"DK5"

Health Rights Commission

12 October 2004

The Honourable Gordon Nuttall 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 2004.

Yours sincerely

David Kerslake
Commissioner

Address: Level 19 288 Edward Street Brisbane Q 4000 **Postal:** GPO Box 3089 Brisbane Q 4001
Telephone: (07) 3234 0272 Toll Free: 1800 077 308 **Facsimile:** (07) 3234 0333 **Web Site:** www.hrc.qld.gov.au

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Foreword

One of the Commission's key functions is to use the lessons learned from individual complaints to promote higher standards of health care for the community. By this means, the entire community stands to benefit from the outcome of individual complaints.

Established in 1991, the role of the Health Rights Commission is to provide an independent and impartial means of reviewing and resolving health service complaints. Complaints may be made about any health service, public or private, provided anywhere in Queensland.

Since the Commission's inception, over 30,000 complaints have been received. More than ever before, health consumers have come to expect the highest standards of care and generally feel more empowered to complain when their expectations are not realised. Where the level of care falls short of their expectations, they reasonably expect that their concerns will at least be listened to and, preferably, acted upon.

Recently, I had cause to remark on how far health professionals have also come in recent years, both in the standard of care they provide and in the way they respond to consumer complaints. Almost every day the media report on significant medical advances that have been made: new treatments for this, a new approach to that. Unfortunately, however, there will be occasions when something goes wrong. Medical science cannot solve all of the problems. Practitioners sometimes make mistakes. When they do, honest and open discussion of what happened is critical for complaints to be avoided.

In the past, health practitioners tended to hold a negative view of complaints. Fear of litigation, or a perceived challenge to their professional competence, were powerful motivators. To be fair, nobody likes being complained about. Fear of litigation is understandable given the significant damages awards that have been made in recent, highly publicised cases. On the other hand, there is ample evidence that a defensive response to complaints is only likely to make matters worse. Complaints need to be seen in a positive light: a treasure trove of information that can assist practitioners to learn from their patients - and from mistakes - and thus improve the overall quality of the care they provide.

It is refreshing to note the significant initiatives that have recently been undertaken, the increased emphasis on dealing with patient concerns candidly and the recognition that is being given to the value of complaints as a quality tool. For example, the Open Disclosure Standard implemented by the Australian Council for Safety and Quality in Health Care is aimed at facilitating open communication between health practitioners and patients when some aspect of treatment does go wrong. The Council has been working collaboratively with the Australian Council of Health Complaints Commissioners to develop guidelines for health services to promote better practice in complaints management. As a result of tort reform in Queensland and in other States, the law now also provides that an apology or expression of regret cannot be used as a basis for establishing liability in medical negligence cases. There is still a long way to go, but these initiatives can only help encourage open discussion between health

practitioners and their patients when some aspect of treatment doesn't go to plan. Of course, there will still be complaints that cannot be resolved in this way and where further enquiry will be needed. This is where organisations such as the Health Rights Commission come into play. The Commission provides an independent and user-friendly forum where complaints can be looked into and issues discussed without the need for legal action. Our services are free. My staff and I would also like to think that the Commission has an enviable reputation for dealing with such matters thoroughly and in a way that is fair to all. Last year alone we received over 4000 complaints. Not all were finalised to the satisfaction of both parties, but many were. Some cases resulted in financial settlements of up to $3/4 million. Many others resulted in apologies or changes to practices and procedures to minimise the likelihood of the problem occurring again. Even where complainants do not achieve the outcomes they are seeking, they still stand to benefit from a full explanation of what happened and why, and many are grateful for this.

Despite the increasing openness by health providers in dealing with patients, there are still a fair few cases where complainants state that they would never have complained to us if the provider had explained things to them in the first place, in the same way that we ended up doing. In one such case, a woman said that when she consulted a dentist suffering from toothache, he examined her, took an x-ray and then referred her to another dentist. She said that when she went to the second dentist, he also took an x-ray and then performed root canal treatment. The woman complained that the first dentist should not have charged her for the initial consultation if he had no intention of continuing with her treatment.

In response to the complaint, the dentist advised that he had no means of determining the appropriate course of action without first examining the patient. It was only with the benefit of a comprehensive examination that he had been able to decide that the woman actually required more specialised treatment by an Orthodontist. He could not have known this beforehand. When the Commission explained these points to the complainant, she accepted that the dentist's approach was reasonable but indicated that she would not have complained in the first place if he had taken the trouble to explain things to her as we had done.

One of my most important aims is to ensure that all complaints to the Commission are dealt with in a timely way. In last year's annual report I commented on a number of initiatives that had been introduced to facilitate timeliness. Some cases, by virtue of their sensitivity or complexity, are always likely to take longer than we would wish, but to date there has been a significant reduction in the overall time taken to finalise complaints. The coming years will provide a truer test, given that complaint numbers are likely to continue to rise while the resources available to deal with them remain the same. One of my aims for the next year is to develop more comprehensive performance indicators to report on the average time taken to finalise complaints.

I also propose to report in more detail on the number of recommendations made for changes to health systems or procedures and the degree to which such recommendations have been accepted and implemented. This is an important means by which the entire community stands to benefit from the outcome of individual complaints. I have included among the selected case studies in this year's report a separate section outlining significant investigations we conducted and the system changes that resulted.

Last, but certainly not least, I wish to thank my staff for their support throughout the year. Dealing with complaints is a difficult and at times stressful task and one that requires a great deal of hard work and dedication. I also wish to extend my appreciation to those practitioners who provided independent opinions and advice to the Commission on clinical issues arising from many of the complaints we received.

David Kerslake
Commissioner

Analysis of Complaints

Commission staff continued to provide a professional and efficient service in the reporting year, receiving 4,281 new complaints and finalising 4,508. At 30 June 2004, the Commission had 278 active complaints. This figure does not include 121 cases awaiting finalisation by Registration Boards. This compares favourably with the previous year's figures of around 440 active complaints as at 30 June 2003.

Complaints to the Commission are dealt with in one or more of the following stages: Intake, Assessment, Investigation and Conciliation.

Intake

Intake is best described as an initial screening stage. When an Intake Officer receives a call or written complaint, they may provide advice to the complainant or contact the provider to assist them to resolve the complaint on an informal basis.

In view of the success in dealing with complaints on a less formal basis the previous year, the Intake area was reorganised and part-time Enquiry Officer positions were replaced with full-time Intake Officer positions at a higher level. The Intake area is usually the first point of contact for most callers and it is important to have experienced staff who can play a positive role in the complaints resolution process.

The overall emphasis is on resolving less complex cases as expeditiously as possible. Of the 4,079 complaints dealt with by the Intake area, the majority were finalised informally with a variety of outcomes, reflecting the value of empowering complainants to take a more proactive role in resolving their concerns. Complainants may benefit from an explanation of why the provider's treatment was reasonable, or through the provider making an offer or gesture of goodwill that is sufficient to resolve the matter.

Below are some examples of how complaints were dealt with at Intake level:

A man contacted the Commission stating that he had attended an amputee clinic at a public hospital to organise a new prosthetic device as he was having problems with his current device, which was 12 years old. He said the doctor showed him a photograph of his leg before it had been amputated, which upset him so much that he left the clinic before a new limb could be organised. The man said he did not wish to see that doctor again and wanted action to be taken against the practitioner. The Commission contacted the Medical Superintendent's Office to see if the hospital was prepared to try and resolve the issue directly with the man. The man later contacted the Commission stating that the hospital had contacted him to formally apologise for the way his treatment had been handled. He was satisfied with this outcome and withdrew his complaint.

A woman complained that four months after treatment for the removal of spider veins in her leg, new veins had appeared which were worse than those prior to treatment. The woman was advised to write to the health service provider outlining her complaint and desired outcome, but to come back to the Commission if she had further concerns. The woman followed the officer's advice and later contacted the Commission stating she had received a response from the provider enclosing a cheque which covered the majority of her expenses. The woman was very happy with this outcome and appreciated the sincerity of the response directly from the provider.

Assessment

By virtue of their complexity or sensitivity, some cases require more detailed assessment or more formal action. During the reporting year, assessment officers finalised 197 complaints in assessment and an additional 29 complaints in conciliation. While this represents a decrease on last year, complaints that now move to this stage are largely of a more complex nature and require more detailed research and analysis.

