service develop culturally appropriate guidelines for staff and patients in relation to the involvement of family members, and appropriate protocols relating to consultation with relatives of patients who have committed suicide. The service revised the relevant protocols as well as increasing the number of indigenous mental health workers available to work alongside other staff in providing services and outreach to remote areas.*

Where health providers agree to systemic changes following complaints to the Commission, the Commission follows up as a matter of course to confirm that the changes have been implemented. In some instances, providers have sought the assistance of the Commission in the actual implementation of recommended changes.

For example, during the investigation of a complaint about a hospital's management of a patient's risk of pressure sores, it became clear that the practices and procedures currently in place were inadequate. This view was based on independent advice the Commission obtained from a clinician with acknowledged expertise in this area. The hospital's CEO and Director of Nursing both acknowledged the problem and undertook to rewrite the relevant protocols. They did so in conjunction with the independent expert. The hospital also arranged educational sessions for particular staff and engaged the expert clinician to undertake those sessions. The Commission was also involved in the educational sessions with clinicians to assist in improving the standard of documentation in individual cases.

As noted earlier in this report, the Commission makes every effort to resolve complaints as informally as possible. Even during the initial assessment stage, if systemic or procedural issues become evident the Commission will seek to negotiate appropriate changes with the provider concerned, if possible without recourse to more formal statutory action.

For example, a woman said that she underwent a curette following a miscarriage and was advised by staff at the hospital that she could try and fall pregnant about one month later. She stated that two months later she had an ectopic pregnancy and lost a fallopian tube as a result. She complained that following the loss of the fallopian tube, she was told that pathology tests following the curette indicated that she should not have tried to fall pregnant for at least 6 months, by which time her hormone levels would have returned to normal.

She said she had not been informed of this at the time and would not have tried to get pregnant had she been informed of the results. After contacting the Commission, arrangements were made for her to meet with the Gynaecology Co-ordinator at the hospital, who acknowledged that there had been a breakdown in the reporting processes and apologised for both the error and the distressing outcome.

The hospital informed the woman and the Commission that: a new protocol was being implemented to identify what action was needed for certain pathology results; all pathology reports in this area would be sighted by the Gynaecology Co-ordinator; and the hospital would correspond with the woman's GP to correct her medical record. While the woman was obviously concerned that her pathology results had not been reported accurately and in a timely manner, she was satisfied that the hospital had taken adequate steps to rectify the cause of the problem.

In another case, a woman said her mother was taken to a private hospital after suffering a stroke. She said that on arrival the hospital advised her that her mother would not survive and kept her in the Accident and Emergency Department for 6 hours before she was admitted. She said that the family were told they could not stay by their mother's side but they would be told when she passed away.

The woman said her mother lived for a further 10 days, during which time she was inadequately cared for. The complaint raised a number of issues including inadequate sedation, problems with the insertion of a nasogastric tube, failure of nursing staff to adequately perform oral-pharyngeal suctioning, cockroaches in the hospital, premature resiting of the intravenous cannula, failure to remove a dental plate leading to oral thrush, and failure to turn her mother as required.

The hospital had previously apologised to the family and had responded to some of the specific issues raised, such as the waiting time for admission, a larger room being assigned for palliative care, problems with the insertion of the nasogastric tube, oral care, care by the doctors, IV removal, and patient repositioning.

Following representations from the Commission, the hospital provided further information relating to changes in the management of bed and ward allocation, eradication of cockroaches, changes in the nursing history form to indicate dentures, and changes to the oral-pharyngeal suctioning competency. The hospital also advised that the employee involved in the suctioning problems was no longer with the hospital.

The medical records were reviewed by the Commission to assess the sedation issue and the Commission submitted information to the hospital to assist in a review of IV management. The Commission was then satisfied that the hospital had made adequate changes to assist in preventing a repetition of the above problem. The woman was also satisfied with the changes and thanked the Commission for its assistance in resolving the complaint.

In some cases, the Commission's conciliation processes serve as an effective and valuable alternative to litigation

It is a common misconception that complaints are always motivated by a desire for compensation. On the contrary, many complainants seek no more than an acknowledgement of the outcome of treatment from their point of view and an assurance that the same thing will not happen to someone else.

For those cases where compensation is a realistic possibility, however, the Commission's conciliation process provides a free, confidential and non-adversarial means of resolving disputes without recourse to the more time-consuming and invariably expensive alternative of litigation. The Health Rights Commission Act requires the Commission to assess whether the standard of treatment provided in individual cases was reasonable in all the circumstances. In claims for compensation, this essentially revolves around whether a case could be established that the health provider was negligent.

The Commission can work with the parties to define the issues that need to be resolved in this context and the questions that need to be asked, as well as by obtaining independent opinions, if necessary, from experts in the appropriate field.

In one case, a woman who underwent treatment for urinary incontinence suffered a known complication when she had a stitch left in her ureter following surgery. The problem was identified at the hospital where the procedure was carried out when the woman subsequently presented with symptoms. Unfortunately, although the problem was identified on two separate occasions, the stitch was not removed for some months.

The hospital responded to the complaint with a full outline of the clinical facts and an acknowledgement that the hospital system had not responded to the woman's problem even though the problem had been identified.

This matter took some time to resolve as the woman had multiple health problems and she felt that many of them arose from the stitch in the ureter, and the delay in correcting this. Although the hospital representative was clear there was an issue of liability in this case, the hospital believed that the liability was limited to the damage caused by the delay in removing the stitch. The hospital did not accept that all of the woman's health problems stemmed from its actions.

There was some time spent in determining the extent of damage the woman had incurred because of the delay in rectifying her problem. The upshot was that a settlement was negotiated at a meeting convened by the Commission. At the settlement meeting the hospital representative apologised to the woman, and said the hospital had taken steps to ensure such an incident would not happen again.

Confidence in the Commission's handling of difficult or sensitive cases is reflected in the fact that providers themselves sometimes refer complainants directly to us for advice or assistance.

One such case stemmed from a hospital's failure to act on signs of pre-eclampsia in a young woman's first pregnancy. The child was born at term but was not alive at the time of delivery. It was clear from the medical records and the mother's reports that the child had been alive less than 12 hours before delivery. It was also clear that the child would probably have survived had there been an earlier response to the mother's symptoms and presentation at antenatal visits. The hospital's Director of Medical Services had already met with, and apologised to, the parents and suggested they contact the Commission for the matter to be conciliated.

Although the negotiations about quantum took some months, the case was conducted very amicably with considerable good will on the part of both parties. A settlement was successfully negotiated in conciliation.

In another case, a woman had surgery commenced on the wrong knee due to a communication breakdown. Although the surgeon immediately recognised the error and did not proceed with the surgery, the woman was nevertheless left with unnecessary scarring on that knee. The hospital immediately advised the woman that the matter needed to be settled and it would be in both parties' interests to seek assistance from the Commission.

During conciliation the woman explained that she had suffered unnecessary pain through having to recover from the operation that should not have been performed and the surgery that was still required to fix her pre-existing problem had been further delayed until the other knee had completely healed. In any event the woman felt that she could no longer trust the hospital but she was unable to afford to seek private treatment elsewhere.

Conciliation resulted in amicable negotiations and an agreement that satisfied both parties. This agreement included a financial settlement and access to future treatment at an alternative hospital.

Sometimes, all that complainants seek by way of compensation is the cost of having unsuccessful treatment performed again, by the same or possibly a different practitioner.

In one such case, a woman was very distressed with the outcome of breast augmentation performed by a plastic surgeon. She felt her augmented breasts were of an unequal size and she felt embarrassed in some of her clothing. The woman wanted sufficient compensation to have the surgery done again by another plastic surgeon. The doctor's insurer contacted the

Commission and asked if the matter could be moved into conciliation as the doctor would like to see the woman compensated for a result the surgeon also felt to be unsatisfactory.

The woman in this case had no intention of seeking legal advice about any potential claim, as she was clear that she wished only to have the surgery redone by a different plastic surgeon.

The woman obtained a quote from another surgeon to have the procedure revised. A settlement to cover those costs was negotiated amicably in conciliation.

> ***Adverse outcomes do not necessarily give rise to a valid claim for compensation.***

Even though a patient may have suffered an adverse outcome, this does not of itself give rise to a justifiable claim for compensation. To establish a legal claim, the complainant would need to establish that the adverse outcome arose as a result of inadequate or negligent treatment. In some instances, however, patients may experience outcomes that are nobody's fault, but are unfortunately part of the risks commonly associated with the particular procedure. If the Commission's enquiries reveal that the risks were adequately explained beforehand and expert advice points to the outcome being one of those unfortunate risks (rather than the result of inadequate treatment), there is usually nothing more the Commission can do. The Commission nevertheless provides the complainant with a full explanation of the findings to provide some reassurance that the treatment in itself was not unreasonable.

One man complained to the Commission about a poor outcome following knee replacement surgery. The procedure had been performed at a regional hospital and the complainant had developed an 'MRSA' resistant infection following the surgery. He was referred to another larger hospital where the prosthesis was removed and the infection treated. He had been left with severely impaired mobility, requiring a complete change of lifestyle.

Central to the complaint was the fact that the surgeon had taken leave immediately following the knee replacement operation. The complainant felt he had not been left in the care of an appropriate locum, so that the development of an infection went unnoticed.

The hospital's response pointed out that there were another three staff specialists who had oversighted the patient's care, none of whom had felt it necessary to alter his treatment regime.

An independent opinion from an interstate specialist suggested that had the pathology results relating to the infection been followed up more aggressively, antibiotic treatment could have been initiated some three days sooner. The expert added, however, that this would have been unlikely to have made a difference to the course of the infection.

This advice did not support the complainant's claim for compensation and the case was closed on that basis.

One of the greatest sources of frustration for either or both of the parties to a complaint is where the Commission is unable to obtain sufficient evidence to reach an informed view. The Commission does all that it can to obtain and weigh up relevant evidence, but if the end result is one person's word against another's with no independent evidence, there is little more that can be done. It is quite understandable that persons who have gone to the trouble of making a complaint would feel disappointed with such an outcome, but no more so than those complained against who may also feel they have right on their side.

For example, a woman complained that her husband who suffered from emphysema and a heart condition was refused treatment by a GP. She said that her husband needed urgent attention and complained that the GP had told him that as he had not stopped smoking he could do nothing more for him and he could get himself another doctor. She said that she believed the GP was uncaring and negligent.

The GP responded stating that the woman's allegations were incorrect. He said that he was the only GP in the area who was prepared to make house calls to the man and his wife. On the last visit he advised the man to give up smoking. He said that he made it clear that he was happy to continue treating the man, but wanted him to understand that the treatment would be of little benefit if the man continued to smoke. He said that the man became angry at his suggestion and ordered him out of his house.