By extending the time available to assess such complaints, in many cases it has been possible to access sufficient information to resolve the complaint by explanation, negotiation or informal recommendation. This approach also allows for continuity by the case officer and avoids delays previously experienced when cases were moved to another stage and therefore had to be re-allocated to another officer. If at the end of assessment there are issues that can readily be resolved through a conciliation process, a decision then needs to be taken as to whether to refer the case to a more senior conciliator. Because most assessing officers also have the delegation to conduct conciliations, these cases are no longer automatically referred to another level. Rather, the decision will depend upon the complexity and sensitivity of the case. Suitable cases can remain with the assessing officer until finalised, if necessary placing the case into formal conciliation to provide the statutory protections and confidentiality that attaches to that process.

This approach has proven to be more acceptable to both complainants and providers who in the past would have had to deal with several different officers and who would have preferred continuity if possible. A further advantage of this approach is that it frees up more senior conciliators to devote their energies to the more complex cases the Commission receives. All round, this approach should lead to a decrease in the average time to finalise cases.

In one case, a woman had taken her 7-year-old son to a General Practitioner (GP) with ongoing pain following a tonsillectomy. She said that the doctor failed to diagnose that her son had an infection and bleeding. She believed that the GP should have performed further investigations to make a correct diagnosis. The woman said that the doctor's manner was insulting and unsympathetic in that he suggested that her son was overreacting. She said her son began haemorrhaging soon after the consultation and was admitted to hospital with an infection. She sought an apology from the doctor to her son for disbelieving him and for the doctor to attend a communication course. The GP responded stating that the child was not exhibiting any signs of infection or bleeding during the consultation and provided a written apology to the child. Independent advice was obtained which, while supporting the care provided by the practitioner, noted that the GP should have arranged to review the child sooner. The woman accepted the apology from the GP and no further action by the Commission was required.

In another case, a man complained that a hospital was negligent in the care of his late father when he was admitted to the hospital for an infection in his liver. He said that his father had a history of falls and was often confused. Even though the hospital was aware of his history, he had a fall during his hospital stay and the nursing staff did not notify any of his family. The family discovered him in bed with a bandage around the head. An after hours co-ordinator said she would look into the matter but this was not done. The father died soon after the fall. The staff were not forthcoming with any information and the complainant considered that they were generally disrespectful towards his family. The family also believed that there was a delay in performing a CT scan following the fall and felt that this may have contributed to their father's death.

During assessment the hospital acknowledged that the family were not contacted following the fall and apologised for the oversight. It also accepted that the family had experienced significant difficulty

in accessing any information in relation to the fall. During the Commission's enquiries independent advice was obtained which supported the clinical care provided following the fall. It also became evident that the hospital's policy and procedures in relation to falls prevention were lacking and as a consequence an appropriate risk assessment was not performed on the man when he was first admitted. Whether this would have prevented the fall from occurring remained a matter of conjecture, but if appropriate procedures had been in place the risks could at least have been reduced. The Commission recommended that the hospital provide a written apology to the family, which it did. The hospital participated in a statewide project on falls management and a significant number of changes were implemented to prevent similar incidents from recurring. The Commission also made a number of other recommendations in relation to record keeping, documentation and adherence to hospital policy documents. The family was satisfied with the outcome and the changes that had been implemented to prevent similar occurrences in future.

Conciliation

As mentioned above, more complex cases are passed on to a team of senior conciliators whose role is to work with the parties to facilitate a resolution. Often the Commission obtains independent expert opinions to assist in the resolution of such cases. The process for obtaining expert advice is set out in a separate article elsewhere in this report.

For the reporting year, 82 cases were finalised by the senior conciliation team. A further 78 cases remained active at the end of the reporting period. Approximately 15% of closed conciliation cases resulted in financial compensation, some settlements involving significant six figure sums. These outcomes demonstrate that the Commission's conciliation process is a very worthwhile alternative to the more expensive, time consuming and stressful process of litigation.

In one case, a man said he underwent endoscopic surgery at a hospital to find the cause of abdominal pain. Complications during surgery resulted in him being admitted to the Intensive Care Unit where he nearly lost his life. The man said that the hospital had delayed getting a second opinion and as a result he had to undergo unnecessary additional surgery and his quality of life had deteriorated. The man complained that he may never eat properly again and felt his entire treatment had been mismanaged. The complaint was referred for conciliation where, following independent expert advice, the case was resolved with a financial settlement amounting to several hundred thousand dollars.

Formal investigations

One of the Commission's important functions is to assist in remedying systemic deficiencies that have been identified as a result of complaints received. While the Commission prefers to resolve complaints with as little formality as possible, at times it is necessary to refer a complaint for more formal statutory investigation. Formal powers of investigation are only invoked when no other avenue is available for the Commission to obtain information, or where the issues are of such significance that they warrant more formal consideration and reporting.

Even where formal investigations are conducted, the Commission remains committed to resolving the complaints in a collaborative manner with service providers and complainants. Our preference wherever possible, however, is to proceed with a minimum of formality and to resolve complaints without recourse to statutory powers. This approach was so successful that no new complaints were referred for formal investigation during the year (compared with 35 referred the previous year). Additionally, of the 56 investigations open at 1 July 2003, 39 were finalised leaving 17 open at 30 June 2004.

One major investigation finalised during the year identified significant systemic issues relating to the care of children at a small regional hospital and the retrieval of patients where they need to be transferred to a more specialised facility.

The parents of a young child took her to a small regional hospital following a fall. The child was assessed by a registered nurse and then by the doctor on duty. In their complaint, the parents stated that the treating doctor had originally agreed to their request for their daughter be kept overnight for observation, but that after consulting with nurses on duty, he returned to say that the hospital did not admit children. The treating doctor, for his part, said that it had never been his intention to keep the child for observation because his clinical judgement was that this was unnecessary.

Although the Commission was not able to reconcile the different views, there remained important systemic issues relating to the hospital's capacity to handle such cases. These included the hospital's policies and the understanding of staff in relation to the treatment of children; when they should be kept for observation; the level of expertise that should be available at that hospital when children presented; and in what circumstances they should be transferred to a hospital with more specialist facilities.

In this particular case the child had been sent home, but within a few hours a critical situation had developed. While being taken to a higher level hospital in the region the child arrested in the ambulance and was taken to the original treating hospital, which was closer. She was resuscitated and arrangements made for her to be transferred to a children's hospital. Sadly, she died without regaining consciousness.

The parents complained to the Commission and to the relevant registration bodies that their child should have been admitted when she first presented. They believed the hospital should have been able to admit children for observation, at least. The parents also complained about the competency of the doctor and the attending nurses. Further issues included the time taken to transfer their daughter to the children's hospital.

The Commission's investigation of this complaint gave rise to a number of actions and recommendations that will improve the level of services provided both in this particular District and across the whole of Queensland. Some of the changes include:

- *increasing the level of care that can be afforded to children who present to the hospital;*
- *improving doctors' rostered hours;*
- *clinical auditing and supervision of accident and emergency staff by senior clinical staff;*
- *development of a centralised clinical co-ordination retrieval system; and*
- *development of standard operating procedures to guide medical retrievals.*

Queensland Health has undertaken to act on the Commission's recommendations as a matter of priority to ensure better outcomes for those who access health care in this and all Queensland Health Districts.

Although the Commission's investigation resulted in significant changes to systems and organisational procedures, other aspects of the complaint relating to individual practitioners had to be dealt with concurrently by other investigative agencies with different jurisdictions. The parents were confronted with the frustration of having the Commission's line of inquiry limited to systems issues when clearly there were overlapping questions of individual clinical judgement. It must have been extremely frustrating for all parties to have separate inquiries being conducted into the one incident with separate findings delivered at different stages.

This is not an optimal complaint handling process. Arguably, a single report covering all of the issues would have given a more complete picture of events. Best practice in complaint handling could perhaps better be achieved by centralising the complaint handling and information gathering processes, at least in the initial stages of dealing with a complaint.

One way of achieving this under the current system would be for the Commission to conduct the initial assessment of all issues raised in a complaint and to refer issues to a registration body once this assessment is completed, if appropriate. For this approach to be effective, however, the Commission would need to be able to access relevant information and have sufficient time to carry out a comprehensive assessment of the various issues raised. Given the inherent complexity of cases such as the one referred to above, it is impossible to carry out a comprehensive assessment within the time frames laid down within the *Health Rights Commission Act 1991* (The Act). Even under the Commission's current approach of relaxing those time frames, there is the separate issue of accessing relevant information. The Commission no longer has the capacity to investigate individual registrants and can only investigate systems issues across an organisation. In practice, this means that we have the power to require organisations to respond to a complaint and to provide information, but no power to make the same requirement of individuals. The Commission's past experience is that individuals are not always keen to respond to a complaint or provide information on a voluntary basis. Without the power to compel provision of relevant information, the Commission often finds that it has no other option but to immediately refer a complaint against an individual registrant to the relevant registration board which does have the power to obtain such information. This can mean that different bodies end up dealing with different aspects of the same complaint. If the relevant board concludes that, even taking the complaint at face value, the case is not sufficiently serious to warrant its intervention, there is the possibility that a person's complaint may not be able to be dealt with at all, if an individual provider simply refuses to cooperate with the Commission's own enquiries.

One way around this problem would be for the Commission to be given the power to obtain relevant information and to require providers to respond to a complaint in assessment. An alternative would be to return to the Commission its former power to investigate individual registrants as well as organisations - the approach adopted in other Australian jurisdictions - but to require consultation between the Commission and the relevant registration board on individual cases to decide which body is the more appropriate to deal with the matter.

The Commission proposes to canvass these issues in more detail in the year ahead. In making these comments, the Commission is in no way being critical of the investigative processes of the various registration bodies. Rather, it is endeavouring to find a way around the frustration that is experienced where there is a plethora of complex issues, systemic and individual, but where the parties have to wait for all pieces of the jigsaw to be put together before they can get a final answer, or where there is the potential for them not to get an answer at all.

Review of registration board investigations

As part of its monitoring role in terms of the *Nurses Act 1992* and the *Health Practitioner (Professional Standards) Act 1999,* the Commission is required to review and comment on investigation reports from the Queensland Nursing Council and the various Registration Boards. It is pleasing to note that where the Commission has commented or raised issues requiring further attention by a Board, the Board has taken those comments into account before making a final decision.

Tables

Table 1: Complaints Resolved by Stage

Stage of Complaint Process	Number of Complaints
Intake	4,079
Assessment	197
Conciliation	111
Investigation	36
Multiple Action	15
Referred to Another Entity	4
Referred to Registration Boards	66
Total	**4,508**

Table 2: Complaints Open as at 30 June 2004

Current Case Stage	Number of Cases in Stage
Intake	69
Assessment	92
Conciliation	78
Investigation	14
Ministerial Investigation	3
Multiple Action	18
Referred to Another Entity	4
Referred to Registration Boards	121
Total	**399**

Table 3: Respondents to Complaints Received

Provider	Number of Complaints
Aboriginal Health Service	4
Aged Care Facility – Commonwealth	21
Aged Care Facility – Private	11
Alcohol & Drug Service	10
Audiologist	2
Breast & Cervical Service	1
Child Community Health Service	2
Chiropractor	26
Community Health Centre	22
Community Health Service	1
Community Mental Health Service	21
Complementary (Alternative)	9
Corrections Health	18
Cosmetic Service	3
Counsellor	12
Day Respite	1
Dental Service	39
Dental Technician / Prosthetist	21
Dentist	191
Dietician	3
Fertility Clinic	2
Hospice	2
Hospital Private	136
Hospital Psychiatric	20
Hospital Public General	812
Insurance	2
Integrated Mental Health Service	156
Medical Centre	97
Medical Practitioner	1,364
Nurse	24
Nursing Service	3
Occupational Therapist	1
Optometrist	22
Other Health Service	59
Pathology Service	10
Pharmacist	29
Pharmacy	12
Physiotherapist	10
Podiatrist	7
Psychiatrist	4
Psychologist	28
QAS – Ambulance	8
Queensland Health	47
Radiographer	7
Radiology Service	19
Residential Care Worker	1
Respite Care	5
Sexual Health Service	4
Social Worker / Welfare Officer	5
Supported Accommodation Facilities	10
Not Disclosed	957
Total	**4,281**

Table 4: Primary Issues in Complaints Received

Access to Service	
Attendance	20
Delay in Admission or Treatment	96
Discharge/Transfer Arrangements	28
Referral	19
Refusal to Admit/Treat	153
Service Unavailable	61
Transport	2
Waiting lists	47
Total	**426**

Communication	
Attitude	297
Inadequate Information	182
Wrong or Misleading Information	37
Interpreter/Special Needs Services	2
Total	**518**

Consent	
Invalid	13
Not Informed/Failed to Warn	9
Not Obtained	15
Failure to Consult Consumer	13
Involuntary Admission	70
Total	**120**

Corporate Services	
Administration Services	45
Hotel Services	11
Hygiene/Environmental Standards	15
Other	563
Total	**634**

Cost	
Billing Practices	237
Government Subsidies	13
Information on Costs	19
Overcharging	26
Private Health Insurance	4
Public/Private Election	3
Total	**302**

Table 4: Primary Issues in Complaints Received *continued...*

Grievances	
Inadequate/No Response to Complaint	15
Reprisal/Retaliation	4
Total	**19**

Privacy/Discrimination	
Access to Records	243
Discrimination	10
Inconsiderate Service	13
Privacy/Confidentiality	82
Total	**348**

Professional Conduct	
Accuracy/Inadequacy of Records	26
Assault	7
Certificates/Reports	43
Competence	48
Financial Fraud	7
Illegal Practices	12
Impairment	6
Sexual Misconduct	47
Total	**196**

Treatment	
Coordination	49
Diagnosis	411
Infection control	49
Medication	306
Misdiagnosis	1
Inadequate	480
Negligent	126
Rough/Painful	65
Withdrawn/Denied	36
Wrong/Inappropriate	195
Total	**1,718**

TOTAL OF ALL ISSUES	**4,281**

Independent Opinions

Many complaints received by the Commission involve episodes where there has been a serious outcome for the complainant. This does not in itself, however, give rise to a case for compensation or suggest that the outcome was necessarily someone's fault. All forms of treatment carry with them inherent risks, such as the possibility that the original problem will remain, or the risk of subsequent infection or some other adverse outcome that may lead to a worsening of the original condition. Provided that the patient was adequately advised of the known risks and that the treatment was carried out in an appropriate way, a case for compensation may not arise. On the other hand, there may be situations where an outcome was a known risk of the procedure, but the particular reason the outcome eventuated was because the treating practitioner failed to follow accepted procedures and thus unreasonably increased the risks. These instances may indeed lead to a claim for compensation or other appropriate remedy.

It falls to the Commission to assist the parties to unravel the issues involved in such cases, sometimes by explaining to a complainant why their outcome was sheer bad luck, in other cases by assisting the parties to negotiate an appropriate remedy. Depending upon the complexity of the issues and the approach of the parties, this may be achieved either by informal means or, in other cases, through the Commission's conciliation process, which is confidential and attracts legal privilege.

One of the greatest aids to the resolution of such complaints is the use of experts to review the clinical issues involved in the case and provide an independent opinion. Although the Commission is experienced in gathering and exchanging relevant information, it does not have the expertise to form a view on the myriad of clinical issues raised by complaints. Independent advice has been of particular significance in all of the Commission's processes, formal and informal, where expert or peer opinion assists in clarifying issues about the adequacy of treatment provided.

Often, expert opinions are obtained informally during the initial assessment stage. The Commission is fortunate in that practitioners often agree to provide advice on a pro bono basis. A typical case would involve the assessing officer setting out the scenario involved in the case, without mentioning the names of either of the parties, and presenting that scenario to an experienced practitioner who practises in the same field as the provider against whom the complaint has been made. The adviser would be asked to comment on whether the approach to treatment had been reasonable in the circumstances, whether the diagnosis was acceptable given the nature of the patient's presentation, and so on. Typically, the adviser would be informed of the substance of both the complaint and the treating practitioner's response, but not the names of either party. Copies of relevant records may be made available but in that case would usually be de-identified. This process ensures that the advice takes into account all relevant information and that both the complainant and provider can be assured of the independence and integrity of the advice obtained.