The GP said he went back to his surgery and arranged for another doctor at the practice to look after the man and his wife. He said the man was admitted to hospital some time after he had stopped seeing him and died from a combination of heart and respiratory related problems. He said he was most offended as he had made a point of always being available to the man and his wife even out of hours.

As there were two conflicting recollections of the event the Commission could not make a decision on the accuracy of either version and the complaint was therefore closed.

Although it is not always possible to reach a view on the facts of a particular case, the Commission remains on the lookout for patterns of behaviour that may be revealed where similar complaints are made about the one provider.

In one such case, a woman stated she attended her GP of 13 years with her 12-year-old son to discuss the difficulties she was experiencing having a prescription filled for him. She said that while she was talking to the GP, her son removed a doorstopper and started playing with it. The woman alleged that the GP then verbally and physically assaulted her son. The woman stated that since the incident she had not been able to get her son to visit a doctor. The GP refuted the woman's version of events, but given the seriousness of the allegations and other complaints of a similar nature, the matter was referred to the Medical Board for further consideration.

Executive Services

Overview

The Executive Services unit is responsible for all of the Commission's corporate support activities, including financial management, human resource management, information technology, community outreach and general administration. This includes the development and management of operational systems, processes and services to ensure effective and efficient support to the Commission's core business activities.

The Executive Services unit also provides receptionist services, which is the first point of contact with the Commission, and direct support services to the Complaints and Conciliation units.

The following highlights provide a brief synopsis of some of the projects and activities undertaken by Executive Services staff during the 2002/2003 financial year.

Security Review

The Commission sought the assistance of the Crime Prevention Unit of the Queensland Police Service to conduct a security assessment of the Commission's offices, and to address staff on matters of personal security. Two police officers attended the Commission and subsequently provided a report containing ten recommendations or suggestions for improving the physical security of the Commission's offices.

The Commission has implemented enhanced physical security arrangements and procedures in accordance with the report's recommendations.

Reception Services

During the year, the Commission's reception received approximately 20,000 enquiry calls. These calls were assessed and direct assistance provided to the caller by reception where appropriate. Approximately 4,500 calls were transferred from reception to Enquiry Officers for further attention.

Human Resources

The Commission continued to experience significant staff movements during the year. The new Commissioner commenced duty in August 2002, following the retirement of the former Commissioner at the end of his five-year term of appointment.

Inservice training for staff

The Minister for Health approved temporary funding to enable the Commission to engage four additional officers for a period of up to twelve months to address the backlog in complaints. In addition, during the year, one officer resigned, one officer commenced twelve months' leave of absence, and four officers accepted secondments to other departments and agencies in order to further develop their skills and broaden their work experience. Internal relieving arrangements provided other staff with the opportunity to gain experience within the assessment, investigation and conciliation processes of the Commission.

It is anticipated that the organisational structure of the Commission will continue to evolve to meet demands from complainants and service providers alike, and to provide more efficient and effective services aligned with a limited resource base.

Enterprise Bargaining Agreement 5 (EBA5)

Negotiations for a new enterprise bargaining agreement commenced in January 2002, with the Manager Executive Services or his delegate representing the Commission on the Single Bargaining Unit, together with representatives from Queensland Health, the Department of Industrial Relations, the Queensland Council of Unions and Affiliated Health Unions. Negotiations were successfully concluded during the year, with the Queensland Health Certified Agreement (No 5) 2003 signed by the Commission on 25 October 2002. This Agreement is effective from 1 September 2002 until 31 August 2005.

Financial Services

The Commission received $2.202 million to fund its operational activities and asset replacement program. In addition, the Minister for Health approved funding supplementation of $345,000 for the employment of four temporary staff for twelve months to address the complaints backlog, and $48,000 for specific operational expenses. Funding of $225,000 was also transferred to meet the cost of employer superannuation contributions, which were previously met by Queensland Health.

The Commission maintains separate investment accounts with the Queensland Treasury Corporation representing its accrued recreation leave liability and a provision for its asset replacement program.

The Commission's audited annual financial statements are provided at the end of this report.

Information Technology

The Commission implemented Corporate Desktop Internet Access for all staff, utilising a commercial Internet Service Provider (ISP). Staff benefits include instant access to reference information available on the World Wide Web, while achieving a reduction in the Commission's costs associated with external network communications.

The review and evaluation of the Commission's complaint management program "proActive", which has been in operation in the Commission since March 1998, was completed. The review was unable to identify real "off the shelf" software alternatives with at least the same functionality and scope as the current system. The Commission will therefore identify and implement appropriate strategies to extend the life of the current database, including an upgrade of the base component, Lotus Notes.

Systems security remains a high priority for the Commission's Information Infrastructure. An internal audit will be undertaken on network access controls, all security policies will be reviewed, and the Firewall and Virus Protection systems will be upgraded to ensure the continued security of the Commission's infrastructure.

Legal Services

The Commission's Legal Services Officer accepted a secondment to Crown Law for a period of twelve months from January 2003. The key duties and functions associated with this position have been performed by the Commissioner and other staff members as required.

Freedom of Information

Seventeen applications were received in the year under the *Freedom of Information Act 1992*, compared with 22 applications in the previous financial year.

Of the applications received in the year under review, 14 were for access to documents of a personal nature and three requests were for access to non-personal documents.

During the 2002/2003 financial year, a total of 795 documents were considered in the applications for access to documents of a personal nature and 95% of those documents were released in part or in full. This represents an increase in the number of documents of a personal nature being released to applicants in part or in full from the previous year.