If the advice is that the treatment provided was reasonable or adequate, the parties would be notified accordingly and the case would normally be closed at that point. If the treatment was found to be less than reasonable, the provider may elect to make some form of offer, financial or otherwise, to resolve the matter. Such cases do not always result in compensation and, indeed, complainants often seek no more than an apology and an acknowledgement of the concerns they have raised. Sometimes, based on the informal advice received, the case may be referred to conciliation to explore the issues in more detail.

The parties involved in the conciliation may then agree on an expert to be consulted with a view to obtaining more formal advice, often in the form of a written report. The parties may also have input into the information to be given to the expert and the specific questions to be asked. The conciliator's role is to assist the parties in this process and to facilitate a resolution. The conciliator's ultimate obligation, however, is to ensure that the questions asked and the information obtained will result in reliable and thorough advice that will assist in a just resolution, whatever that outcome may be. It is important for the expert opinion to be obtained through a process that is seen to be fair and balanced and whose independence can be accepted by both parties, regardless of the way the case pans out. In this way, cases in which liability was previously disputed or at least unclear, can frequently be resolved through conciliation.

When all parties agree both to obtain advice from an independent practitioner and on the qualifications or experience the adviser needs to hold, that agreement contributes to an efficient negotiation process. There are times, however, when there is a disagreement about who would be the most appropriate practitioner to provide an opinion, or where the complaint involves a subspecialty that requires particular expertise which is not readily available. In such cases the conciliator may need to undertake an enquiry process to identify an expert who will be acceptable and relevant to the particular dispute. The conciliators have accumulated the names of many experts through a range of sources. These sources include:

- Health Complaints Commissions in other States;
- Professional associations;
- Royal Colleges;
- Medical Superintendents and Heads of Departments in hospitals;
- Experts who have previously provided opinions; and
- Personal contacts.

Sometimes a specialist may be found quickly, with the assistance of supportive practitioners in the field who are happy to recommend a particular expert. All that may be required is a telephone call to a Medical Superintendent who may provide the name of a practitioner who is willing to provide advice and is acceptable to all parties. At other times, finding the best available practitioner for the process can be difficult and time-consuming. Relevant considerations may be whether the provider needs to be drawn from public or private practice, from a rural or metropolitan background, and so on, to ensure that the training and experience of the adviser is an appropriate match. Complainants and providers are anxious to ensure that advisers are highly regarded in their field and demonstrably independent in their opinions.

The process of gaining independent opinions provides a positive alternative to opinions presented by either side that may reflect their own interests. The opinion can provide an opportunity for the complainant to understand what has happened to them as well as for the parties to make a realistic assessment of the likely outcome of a case if the matter proceeded to litigation. Conciliation is very much a desirable and viable alternative to litigation and provides an opportunity to address issues in a more user-friendly and less adversarial setting.

Case example

A woman complained about the care provided to her husband by a specialist in a public hospital, and subsequently by another specialist in a private hospital. The specialists were from the same discipline, and were unable to diagnose the man's rare syndrome until he became very ill. The woman believed that, with better care, her husband's diagnosis could have been made earlier and that this may have saved his life. In this case, it was important to obtain an opinion about the man's care from a specialist who would be accepted as appropriate by all parties. The family was keen to obtain an opinion from another specialist who had cared for the man in ICU, because they liked and respected

him. The providers and their legal advisers believed that, as a party to the man's care, it would be difficult for that doctor to give an objective opinion. The legal advisers for the private specialist preferred a local doctor who was highly regarded by the professional community to provide advice, but the Commission considered that the local doctor may already be aware of the unusual case, or the people involved, and possibly be compromised by that knowledge.

The conciliator made enquiries from sources in other States and located the name of a highly regarded specialist. The specialist provided his curriculum vitae for the parties to consider. While the family and the hospital were happy with his qualifications and experience, the private provider had not heard of him and felt less comfortable.

The family became frustrated and annoyed that one of the providers would attempt to influence the process in such a way, and negotiations could have collapsed at this stage. Understandably, the family did not want to accept any specialist who had been recommended by a provider. This posed a dilemma for the conciliator handling the case, bearing in mind that conciliation is a voluntary process and that either party could have withdrawn at any stage. Clearly, the expert needed to be someone whose reputation was such that it made them acceptable to all parties. Fortunately, the expert who the Commission had originally suggested was happy to provide names of alternative colleagues for consideration. The conciliator also reinforced with all parties that, to resolve the dispute, a compromise would be necessary. Ultimately, further recommendations located a specialist who had taken a particular interest in the specific condition the man had suffered. That specialist was keen to undertake the review of the case because of her interest in that area and all parties were anxious to seize that opportunity.

After an opinion has been received

After an opinion has been received, a copy is provided to the complainant and the provider who are given an opportunity to comment on the opinion. Sometimes the opinion raises questions for one or both parties, or is not clearly understood and clarifications are sought with the help of the conciliator. In addition the conciliator will canvass with the parties the direction of the conciliation process in light of the report. This may lead to the complaint being discontinued, or, if the provider accepts liability, to further negotiations about how the matter may be resolved.

Under the Act, the conciliator is also required to assess the report to identify if the standard of care provided was appropriate, or whether the matter should be referred to the relevant professional board for further consideration of the provider's professional competence.

Conclusion

The Health Rights Commission provides a specialised service for people with complaints about health services or individual health practitioners. Within that specialised service the Commission seeks to provide information to complainants to help them understand the treatment they have received. The service also includes the option of conciliating complaints in a confidential manner. The use of independent opinions from people with clinical expertise is an essential tool in resolving complaints, both in terms of increasing people's understanding of what has happened and in indicating whether a provider is liable for an adverse outcome. Independent opinions assist the Commission in dealing appropriately with a range of complex clinical issues and in tailoring the complaint process to the specific complaint. They also enable the Commission to maintain a neutral role, rather than a judicial one, to facilitate where possible the mutually satisfactory resolution of complaints.

Case Studies

Conciliation serves as a valuable alternative to the more adversarial process of litigation

An elderly woman who underwent a knee replacement at a public hospital said that during two appointments prior to surgery, she clearly indicated that she did not want an epidural and this was noted in her record. She said that on the day of surgery, a staff member pressured her 3 or 4 times to have an epidural, claiming it would make it easier for her and the doctors. She said that she finally agreed, but only under duress because of the pressure she was placed under and because she did not wish to appear to be a bother. The woman said that as a result of complications from the epidural she had now lost the use of her legs and was confined to a wheelchair. She said she lived independently before the procedure but now had to live in a nursing home. She wanted assurance that the staff member who pressured her into the epidural would not do so again and compensation for the permanent disability.

The hospital medical records confirmed that the woman had requested an alternative method of pain control at her pre-anaesthetic consultation. The hospital advised that there were two failed attempts before the epidural was successfully inserted but maintained that its treatment of the woman's symptoms was timely and appropriate.

An independent advisor was critical of the time taken by the hospital to respond to the complication, stating that increased attempts prior to successful insertion of the epidural increased the risk of a haematoma. The matter was referred to conciliation and the woman received a substantial six-figure settlement.

In another case, a woman said she underwent bowel surgery by a private surgeon. Five years later she had x-rays taken and it was only then that she discovered that a surgical drain had been left inside her. The woman believed that the drain had been left following surgery and sought to have the drain removed.

The complaint was referred to the Commission's conciliation process during which time the woman underwent further surgery to remove the drain. A financial agreement was reached between the two parties.

Often complainants' chief motivation is to avoid the same problem happening to someone else

A woman complained about treatment that her elderly mother received after she was admitted to hospital following a fall. She said her mother was given panadeine and tramadol for pain relief. When she advised the admitting doctor that her mother was also on warfarin, she was reassured that the pain relief medication would not interact with the warfarin. The woman stated that her mother's warfarin levels were not properly monitored and she was subsequently discharged with a warfarin toxicity. Although her mother was immediately readmitted to hospital, her condition deteriorated rapidly and she died in the emergency department.

During assessment the hospital acknowledged that the patient had an INR (a measurement to monitor the rate of blood clotting) that was higher than the therapeutic range and that the test result was overlooked. The hospital said that it was likely that the woman had experienced a drug interaction between the tramadol and warfarin, which caused the high INR. An interaction between these two drugs was not recognised in the standard reference resource used in the hospital.

The hospital apologised to the woman and outlined the policy and procedural changes that it had implemented as a result of this case. Independent advice was critical of the care provided and the lack of action taken in response to the elevated INR. At the conclusion of the assessment the parties agreed to a financial settlement offered on an ex gratia basis. The complainant was happy for the case to be closed on that basis, but more particularly in view of the systems improvements that had occurred.

Even where a complaint cannot be substantiated, the complainant still stands to benefit from the Commission's independent assessment and explanation

A man stated that he consulted a GP because he had sunspots and growths on his ears. His doctor diagnosed the growths as cysts and burnt the sunspots off. The man said the lesions on his ears became larger and he also developed a sunspot on his thigh. He went back to the doctor, who followed the same approach as before. The man said that the sunspot on his thigh continued to grow and became very painful so he consulted a second doctor who diagnosed cancer on his thigh and ears and referred him for surgery. Subsequently, he had part of both ears removed and part of his thigh. He said he wanted action taken against the doctor and wanted to receive compensation.

In conciliation it was established that the GP had in fact offered the man a referral to a plastic surgeon but the man had declined the offer. The GP also pointed out that he had given the man two previous referrals about an unrelated matter but the man had never followed through with these. Independent advice was obtained which stated that you "cannot force a patient to accept a referral" and also commented that the provider had acted appropriately in agreeing to review the man's ears in two months time when the man had declined the referral. In relation to the sun spots on the man's arms and right thigh, the adviser stated that the provider had acted appropriately in treating these with dry ice because, "unless lesions looked like classic presentations for basal cell carcinomas and squamous cell carcinomas, referral to a specialist is not indicated". The adviser noted that the man was subsequently diagnosed with basal cell carcinoma, squamous cell carcinoma and ratoachanthoma on his right thigh by another doctor, but said that as the man had not returned to the provider after the lesion on his thigh was treated with dry ice, the provider had therefore not been given the opportunity to review him. When advised that the matter may be closed, the man stated that based on the information obtained, he accepted this outcome. The matter was subsequently closed in conciliation.

One of the Commission's main functions is to use feedback from complaints to help improve health systems and procedures

A couple complained that their baby had been delivered stillborn at a hospital as a result of negligent care by staff. They believed that the pregnancy should have been induced earlier, particularly given the baby's known size and earlier tests that had shown borderline gestational diabetes. They said that the wife had experienced many difficulties in the last ten days of pregnancy, including severe swelling of her legs, blurred vision, high blood pressure and signs of pre-eclampsia. They believed that with more appropriate care the baby would not have died.

In its response, the hospital maintained that the woman had been appropriately investigated for gestational diabetes and that the tests were normal. The hospital considered that the baby's death was related to a cord prolapse and not the management during the latter stages of her pregnancy.

The Commission obtained independent obstetric advice which confirmed that the cause of death might well have been a cord prolapse and indicated that the overall care had been of an appropriate standard. The hospital had taken reasonable steps

to exclude pre-eclampsia. Midwifery advice was also obtained which indicated that there were some deficiencies in the practice of a midwife involved in the woman's care. Although the advisor did not consider that there was any link between these deficiencies and the baby's death, they nevertheless pointed to areas where the hospital's overall procedures could be improved.

As a result of the complaint, the hospital identified and implemented a number of strategies to more appropriately care for high-risk antenatal women. These included having an area specifically dedicated to the care of women requiring antenatal assessment outside of clinic hours; ensuring the section was appropriately equipped to ensure minimal delay in assessment; and development of new protocols specifically targeting assessment requirements of high-risk antenatal women. Additionally, the hospital developed new guidelines to inform midwifery staff of when medical referral was required and documentation workshops were conducted within the maternity unit, which included both midwifery and multidisciplinary staff. Additionally, the hospital developed new guidelines to inform midwifery staff of when medical referral was necessary. The midwife acknowledged that her documentation had been inadequate and documentation workshops were conducted within the maternity unit, including both midwifery and multidisciplinary staff.

While the expert advice was unable to draw a link between the identified deficiencies and the unfortunate outcome, the complaint nevertheless led to significant changes to practices and procedures that would substantially improve the standard of future care.

In another case, a woman stated that her adult son was admitted to a public hospital following an accident at home. She said that during his admission her son's condition deteriorated but the doctor was not called and his condition was not adequately monitored by nursing staff. The woman said she was advised her son was resting comfortably but three hours later he died. The woman believed the hospital was negligent in failing to provide adequate medical care. The receipt of the son's medical record raised concerns about the level and quality of entries in those records and the complaint was referred for investigation.

The Commission in its findings formed the view that the man was not accorded adequate nursing observations and there seemed to be confusion about the protocols for resuscitation. This view was supported by independent advice and a registered nurse was subsequently referred to the Queensland Nursing Council for further action. The hospital accepted that there was a need for further education of nursing staff and developed new protocols in relation to resuscitation of patients with assistance from the Commission. The man's family said that in view of the changes that had resulted from their complaint, they were satisfied with the outcome and did not wish to take the matter further.

One of the realities of the Commission's independent role is that we are not always able to fulfil the wishes of complainants

A man said his wife who was a resident in a private nursing home, was in constant distress, trauma and fear. He said that his wife's care had been compromised by the inactivity and poor management by the Director of Nursing (D o N). He said that he had complained to the facility about the way his wife was treated by one of the nursing staff but the D o N had taken no action and as a result his wife was still at risk. The man sought to have the nurse in question removed from his wife's area. The nursing home responded to the Commission enclosing an Investigation Report commissioned by the nursing home's governing agency. The report included 14 staff statements, minutes of various meetings, discussions between the man and management at the nursing home, incident reports, correspondence and progress notes, which identified there had been ongoing disputes between the man and some of the facility's

staff but provided no evidence to support the man's allegations. The Commission was unable to obtain any information which would substantiate the complaint, and the man was therefore advised that the matter was to be closed. The man was very dissatisfied that the matter was to be closed and at a meeting with Commission officers, it was agreed that the Commission would follow up on four additional issues that he had raised in relation to the complaint. The additional enquiries included consultations with Queensland Police and the Queensland Nursing Council but no new evidence came to light to support the man's allegations. The complaint was subsequently closed in assessment and the man remained dissatisfied with the Commission's efforts to resolve his complaint.

The Commission's usual approach is to refer serious allegations of misconduct to the appropriate registration board

In one case, a woman contacted the Commission to advise that during a home visit, a GP had examined her and then got into her bed and began to kiss her and touch her in a sexually inappropriate manner. Given the seriousness of the allegations, the matter was immediately referred to the Medical Board of Queensland for investigation.

Executive Services

Overview

The Executive Services program experienced a challenging year providing management, development and support to the Commission's core business activities. Executive Services encompasses the following activities: financial management, human resource management, information technology, community outreach and general administration.

The following highlights provide a brief synopsis of some of the projects and activities undertaken by Executive Services staff during the 2003-2004 financial year.

Reception Services

As part of the Executive Services program, reception provides the Commission's first point of contact for external parties and direct support to the Complaints and Conciliation Units.

During the year, the Commission's reception received 11,542 calls. These calls were assessed and where appropriate, direct assistance was provided to the caller by reception or the call was referred to an Intake Officer for further attention.

Human Resources

At the end of the financial year, the Commission had a workforce of 25.2 Full Time Equivalent's (FTE), inclusive of temporary and seconded positions. While we continued to experience a relatively high movement of staff during the year, the Commission's priority remains to maximize the number of officers dedicated to the complaints handling process, which is the core business of the Commission.

During the year, nine new staff were appointed to permanent and temporary/ seconded positions. The Commission continues to offer staff opportunities to further develop skills and broaden their work experience through external secondments or internal relieving arrangements in 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.