In the 2001/2002 financial year, 93.4% of documents considered in applications for documents of a personal nature were released.

A total of 100 documents were considered in the applications for non-personal documents during the 2002/2003 financial year. Of these 73% were released in part or in full with the remaining 27% being exempt from access. These figures demonstrate a decrease in the rate of release of documents in non-personal applications. In 2001/2002, 75.9% of the documents applied for in non-personal applications were released in part or in full.

There were no applications for amendment of information under the *Freedom of Information Act 1992* made to the Commission in the year under review.

Equal Employment Opportunity Report

In accordance with the *Equal Opportunity in Public Employment Act 1991*, the following information is provided in respect of age, gender and classification statistics as at 30 June 2003.

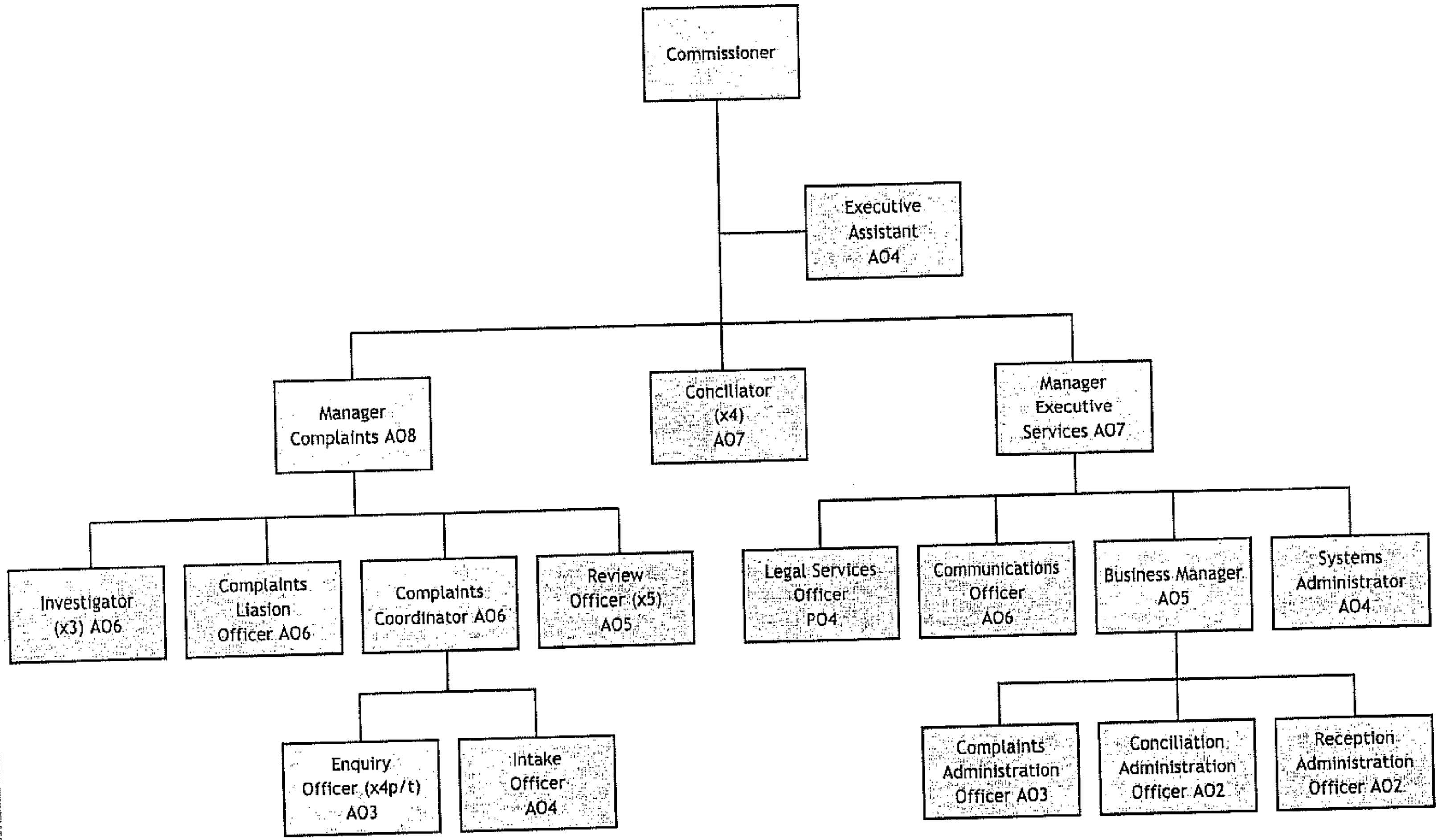
Staff by Age & Gender

	15-24	25-34	35-44	45-54	55+	Total
Male	0	1	4.8	1	2	8.8
Female	2	11.6	4	3.8	2	23.4
Total	2	12.6	8.8	4.8	4	32.5

Staff by Administrative Classification Stream

	AO2	AO3	AO4	AO5	AO6	AO7	PO4	AO8	SES	Total
Male	0	0.8	1	1	2	2	1	0	1	8.8
Female	2	4.4	2	6	5	3	0	1	0	23.4
Total	2	5.2	3	7	7	5	1	1	1	23.2

Health Rights Commission - Organisational Chart



Communications and Outreach

The primary function of the Communications and Outreach section is to co-ordinate activities aimed at achieving the education, information and promotional requirements of the Health Rights Commission Act.