FTE distribution of male and female staff across the classification levels

Classification Level	Female	Male	Total
SES		1	1
AO 7	3.2	2	5.2
AO 6	2		2
AO 5	7	3	10
AO 4	4		4
AO 3	2		2
AO 2	1		1
Total	19.2	6	25.2

Financial Services

The Commission's operations are funded by quarterly endowments received from Queensland Health, which totalled $2,728,800 in 2003-2004. Actual expenditure for the year was $2,314,780, down 13% on last financial year's expenditure. Employee expenses were again the major constituents, comprising 76% of the Commission's total expenditure.

At the end of the financial year, the Commission's assets were valued at $1,408,024. The replacement of office equipment and the preliminary cost of the Level 18 Relocation Project increased the asset holding by $38,501.

Liabilities totalled $460,850 at the close of the financial year. Accounts payable ($306,509) and Provisions for Employee Entitlements ($145,167) constituted the majority of the liabilities.

The Commission's assets exceed its liabilities by $947,174.

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

Information Technology

As reported in last year's annual report, an internal audit was undertaken on network access controls, and a review and updating of all security policies to reflect the current climate was conducted. This is now an ongoing process to ensure the security and confidentiality of the Commission's core systems.

The Firewall and Virus systems were also upgraded inline with product releases from the manufacturer to ensure the Commission's infrastructure remains secure.

Legal Services

The position of Legal Services Officer remains vacant. The Commissioner and other staff members have undertaken the key duties and functions associated with this position as required.

In a previous case, in the course of referring a matter to a registration board, the Commission was obliged to disclose that during the investigation of a complaint, difficulties had been experienced in obtaining information from the provider's office. A staff member of that office subsequently sued the Commission for defamation. The matter was heard in the Supreme Court of Queensland. The case was dismissed and the actions of the Commission's officers were fully vindicated.

Freedom of Information

There was a noticeable increase in the number of Freedom of Information (FOI) applications received in the last financial year. Thirty-six applications were received in the year under the Freedom of Information Act 1992, compared with seventeen in 2002/2003.

The Commission believes that the introduction of the Personal Injuries Proceedings legislation may have had an impact on the increase of FOI requests, as many complainants are being referred to the Commission by their legal advisors as a first course of action.
Of the applications received in the year under review, 30 were for access to documents of a personal nature and 6 were requests for access to non-personal documents.

During the year, a total of 5,473 documents were considered in the applications for access to documents of a personal nature and 97.3% of those documents were released in part or in full (compared with 95% of documents released in the previous year).

In addition, a total of 471 documents were considered in the applications for non-personal documents. Of these 85% were released in part or in full with the remaining 15% being exempt from access. These figures represent an increase in the rate of release of documents in non-personal applications, up from 73% in 2002/2003.

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

As at 30 June 2004, the Commission was awaiting decisions on two external reviews by the Information Commissioner. In both cases, the subject of the review related to the release of matter supplied in confidence (FOI Act, Section 46). In dealing with health complaints, the Commission frequently needs to obtain independent expert advice from appropriately qualified practitioners, who often request that their names not be released. When making a decision on a FOI request, normal practice is to release only the content of the independent advice. If there were a risk of the independent advisors' names being released against their wishes, the functions of the Commission would be in jeopardy.

Until such time as the Information Commissioner hands down his decisions, however, uncertainty remains on the application of Section 46 of the FOI Act.

Community Outreach

The primary function of Community Outreach is to co-ordinate activities to promote, educate and interact with the community, providers and consumers to increase awareness of the role and services of the Health Rights Commission.

We aim to achieve this by:

- the education of consumers and providers about health services and outcomes of care;
- developing and maintaining a liaison with consumer and provider organisations;
- ensuring special needs groups and individuals have access to information and assistance regarding the Commission's processes; and
- developing and coordinating promotional projects and managing media liaison and publicity.

This year Community Outreach focused on multicultural groups and health service providers. We increased awareness within these target areas through community presentations, active participation on committees and involvement in community awareness exhibitions.

Highlights 2003-2004

- Participation in the Australian Medical Association Queensland (AMAQ) Health Expo on 23-25 July. We engaged directly with the community in raising awareness of the HRC, and were able to readily network with a range of health service providers.
- Representation at NAIDOC Family Day. This day gave the Commission the opportunity to interact with and increase mutual understanding and awareness between the indigenous community and the Commission.
- Continuing involvement in a joint initiative of Queensland Commissions and the Ombudsman to increase awareness of complaints handling agencies in Queensland.
- Visiting the Rockhampton area in February 2004 to increase awareness in the Capricorn community, to interact with health care providers, and generally to promote the role of the Commission.

Commission staff participated in a wide range of presentations that targeted a variety of groups in the community. The presentations were aimed at increasing understanding of what we do and our role and responsibilities as a complaint-handling agency. The Commission encourages all staff to take on public awareness activities and is keen to involve staff more widely in these activities in future.

The Commission is currently revising its promotional material and is developing a brochure specifically for health service providers to accompany the existing consumer brochure.

Presentations were made to various groups, including:

- Australian Gynaecological Endoscopy Society National Conference
- Queensland Health Complaints Coordinators Training
- Queensland Aged & Disability Advocacy
- Independent Retirees Toowong Branch
- James Cook University - Fourth Year Occupational Therapy students
- Mayne Health at Nambour & Caloundra
- Psychotherapy & Counseling Federation of Australia Conference
- University of Queensland Dental and Applied Health students
- Women's and Children's Hospital Australasia National Conference
- Mater Hospitals' Executive Directors' Group
- Australian Society of Cosmetic Surgeons' National Conference

Health Rights Advisory Council

The current Council appointed by the Minister for Health on 1 May 2003 for a term of three years is comprised of:

Consumer Representatives

Mr Joe Veraa
Dr Colleen Cartwright

Provider Representatives

Ms Kym Barry
Dr Zelle Hodge

Other Representatives

Dr Derek Lewis (President)
Ms Jane Sligo

The Council met on 9 September 2003, 9 December 2003, 30 March 2004 and 22 June 2004 and considered such issues as the proposed Coroners Act Amendments, FOI and the Personal Injuries Proceedings Act.

The Council wishes to congratulate Dr Colleen Cartwright in recognition of the completion of her PHD titled "Factors Impacting on Terminally Ill Older People Leading to Requests for Euthanasia".

The Commission wishes to express appreciation to members of the Advisory Council during the past twelve months and looks forward to an ongoing cooperative relationship.

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)

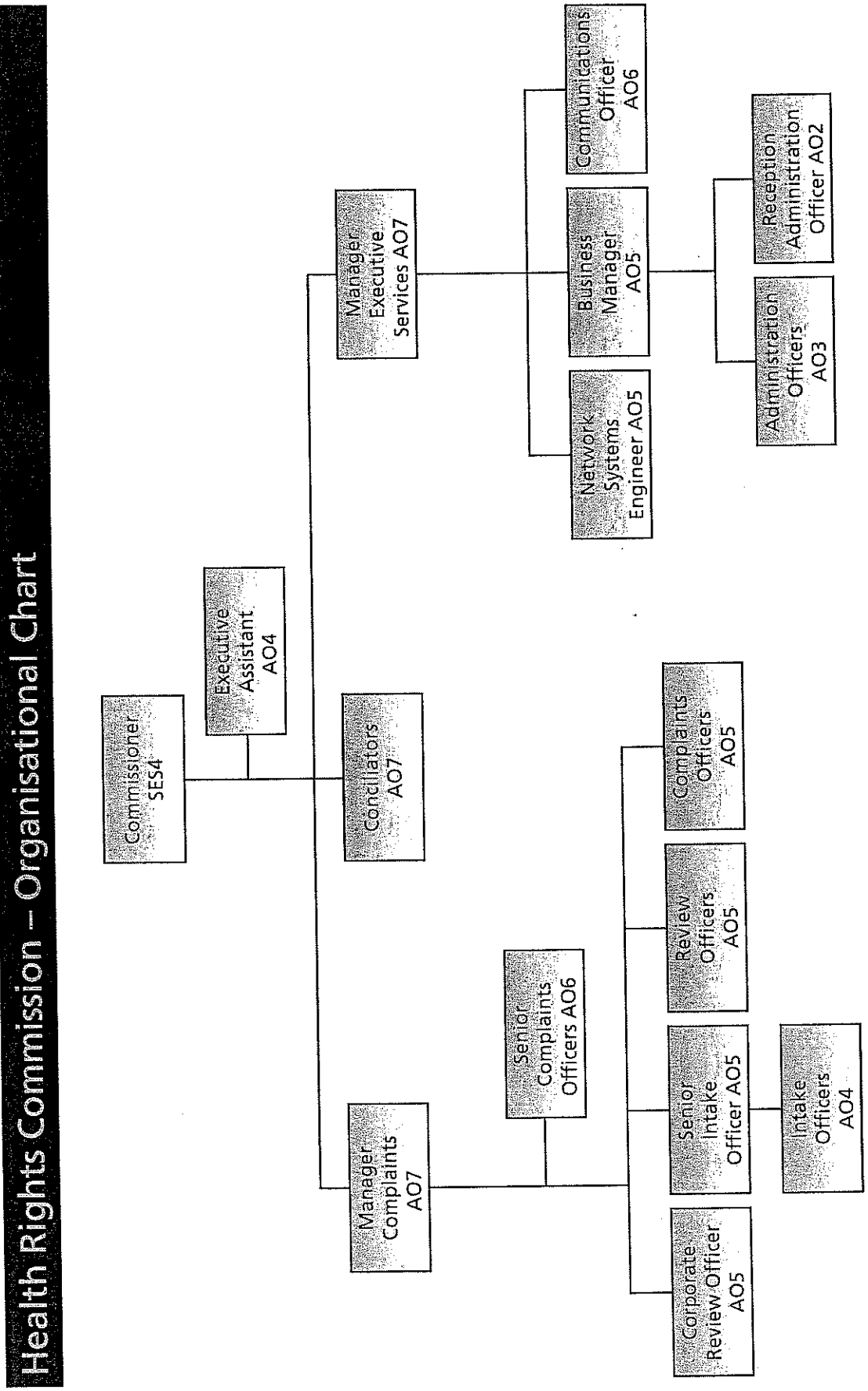
The principal objectives of this Act are –

(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.


Health Rights Commission – Organisational Chart
Commissioner SES4
Executive Assistant AO4
Conciliators AO7
Manager Executive Services AO7
Business Manager AO5
Communications Officer AO6
Network Systems Engineer AO5
Reception Administration Officer AO2
Administration Officers AO3
Manager Complaints AO7
Senior Complaints Officers AO6
Complaints Officers AO5
Review Officers AO5
Senior Intake Officer AO5
Intake Officers AO4
Corporate Review Officer AO5

Financial Statements

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL PERFORMANCE
For year ended 30 June 2004

	Note	2004 $	2003 $
Revenue from Ordinary Activities			
Government Endowment	3(a)	2,728,800	2,820,000
Other	3(b)	93,933	79,689
Total Revenues from Ordinary Activities		**2,822,733**	**2,899,689**
Expenses from Ordinary Activities			
Employee Expenses	10	1,769,633	1,992,707
Executive Services	2(a)	452,076	511,914
Health Rights Services	2(b)	56,388	100,187
Depreciation	6(b)	36,684	48,680
Total Expenses from Ordinary Activities		**2,314,781**	**2,653,488**
Operating Result from Ordinary Activities		**507,952**	**246,202**
Net Operating Result	14	**507,952**	**246,202**
Total revenues, expenses and valuation adjustments recognised directly in equity		-	-
Total changes in equity other than those resulting from transactions with owners as owners		**507,952**	**246,202**

The accompanying notes form part of these statements.

HEALTH RIGHTS COMMISSION

STATEMENT OF FINANCIAL POSITION
As at 30 June 2004

	Note	2004 $	2003 $
Current Assets			
Cash Assets	4	1,257,170	559,767
Receivables	5	35,997	74,944
Prepayments		3,966	3,404
Total Current Assets		**1,297,132**	**638,115**
Non-Current Assets			
Property, Plant and Equipment	6(a)	110,892	115,379
Total Non-Current Assets		**110,892**	**115,379**
Total Assets		**1,408,024**	**753,494**
Current Liabilities			
Payables	7	315,683	183,445
Provisions	8	145,167	130,830
Total Current Liabilities		**460,850**	**314,274**
Total Liabilities		**460,850**	**314,274**
Net Assets		**947,174**	**439,221**
EQUITY			
Accumulated Funds	14	947,174	439,221
Total Equity		**947,174**	**439,221**

The accompanying notes form part of these statements.

HEALTH RIGHTS COMMISSION

STATEMENT OF CASH FLOWS
For year ended 30 June 2004

	Note	2004 $	2003 $
Cash flows from operating activities			
Inflows:			
Government Endowment		2,728,800	2,761,930
Interest receipts		62,106	38,932
FOI Application Fees		334	95
LSL Reimbursement		37,318	55,906
GST Refunds from ATO		109,059	276,195
GST received from customers		909	22,784
Outflows:			
Employee expenses		(1,731,885)	(2,287,337)
Supplies and services		(410,393)	(595,434)
GST paid to suppliers		(60,344)	(57,821)
GST remitted to ATO		-	(230,314)
Net cash provided by (used in) operating activities	9	**735,904**	**(15,065)**
Cash flows from investing activities			
Inflows:			
Proceeds from sale of Property, Plant & Equipment		-	3,100
Outflows:			
Payments for Property, Plant & Equipment		(38,501)	(36,508)
Net cash provided by (used in) investing activities		**(38,501)**	**(33,408)**
Net increase / (decrease) in cash		**697,403**	**(48,473)**
Cash at beginning of financial year		**559,767**	**608,240**
Cash at end of financial year	4	**1,257,170**	**559,767**

The accompanying notes form part of these statements.

HEALTH RIGHTS COMMISSION

NOTES FORMING PART OF THE FINANCIAL STATEMENTS
For the year ended 30 June 2004

Objective of the Commission

The objective of the Health Rights Commission is 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.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Basis of Accounting

This financial report is a general purpose financial report that has been prepared in accordance with applicable Australian Accounting Standards, the Financial Administration and Audit Act 1977, Financial Management Standard 1997 and other authoritative pronouncements.

The financial report has been prepared on the accrual and going concern basis.

Except where stated, the Financial Statements have been prepared in accordance with the historical cost convention.

In the determination of whether an asset or liability is current or non-current, consideration is given to the time when each asset or liability is expected to be realised or paid. The asset or liability is classified as current if it is expected to be turned over within the next twelve months.

The accounting policies adopted are materially consistent with those for the previous year.

b. The Reporting Entity

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

c. 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.

d. 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 at 30 June as well as deposits at call with financial institutions.

e. 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.

f. Payables

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

g. Acquisitions of Assets

Actual cost is used for the initial recording of all asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use.

h. Property, Plant and Equipment

All items of plant and equipment with a cost or other value in excess of $500 are recognised for financial reporting purposes in the year of acquisition

Items with a lesser value are expensed in the year of acquisition.

i. Depreciation of Property, Plant and Equipment

Depreciation on all fixed assets is calculated on a straight-line basis so as allocate the net cost of each asset, less its estimated residual value, progressively over its estimated useful life to the Commission.

Items comprising the Commission's technical library are expensed on acquisition.

For each class of depreciable asset the following depreciation rates were used:

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

j. 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.*

k. Employee Benefits

Wages, Salaries, Annual Leave and Sick Leave

Wages, salaries and annual leave due but unpaid at reporting date are recognised in the Statement of Financial Position at the remuneration rates expected to apply at the time of settlement and include related on-costs such as payroll tax, WorkCover premiums, long service leave levies and employer superannuation contributions.

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to recur in future periods. Accordingly, it is unlikely that existing accumulated entitlement will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

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 by 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".*

l. Outputs/Major Activities of the Commission

The core activity of the Commission is to provide an independent and impartial avenue for reviewing health service complaints.

m. Insurance

The Commission's non-current physical assets are insured through the Queensland Government Insurance Fund, premiums being paid on a risk assessment basis. In addition, the department pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

n. 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.

o. 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.

p. 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.

q. Adoption of Australian Equivalents to International Financial Reporting Standards

Australia is currently preparing for the introduction of International Financial Reporting Standards (IFRS) effective for financial years commencing 1 January 2005. This requires the production of accounting data for future comparative purposes at the end of the current financial year.