This encompasses 5 major areas of responsibility:

1. Education and raising awareness in Queensland about the Commission's functions, with a particular focus on consumers and providers of health services;
2. Liaison with consumer and provider organisations to facilitate collaborative working relationships;
3. Fostering relationships with special needs groups such as Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities and people with disabilities;
4. Development and evaluation of educational, promotional and information materials; and
5. Co-ordinating media activities and publicity.

Raising Public Awareness

This year has seen an increased focus on awareness and educational activities.

Commission staff participated in 53 presentations targeting consumers, health providers, tertiary institutions, state and national conferences and public events.

Meeting participants at the Ethnic Youth Health Expo at Annerley

Public Awareness/ Education/ Presentations 2002/2003	
Events/Expos/Displays	7
Tertiary Institutions/Colleges/Universities	12
Hospitals	2
Allied Health/Medical Services	5
Health Associations	5
Seniors/Carers Groups	8
Culturally and Linguistically Diverse Groups	4
Aboriginal and Torres Strait Islander Groups	2
Community Organisations	8
Total	**53**

The Commission's increased emphasis on direct resolution formed the focal point for a number of educational activities including the development of new information materials such as Consumers - A Guide to Help You Resolve Your Concerns/Complaint.

The continuing demand for information materials indicates an increased awareness of Commission functions in the community.

Enhancing Access and Awareness to Multicultural Queensland

Complaints in Health, Employment, Equity and Rights (CHEER) was established as a partnership project with the Anti-Discrimination Commission and Multicultural Development Association, working collaboratively across government and community sectors to enhance awareness and access to complaint mechanisms in the health and employment sectors. The project formed a reference group with community representation, resulting in a proposal to be submitted for funding of a 12-month pilot project. This includes the employment of a project co-ordinator operating within an action research model and also providing liaison and support to the multicultural community to access complaint mechanisms.

The Commission also participated in the Logan and Beenleigh Information Project whose key objective is the provision of information on services available to women and families in that region who come from culturally and linguistically diverse backgrounds.

Acknowledging the importance of improving agency practice and increasing cultural sensitivity, Commission staff participated in Intercultural Foundation Skills Training provided by Multicultural Affairs Queensland.

Building Bridges - A Focus on Consultation and Collaboration with Health Providers

The Commission identified the need to develop information materials targeting health providers with the aim of improving the handling and management of complaints.

The Provider Information Project consulted with a range of services and practitioners as part of a regular focus group. Organisations represented include the Australian Medical Association Queensland, Australian Dental Association Queensland, Accreditation General Practice Australia Ltd, Aboriginal and Islander Community Health Services, Quality Improvement Princess Alexandra Hospital, Royal College of Nursing Australia, Australian College of Midwives, Mater Hospital and the Australian College of Natural Medicine.

The group has provided valuable insight and expertise, with the project at the stage of developing draft materials and an information strategy targeting health providers. These materials are aimed at encouraging and enhancing effective complaints management and resolution at the local level.

Evaluation of the program

In the course of the year, the Communications and Outreach section also provided supervision to two social work students from the University of Queensland as part of their practical experience. Significant tasks undertaken by the students included Power Point training for staff, development of guidelines for publications and a review of the Community Outreach Strategy.

The aim of the review was to evaluate the effectiveness of the Community Outreach Strategy to date, increase participation of staff, consumers and providers, and make recommendations for further improvement. Evaluations were conducted both internally, obtaining staff views, and externally, with surveys conducted via public events, education sessions and project groups.

The evaluation highlighted the importance of community outreach and education within a complaints agency, identified the importance of collaborative and participatory practices, reinforced the continuation of activities which raised the Commission's profile, and identified the need to conduct regular reviews in future.

The Provider Information Project, Focus Group commencing their review and development of materials

Health Rights Advisory Council

The three year term of the Health Rights Advisory Council expired on 23 March 2003.

Membership of that Council comprised:

Consumer Representatives

Mr Pat Nolan (President)

Ms Colleen Cartwright

Provider Representatives

Ms Kym Barry

Dr Jean Collie

Other Representatives

Dr Derek Lewis

Ms Jane Sligo

As reported in the Annual Report for 2001/2002, Dr Jean Collie resigned as a member of the Council on 15 May 2002. The Minister for Health appointed Dr Zelle Hodge on 13 November 2002 as a provider representative.

The Council met on 10 September 2002, 10 December 2002, 11 March 2003 and 10 June 2003 and considered such issues as the Code of Health Rights and Responsibilities, the Review of the Health Rights Commission and the Personal Injuries Proceedings Act.

The Commission wishes to express appreciation to Mr Pat Nolan for his contribution to the Council and his support of the activities of the Commission. Mr Nolan held his membership on the Council from February 1998 to 23 March 2003 and did not seek reappointment for a third term.

The Minister for Health appointed a new Council on 1 May 2003 for a term of three years. This Council comprises:

Consumer Representatives

Mr Joe Veraa

Ms Colleen Cartwright

Provider Representatives

Ms Kym Barry

Dr Zelle Hodge

Other Representatives

Dr Derek Lewis (President)

Ms Jane Sligo

The new Council met for the first time on 10 June 2003.

Statutory Objectives

Purpose

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

Objectives (section 4)

The principal objectives of this Act are -

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

(i) preserve and promote health rights; and

(ii) receive and resolve health service complaints; and

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

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

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

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

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

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

Commissioner's Functions (section 10)

The functions of the commissioner are -

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

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

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

(i) health rights and responsibilities; and

(ii) procedures for resolving health service complaints; and

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

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

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

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

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

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

(j) to provide advice to the Council; and

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

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

Financial Statements

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL PERFORMANCE
For year ended 30 June 2003

	Notes	2003 $	2002 $
Revenue from Ordinary Activities			
Government Endowment	3(a)	2,820,000	2,231,515
Other Income	3(b)	79,689	35,322
Total Revenue from Ordinary Activities		2,899,689	2,266,837
Expenses from Ordinary Activities			
Employee Expenses	10	1,992,707	1,543,230
Executive Services	2(a)	511,914	577,637
Health Rights	2(b)	100,187	64,149
Depreciation	6(b)	48,680	45,507
Total Expenses from Ordinary Activities		2,653,487	2,230,523
Net Surplus from Ordinary Activities		246,202	36,314
Net Surplus	14	246,202	36,314
Total revenue and expense adjustments recognised directly in equity		-	-
Total changes in equity other than those resulting from transactions with owners as owners		246,202	36,314

The above Statement of Financial Performance should be read in conjunction with the accompanying notes

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL POSITION
As at 30 June 2003

	Notes	2003 $	2002
CURRENT ASSETS			
Cash Assets	4	559,767	608,240
Receivables	5	74,944	43,837
Prepayments		3,404	1,275
Total Current Assets		638,116	653,352
NON-CURRENT ASSETS			
Property, Plant and Equipment	6(a)	115,379	130,172
Total Non-Current Assets		115,379	130,172
Total Assets		753,495	783,524
CURRENT LIABILITIES			
Payables	7	183,445	470,064
Provisions	8	130,830	120,441
Total Current Liabilities		314,274	590,505
Total Liabilities		314,274	590,505
Net Assets (Liabilities)		439,221	193,019
EQUITY			
Accumulated Funds	14	439,221	193,019
Total Equity		439,221	193,019

The above Statement of Financial Position should be read in conjunction with the accompanying notes

HEALTH RIGHTS COMMISSION

STATEMENT OF CASH FLOWS
For year ended 30 June 2003

	Notes	2003 $	2002 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Inflows:			
Government Endowment		2,761,930	2,231,515
Interest received		38,932	34,643
FOI Application Fees		95	402
LSL Reimbursement		55,906	36
Other Revenue		-	5
GST Received From Endowment		276,195	223,152
GST Received From ATO		22,784	6,848
Outflows:			
Salaries and Wages		(2,287,337)	(1,147,486)
Suppliers		(595,434)	(636,101)
GST Paid on Purchases		(57,821)	(69,099)
GST Paid To ATO		(230,314)	(179,822)
Net Cash Provided by Operating Activities	9	**(15,065)**	**464,092**
CASH FLOWS FROM INVESTING ACTIVITIES			
Inflows:			
Sale of Assets		3,100	-
Outflows:			
Payments for Purchase of Plant and Equipment		(36,508)	(71,026)
Net cash used in investing activities		**(33,408)**	**(71,026)**
Net increase / (decrease) in cash		**(48,473)**	**393,066**
Cash at beginning of reporting period		**608,240**	**215,174**
Cash at end of reporting period	4	**559,767**	**608,240**

The above Statement of Cash Flows should be read in conjunction with the accompanying notes

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2003

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

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

(a) **Basis of Accounting**

These financial statements are a general purpose financial report and have been prepared in accordance with the *Financial Administration and Audit Act 1977*, the *Financial Management Standard 1997*, applicable Australian Accounting Standards and other prescribed requirements.

Except where stated, the Financial Statements have been prepared in accordance with the historical cost convention and the accounting policies adopted are consistent with those for the previous year.

(b) **Going Concern / Economic Dependency**
The Commission relies on the continued funding from Queensland Health to meet its debts and obligations.

(c) **The Reporting Entity**

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

(d) **Revenue**

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

(e) **Cash Assets**

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked as well as deposits at call with financial institutions.

(f) **Receivables**

Debtors are recognised at the nominal amounts at their assessed values and settlement being generally required within 30 days from the invoice date. Debtors are generally in the form of reimbursements and are only with other government Departments or agencies.

(g) **Payables**

Creditors are recognised upon receipt of the goods or services ordered and are measured at the agreed purchase/contract price. Amounts owing are unsecured and are generally settled on 30 day terms.

(h) **Property, Plant and Equipment**

Acquisitions
All items of plant & equipment with a cost or other value in excess of $500 are recognised in the financial statements in the year of acquisition.

Depreciation
Depreciation on all fixed assets is calculated on a straight-line basis so as to write-off the net cost or revalued amount of each depreciable asset, less its estimated residual value, progressively over its estimated useful life to the Commission.The depreciation rates used for each class of depreciable asset are:

Class of Fixed Asset	Depreciation Rate
Computer Equipment	20% - 30%
Office Equipment	10% - 30%
Furniture & Fittings	5% - 10%

Revaluation of Non-Current Physical Assets
From 1 July 2001 property, plant and equipment are measured at cost in accordance with AASB 1041 *Revaluation of Non-Current Assets* and Queensland Treasury's *Non-Current Asset Accounting Guidelines for the Queensland Public Sector.*

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2003

NOTE 1 STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

(i) Employee Benefits

Wages, Salaries and Annual Leave

Wages,salaries and annual leave due but unpaid at reporting date are recognised in the Statement of Financial Position and include related on-costs such as payroll tax and workcover premiums.

Long Service Leave

Under the State Government's long service leave scheme a levy is made on the Commission to cover this expense. Amounts paid to employees for long service leave are claimed from the scheme as and when leave is taken. No provision for long service leave is recognised in the financial statements, the liability being held on a whole-of-Government basis and reported in the financial report prepared pursuant *AAS 31 - "Financial Reporting For Governments".*

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation plan for Queensland Government employees at a rate determined by the State Actuary. No liability is recognised for accruing superannuation benefits in these financial statements, the liability being held on a whole-of-Government basis and reported in the financial report prepared pursuant to *AAS 31 - "Financial Reporting by Governments"*.

(j) Taxation

The Commission's activities are exempt from Commonwealth taxation except for Fringe Benefits Tax and Goods and Services Tax ("GST"). As such, input tax credits receivable and GST payable from/to the Australian Taxation Office are recognised and accrued as a net receivable. Revenues, expenses and assets are recognised net of the amount of GST. Cashflows relating to GST payments or receipts are disclosed on a gross basis in the Statement of Cash Flows.

(k) Rounding And Comparatives

Amounts included in the financial statements have been rounded to the nearest $1.

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

(l) Leases

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

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

Operating lease payments are representative of the pattern of benefits derived from the leased assets and accordingly, are recognised as an expense of the period in which they are incurred.

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2003

		2003 $	2002 $
NOTE 2	**OPERATING EXPENSES**		
(a)	**Executive Services**		
	Administrative Expenses	39,808	34,056
	External Audit Fees	5,800	7,250
	Catering Expenses	2,010	2,737
	Consultancy	43,307	88,885
	Fringe Benefits Tax	12,685	10,366
	Library Expenses	4,679	7,236
	Maintenance Costs	21,961	16,077
	Motor Vehicle Expenses	30,291	30,469
	Plant & Equipment Purchases <$500	4,833	2,188
	Printing Expenses and Postage	26,306	35,633
	Network Support	18,259	17,641
	Rent	188,658	202,466
	Software Licenses	13,700	13,398
	Staff Development	6,146	7,194
	Stationery and Office Supplies	10,830	20,515
	Telephone Expenses	52,390	65,267
	Temporary Staff Expenses	27,155	3,735
	Travel Expenses	870	6,904
	Translation Services	1,733	3,585
	Memberships	494	2,035
		511,914	**577,637**
(b)	**Health Rights**		
	Consultancy	48,417	49,261
	Library Expenses	265	1,644
	Staff Development	5,248	5,199
	Travel Expenses	46,256	8,045
		100,187	**64,149**
NOTE 3	**REVENUE FROM ORDINARY ACTIVITIES**		
(a)	**GOVERNMENT ENDOWMENT**		
	Salaries	2,118,000	1,518,515
	Asset Depreciation	34,400	90,800
	General	667,600	622,200
		2,820,000	**2,231,515**
(b)	**OTHER INCOME**		
	Interest earned	39,103	34,879
	Gain on disposal of equipment	1,058	-
	Other sales	-	5
	LSL Reimbursement	39,433	36
	FOI Application Fees	95	402
		79,689	**35,322**

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2003

		2003 $	2002 $
NOTE 4	CASH ASSETS		
	Cash at Bank	46,753	42,384
	Cash On Hand	300	300
	QTC General Investment	279,773	451,896
	QTC Asset Depreciation Investment	106,258	61,761
	QTC Accrued Recreation Leave Investment	126,684	-
	QTC Capital Works Investment	-	51,899
		559,767	608,240
NOTE 5	RECEIVABLES		
	Accrued Interest	171	236
	Salary Recoverable	-	1,054
	Sundry Debtor	3,167	19,763
	GST Input Tax Credits Receivable	71,606	22,784
		74,944	43,837
NOTE 6 (a)	PROPERTY, PLANT AND EQUIPMENT		
	Computers & Equipment - at Cost	222,481	297,734
	Less Accumulated Depreciation	(136,262)	(177,220)
		86,219	120,514
	Furniture & Fittings - at Cost	36,119	13,852
	Less Accumulated Depreciation	(6,959)	(4,194)
		29,160	9,658
	Total Office Furniture & Equipment	115,379	130,172

Reconciliation

	Bal 01/07/02 $	Acquisition $	Disposals $	Bal 30/06/03 $
Computers & Equipment - at Cost	297,734	13,726	88,979	222,481
Furniture & Fittings - at Cost	13,852	22,782	515	36,119
Total	311,586	36,508	89,494	258,600

		2003 $	2002 $
(b)	ACCUMULATED DEPRECIATION		
	Accumulated Depreciation 1 July 2002	181,415	141,108
	Total Depreciation Charge for 2002/2003	48,680	45,507
	Less Depreciation of Assets Written Off 2002/2003	(86,874)	(5,200)
	Accumulated Depreciation as at 30 June 2003	143,221	181,415

Reconciliation

	Bal 01/07/02 $	Depn $	Disposals $	Bal 30/06/03 $
Computers & Equipment	177,220	45,914	86,873	136,261
Furniture & Fittings	4,194	2,765	-	6,959
Total	181,414	48,679	86,873	143,220

		2003 $	2002 $
NOTE 7	PAYABLES		
	Creditors *	173,537	462,338
	FBT Liability	2,952	2,073
	Withholding Tax	576	-
	Other Accruals	6,380	5,653
	Total Payables	183,445	470,064

* Creditors include the 4th quarter salaries & wages reimbursement ($148,264) that is payable to Queensland Health. (2002: $430,059)

		2003 $	2002 $
NOTE 8	PROVISIONS		
	Annual Leave - Current	130,830	120,441
	Total Provisions	130,830	120,441
NOTE 9	RECONCILIATION OF NET SURPLUS/DEFICIT TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES		
	Net surplus (deficit)	246,202	36,314
	Depreciation	48,680	45,507
	(Gain) on Disposal of Plant & Equipment	(480)	-
	(Increase)/Decrease in Receivables	(31,107)	(34,968)
	(Increase)/Decrease in Prepayments	(2,129)	1,172
	Increase/(Decrease) in Payables	(287,922)	432,008
	Increase/(Decrease) in Payroll Accruals	-	(28,562)
	Increase/(Decrease) in Withholding Tax	576	-
	Increase/(Decrease) in Other Accruals	727	5,653
	Increase/(Decrease) in Provisions	10,389	6,968
	Net cash provided by (used in) operating activities	(15,065)	464,092

HEALTH RIGHTS COMMISSION

NOTES TO AND FORMING PART OF THE ACCOUNTS FOR THE YEAR ENDED 30 JUNE 2003

	2003 $	2002 $
NOTE 10 EMPLOYEE EXPENSES		
Salaries costs during the year ended 30 June 2003 included superannuation contributions made on behalf of employees.	1,992,707	1,543,230

In the year ended 30 June 2002 superannuation costs of $171,636 were met by Queensland Health.

NOTE 11 NON-CANCELLABLE LEASING COMMITMENTS

Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:

	2003 $	2002 $
Within 1 year	201,650	205,047
1 to 5 years	926	355,911
	202,577	560,958

NOTE 12 CONTINGENT ASSETS/LIABILITIES

There were no contingent assets or liabilities of a significant nature at 30 June 2003.

NOTE 13 FINANCIAL INSTRUMENTS

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

Interest Rate Risk

	Weighted Average Rate 2003 %	Floating Rate 2003 $	Non - Interest Bearing 2003 $	Weighted Average Rate 2002 %	Floating Rate 2002 $	Non - Interest Bearing 2002 $
FINANCIAL ASSETS						
Cash	3.11%	46,753	300	4.00%	42,384	300
Asset Depn Investment A/c	4.81%	106,258	-	5.21%	61,761	-
Accrued Recreation Investment A/c	3.86%	126,684	-	5.21%	51,899	-
General Investment A/c	4.93%	279,773	-	5.21%	451,896	-
TOTAL FINANCIAL ASSETS		559,467	300		607,940	300

Credit Risk

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

Net Fair Values

Methods and assumptions used in determining net fair value.

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

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

Note 14 ACCUMULATED FUNDS

	2003	2002
Accumulated Funds at beginning of financial year	193,019	156,705
Net Surplus	246,202	36,314
Accumulated Funds at the end of the financial year	439,221	193,019

Note 15 COMMISSION DETAILS

The principal place of business is Lvl 19, 288 Edward Street, Brisbane, Queensland.

CERTIFICATE OF THE HEALTH RIGHTS COMMISSION

These general purpose financial statements have been prepared pursuant to *section 46 F(1) of the Financial Administration and Audit Act 1977* (the Act), and other prescribed requirements. In accordance with *Section 46 F(3) of the Act* we certify that in our opinion:

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

(b) the statements have been drawn up so as to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Health Rights Commission for the financial year ended 30 June 2003, and of the financial position of the Commission at the end of that year.

David Kerslake
Commissioner

Date: 22. 9. 03

John G Hows CPA
Manager Executive Services

Date: 22. 9. 03

INDEPENDENT AUDIT REPORT

Health Rights Commission

Scope

The financial statements
The financial statements of the Health Rights Commission consist of the statement of financial performance, statement of financial position, statement of cash flows, notes to and forming part of the financial statements and certificates given by the Commissioner and officer responsible for the financial administration of the Health Rights Commission, for the year ended 30 June 2003.

The Commissioner's responsibility
The Commissioner is responsible for the preparation and true and fair presentation of the financial statements, the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial statements.

Audit approach
As required by law, an independent audit was conducted in accordance with *QAO Auditing Standards* to enable me to provide an independent opinion whether in all material respects the financial statements present fairly, in accordance with the prescribed requirements, including any mandatory financial reporting requirements as approved by the Treasurer for application in Queensland.

Audit procedures included -

- examining information on a test/sample basis to provide evidence supporting the amounts and disclosures in the financial statements,
- assessing the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Commission,
- obtaining written confirmation regarding the material representations made in conjunction with the audit, and
- reviewing the overall presentation of information in the financial statements.

Independence
The *Financial Administration and Audit Act 1977* promotes the independence of the Auditor-General and QAO authorised auditors.

The Auditor-General is the auditor of all public sector entities and can only be removed by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which powers are to be exercised.

The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Audit Opinion

In accordance with section 46G of the *Financial Administration and Audit Act 1977* -

(a) I have received all the information and explanations which I have required; and
(b) in my opinion -

(i) the prescribed requirements in respect of the establishment and keeping of accounts have been complied with in all material respects; and
(ii) the statements have been drawn up so as to present a true and fair view, in accordance with the prescribed accounting standards of the transactions of the Health Rights Commission for the financial year 1 July 2002 to 30 June 2003 and of the financial position as at the end of that year.

D R ADAMS, CPA
Acting Audit Manager
(as Delegate of the Auditor-General of Queensland)

AUDIT MANAGER
26 SEP 2003
QUEENSLAND AUDIT OFFICE

Queensland Audit Office
Brisbane