The Commission is assessing the significance of these changes and preparing for their implementation.

The Commission is of the opinion that the key difference in the Comission's accounting policies which will arise from the adoption of IFRS is:
- Impairment of Assets. The Commission currently determines the recoverable amount of an asset on the basis of undiscounted net cash flows that will be received from the assets use and subsequent disposal. In terms pending *AASB 136 Impairment of Assets*, the recoverable amount of an asset will be determined as the higher of fair value less costs to sell and value in use. It is likely that this change in accounting policy will lead to impairments being recognised more often than under the existing policy.

HEALTH RIGHTS COMMISSION

NOTES FORMING PART OF THE FINANCIAL STATEMENTS
For the year ended 30 June 2004

		2004 $	2003 $
NOTE 2	OPERATING EXPENSES		
(a)	**Executive Services**		
	Administrative Expenses	39,739	39,807
	External Audit Fees	6,000	5,800
	Catering Expenses	860	2,010
	Consultancy	13,430	43,307
	Fringe Benefits Tax	9,920	12,685
	Library Expenses	2,387	4,679
	Maintenance Costs	16,140	21,961
	Motor Vehicle Expenses	28,184	30,291
	Plant & Equipment Purchases <$500	1,945	4,833
	Printing Expenses and Postage	19,255	26,306
	Network Support	9,736	18,259
	Rent (Operating Leases)	193,930	188,658
	Software Licenses	14,849	13,700
	Staff Development	5,146	6,146
	Stationery and Office Supplies	17,264	10,830
	Telephone Expenses	61,099	52,390
	Temporary Staff Expenses	7,046	27,155
	Travel Expenses	3,268	870
	Translation Services	830	1,733
	Memberships	1,048	494
		452,076	511,914
(b)	**Health Rights**		
	Consultancy	40,552	48,417
	Library Expenses	1,195	265
	Staff Development	5,339	5,249
	Travel Expenses	9,302	46,256
		56,388	100,187
NOTE 3			
(a)	GOVERNMENT ENDOWMENT		
	Salaries	2,066,800	2,118,000
	Asset Depreciation	34,400	34,400
	General	627,600	667,600
		2,728,800	2,820,000
(b)	OTHER INCOME		
	Interest earned	62,586	39,103
	Gain on disposal of equipment	(6,305)	1,058
	LSL Reimbursement	37,318	39,433
	FOI Application Fees	334	95
		93,933	79,689
NOTE 4	CASH ASSETS		
	Cash at Bank	102,918	46,753
	Cash On Hand	300	300
	QTC General Investment	850,947	279,772
	QTC Asset Depreciation Investment	169,549	106,258
	QTC Accrued Recreation Leave Investment	133,456	126,684
		1,257,170	559,767
NOTE 5	RECEIVABLES		
	Accrued Interest	651	171
	Sundry Debtor	13,348	3,167
	GST Input Tax Credits Receivable	21,998	71,606
		35,997	74,944

HEALTH RIGHTS COMMISSION

NOTES FORMING PART OF THE FINANCIAL STATEMENTS
For the year ended 30 June 2004

		2004 $	2003 $
NOTE 6			
(a)	**PROPERTY, PLANT AND EQUIPMENT**		
	Computers & Equipment - at Cost	228,676	222,481
	Less Accumulated Depreciation	(151,983)	(136,262)
		76,693	86,219
	Furniture & Fittings - at Cost	36,119	36,119
	Less Accumulated Depreciation	(10,546)	(6,959)
		25,574	29,160
	Office Relocation and Furbishment - at Cost	8,625	-
	Total Office Furniture & Equipment as at 30 June 2004	**110,892**	**115,379**

Reconciliation

	Bal 30/06/03 $	Acquisition $	Disposals $	Bal 30/06/04 $
Computers & Equipment - at Cost	222,481	29,876	23,681	228,676
Furniture & Fittings - at Cost	36,119	-	-	36,119
Office Relocation and Furbishment - at Cost	-	8,625	-	8,625
Total	258,600	38,501	23,681	273,420

(b)	**ACCUMULATED DEPRECIATION**		
	Accumulated Depreciation 1 July 2003	143,221	181,415
	Total Depreciation Charge for 2003/2004	36,684	48,680
	Less Depreciation of Assets Written Off 2003/2004	(17,376)	(86,874)
	Accumulated Depreciation as at 30 June 2004	**162,529**	**143,221**

Reconciliation

	Bal 01/07/03 $	Depn $	Disposals $	Bal 30/06/04 $
Computers & Equipment	136,262	24,963	9,242	151,983
Furniture & Fittings	6,959	11,721	8,135	10,545
Total	143,221	36,684	17,377	162,528

NOTE 7	**PAYABLES**		
	Creditors *	306,509	173,537
	FBT Liability	-	2,952
	Withholding Tax	-	576
	Other Accruals	9,174	6,380
		315,683	**183,445**

* Creditors include the 4th quarter salaries & wages reimbursement ($171,690) that is payable to Queensland Health and the Anti-Discrimination Tribunal. (2003: $148,264)

NOTE 8	**PROVISIONS**		
	Annual Leave - Current	145,167	130,830
		145,167	**130,830**

NOTE 9	**RECONCILIATION OF NET SURPLUS/DEFICIT TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES**		
	Net surplus (deficit)	507,952	246,202
	Depreciation	36,684	48,680
	(Gain) on Disposal of Plant & Equipment	6,306	(480)
	(Increase)/Decrease in Receivables	38,946	(31,107)
	(Increase)/Decrease in Prepayments	(561)	(2,129)
	Increase/(Decrease) in Payables	132,973	(287,922)
	Increase/(Decrease) in Withholding Tax	(576)	576
	Increase/(Decrease) in Other Accruals	(158)	727
	Increase/(Decrease) in Provisions	14,338	10,389
	Net cash provided by (used in) operating activities	**735,904**	**(15,065)**

HEALTH RIGHTS COMMISSION

NOTES FORMING PART OF THE FINANCIAL STATEMENTS
For the year ended 30 June 2004

		2004 $	2003 $
NOTE 10	**EMPLOYEE EXPENSES**		
	Salaries	1,596,614	1,792,410
	Superannuation contributions made on behalf of employees	173,019	200,297
		1,769,633	1,992,707
	Number of Full Time Equivilant Staff at year end	25.2	32.2
NOTE 11	**NON-CANCELLABLE LEASING COMMITMENTS**		
	Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:		
	Within 1 year	7,022	201,650
	1 to 5 years	0	926
		7,022	202,576

NOTE 12 CONTINGENT ASSETS/LIABILITIES

There were no contingent assets or liabilities of a significant nature at 30 June 2004 (30 June 2003: $Nil).

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	Floating Rate	Non - Interest Bearing	Weighted Average Rate	Floating Rate	Non - Interest Bearing
	2004	2004	2004	2003	2003	2003
FINANCIAL ASSETS	%	$	$	%	$	$
Cash	4.31%	102,918	300	3.11%	46,753	300
Asset Depn Investment A/c	5.14%	850,947	-	4.81%	106,258	-
Accrued Recreation Investment /	5.30%	169,549	-	3.86%	126,684	-
General Investment A/c	4.66%	133,456	-	4.93%	279,773	-
TOTAL FINANCIAL ASSETS		1,256,871	300		559,468	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.

		2004 $	2003 $
Note 14	**ACCUMULATED FUNDS**		
	Accumulated Funds at beginning of financial year	439,222	193,019
	Net Surplus	507,952	246,202
	Accumulated Funds at the end of the financial year	947,174	439,221

Note 15 COMMISSION DETAILS

The principle 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 2004, and of the financial position of the Commission at the end of that year.

David Kerslake
Commissioner
Date: 28 · 9 · 04

John G Hows CPA
Manager Executive Services
Date: 30 · 9 · 2004

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 2004.

The Commissioner's responsibility
The Commission 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 are presented 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 Board,
- 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 2003 to 30 June 2004 and of the financial position as at the end of that year.

AUDIT MANAGER
30 SEP 2004
QUEENSLAND AUDIT OFFICE

M T BOOTH, CPA
Audit Manager
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane