Office of Health Review

Annual Report 2000-2001

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HON BOB KUCERA APM MLA
MINISTER FOR HEAL TH

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

This is our fifth annual report and contains an account of our work for the year ending 30 June 2001. The report aims to provide a flavour of the matters dealt with by my office during the year and thus includes a cross-section of case studies as well as articles on matters of interest.

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

David Kerslake
DIRECTOR

29 August 2001

HEALTH AND DISABILITY COMPLAINTS
Level 17, St Martins Tower, 44 St Georges Terrace, Perth, WA 6000 GPO Box B61, Perth, WA 6838
Telephone (08) 9323 0600 Facsimile (08) 9221 3675 Country Free Calls 1800 813 583

Foreword

This report serves two purposes. Firstly, my statutory obligations require me to report to the Parliament on the Office of Health Review's performance over the past year. Secondly, it provides an important means of disseminating information about the Office's role to the wider community, promoting awareness of the services that we offer. The report also marks the first five years of operation for the Office and is a useful standpoint from which to reflect on what has been achieved and what remains to be done.

The past 12 months have been particularly busy, but rewarding nonetheless. The total number of complaints received rose to 1496, 5% up on the previous year and an overall increase of 160% since the Office first opened. It is particularly pleasing to report that there has been a steady increase in the number of disability complaints received, as well as an increase in the number of health complaints from people with disabilities. Overall, the continuing steady increase in complaints reflects well on the effectiveness of our public awareness activities and the confidence that consumers have in our Office. I anticipate that the upward trend in complaints will continue for some time, as health consumers become increasingly conscious of their rights and increasingly aware of the Office's functions.

Both consumers and providers quite rightly expect investigations to be conducted in an efficient and timely manner. It is also pleasing to report that, despite the increase in complaints and with no addition to resources, the number of complaints closed during the year increased by 6% when compared to the previous year. I extend my thanks and appreciation to my hard-working staff for the way that they responded to this challenge.

Members of the community would also rightly expect this Office to contribute to the overall quality of health and disability services by identifying complaints that reveal systemic deficiencies. Indeed, this is one of the outcomes most frequently sought by individuals who lodge complaints. I am pleased to record that 19% of all complaints that were resolved in favour of complainants also resulted in broader improvements in policies or procedures.

I would like to take this opportunity to acknowledge the good relationships we have with key stakeholders and to express my appreciation of the work of these organisations. Consumer advocacy groups regularly refer to us individuals who have concerns about the level of health or disability services they have received. On numerous occasions medical practitioners and other health providers have given generously of their time and expertise to provide independent opinions to assist in our assessment of complex complaints. The Office has also maintained strong relations with Registration Boards and complaints officers in public and private hospitals. We find that maintaining good working relationships with these organisations is helpful in ensuring all parties feel comfortable with the way in which complaints are handled by the Office.

In each of my previous reports I have stressed that a complaints mechanism is never completely effective unless it is completely accessible. We have continued to work hard to extend awareness of our Office to people from all ethnic and cultural

backgrounds, with outreach visits to Aboriginal communities in the Kimberley and extensive consultation with disability groups.

Notwithstanding these activities, I am conscious of the fact that the Office is still not reaching all parts of the community. I am also aware that, by virtue of their cultural background or perceived vulnerability, some groups remain reluctant to complain. A key program in the next 12 months will be the establishment of a focus group, with community representation, to assist the Office to develop further strategies to promote access and awareness among Aboriginal and ethnic groups. I am also mindful of the importance of promoting awareness among inmates within Western Australia's prison system, given that this Office's jurisdiction covers health services provided within that system. Special brochures are currently being prepared for distribution to prisons.

The legislation under which the Office was established – the *Health Services (Conciliation and Review) Act* 1995 – requires that the Minister for Health carry out a review of the Office's effectiveness after the first five years of operation. A report based on the review will be tabled in Parliament. That review will commence shortly I intend to make a number of recommendations to give the Office greater flexibility in dealing with complaints. These include:

- the capacity to accept complaints orally where appropriate, rather than requiring that all complaints be in writing;
- a change of name for the Office ('Health and Disability Complaints Commission' or 'Health and Disability Ombudsman'), to more clearly identify and reflect its role;
- consolidation of health complaints and disability complaints legislation into a single Act to ensure consistency and uniformity;
- an extension (from one to two years) of the time limit on making health complaints, in line with the current time limit for disability complaints;
- the ability for the Office to pursue systemic or public interest issues arising from a complaint, even though the original complaint may have been withdrawn; and
- the capacity for the Office to undertake investigations under its own motion, where important public interest issues are at stake.

I feel that these changes will increase the effectiveness of this Office and will therefore lead to improvements in health and disability services in Western Australia.

All staff of the Office of Health Review can be justifiably proud of the achievements of the first 5 years. Not everyone gets the outcomes they would like to achieve through our processes, but everyone is dealt with fairly, impartially and with respect. Five years of operation has certainly demonstrated the value of conciliation as an alternative to litigation.

Analysis of complaints

In 2000-2001, the Office of Health Review (OHR) received 1496 health and disability complaints. 1479 cases were finalised. The figures represent an increase of approximately 5% over the previous year when 1427 complaints were received.

We also take enquiries about matters that are outside our jurisdiction. 224 enquiries were received about issues outside our jurisdiction, this is a similar figure to last year. Wherever possible, complainants are referred to the appropriate agency or jurisdiction.

Health Complaints

Most health complaints received related to treatment (53%). This was also the main area of concern last year when 47.5% of cases fell into this category.

The next most common cause for complaint, both this year and last year, was cost. Complaints in this category were 16% of all complaints this year compared with 14.6% in 1999-2000.

Other significant categories related to access to services (8.5%), alleged breaches of privacy (6.5%), inadequate information being given by providers (8%), inadequate or unreasonable decision making (3%) and a provider acting unreasonably in response to a consumer's complaint (1%).

Which services do people complain about?

As with previous years, the largest number of complaints were against Medical Practitioners (35% of all complaints) which is a reduction of almost 19% from the last financial year. A majority of these practitioners were General Practitioners. The following table shows the breakdown, by specialty of the number of complaints against Medical Practitioners.

23% of all complaints were against Public Hospitals. Complaints about doctors and nurses in public hospitals are included in this category. Complaints about Private Hospitals accounted for 2% of all complaints. Complaints about dentists (6%) and other dental providers (3.5%) fell compared with last year's figures. Complaints against alternative providers including acupuncturists, chiropractors, naturopaths and osteopaths made up 1.3% of overall complaints.

Complaints about Medical Practitioners.

Providers	Number of Complaints
General Practitioners	402
Anaesthetists	26
Obstetricians/Gynaecologists	24
Psychiatrists	20
General Surgeons	15
Plastic/Cosmetic Surgeons	15
Dermatologists	12
Orthopaedic Surgeons	12

Outcomes of complaints

Most complaints to this office begin with a telephone call. Staff are often able to resolve the matter quickly and informally by making some preliminary enquiries without requiring the complainant to put the complaint in writing. Typically, if an enquiry is relatively straight forward, a staff member might contact the provider to seek further information and clarify the issues. At other times, staff are able to provide the complainant with sufficient information and advice so that they may resolve the matter themselves. It is a tribute to complainants and providers that a number of complaints can be resolved in this informal manner. In other cases, where the matter is more complex, or where we feel we required more information and need to take the matter further, we ask that the complainant put their concerns in writing.

Of the 688 written cases that we received, 113 were resolved completely or mainly in favour of the complainant, and a further 104 were resolved partly in favour of the complainant. Of these 217 cases, 19% led to some change in policy and/or procedure of the health provider.

In 231 cases the complaint was not upheld and the outcome was usually that complainants were provided with an explanation in relation to the circumstances which had led to their complaint. There are some complaints that cannot be determined because we are unable to prefer one person's version of events over another person's. These cases are frustrating for all parties involved, and for the staff of this office.

Disability Complaints

17 disability complaints were received in 2000/2001 and 12 complaints were closed in 2000/2001 including 2 from the previous financial year.

What issues and services do people complain about?

54% of the complaints were about non-government service providers, 29% were about the Disability Services Commission and 17% about other public authorities. The largest single category of complaint was about accommodation services (29%), with therapy, in-home support and funding complaints each accounting for 12% of complaints. The remaining complaints were about respite, education, transport, recreation, employment and counselling services.

53% of complaints were about access to services or funding, 35% were about the manner of the provision or the standard of services received and 12% were about privacy and breaches of confidentiality.

Outcomes

Complaints finalised and closed during 2000/2001 resulted in 17% resolved partly in favour of the complainant, 17% not upheld, 8% unable to be determined, 8% withdrawn by the complainant, 17% were allowed to lapse, 33% were not pursued by the complainant.

Articles

Disability complaints

It is now over twelve months since the Office of Health Review acquired jurisdiction to investigate complaints about disability services. An investigation officer has been appointed specifically to deal with disability enquiries and complaints and to promote the office as an avenue of complaint for people with disabilities. This officer also assists people with disabilities with complaints about health services. It is clearly appropriate and convenient for people with disabilities to have these two avenues for complaint within one jurisdiction.

The number of complaints has steadily risen through the year. Clearly, however, there is still a long way to go to raise awareness of our office among the 19.5% of Western Australians who have a disability, many of whom receive services from the Disability Services Commission, non-government or private organisations or public authorities.

Inability to access available funding through the Disability Services Commission has been a common complaint and one that is difficult to resolve as the decision to fund or not to fund is largely driven by the resources available to the Commission. Complaints have also been received about the standard of accommodation in group homes, access to therapy services, breaches of confidentiality in counselling services and the adequacy of staff training for in-home support. Outcomes of these cases have included changes to policies and procedures to bring about service improvement.

Disability complaints tend to be multi-faceted and may take some time to resolve. As with health complaints we are required to form a view as to whether the level of service provided was reasonable in all the circumstances. In forming that view, we are required to have regard to the Principles and Objectives laid down in the Disability Services Act. These Principles and Objectives provide a framework within which our enquiries and investigations occur.

People with disabilities are among the most vulnerable members of our society. Making a formal complaint about a service provider who may be responsible for providing the necessities of life on a day to day basis is a big step to take. Although the Act provides protection for complainants against victimisation, there is little doubt that people with disabilities and their families are often reluctant to complain. An important role for the Office of Health Review is to create a climate of trust and safety for people who wish to make a complaint about service provision and for service providers to feel confident they will receive a fair and impartial hearing.

Public Awareness Activities

Public Awareness activities continued to be a primary focus this year. As stressed in previous reports, often those most in need of our help are least likely to know of our existence. Disseminating information throughout the community ensures that all members of the public can access the Office and that they are aware of our role and functions.

I visited the Kimberley during the 2000-2001 financial year and spoke to health service providers and consumers in towns and remote Aboriginal communities in the area. I was interviewed on ABC Radio in Kununurra and Aboriginal radio in Halls Creek and Kununurra. The trip included visits to the remote communities of Warmun, Balgo, Imintji, Kulumburu, Ngallagunda and Kupungurri. During this trip I was able to become more familiar with the specific health complaints issues for people in the Kimberley region. I was also able to advise the communities of the role of our office and how we are able to assist with health and disability complaints.

During the year our complaint forms and brochures were reviewed and re-designed. The brochures are now available on audiotape and can be translated into braille. To heighten public awareness, samples of our brochures were sent to over 300 agencies. As a result, there has been a strong demand for our published material. In addition to material produced in-house, the role of the Office is also being promoted by external organisations. For example, the Commonwealth Carelink Centre is promoting our services among older Australians.

To continue our outreach to multicultural groups we published a Multilingual Guide which contains translations of 14 languages including Arabic, Bosnian, Chinese, Croatian, Farsi, Indonesian, Italian, Polish, Portuguese, Russian, Serbian, Somalian, Spanish and Vietnamese. In addition to ensuring that written material is disseminated throughout the community, staff also visited a number of community groups to raise public awareness.

It is also important to ensure that health service providers and their representative bodies are aware of the role and functions of this Office. Throughout the year, monthly meetings with the Medical Board were held and we maintained regular contact with other Registration Boards. To enhance our profile, staff also represented the Office at Law Week, the Health Complaints Network Meetings, and met with a variety of professional groups such as medical staff working within the prison system.

To develop relationships with specific organisations who provide care and support to the wider community, organisations such as Derbarl Yerrigan Health Service, the Mental Health Review Board, the Inspector of Custodial Services, and the Council of Official Visitors were invited to the office to discuss with investigative staff the services they offer. These meetings both enhanced our relations with these organisations, and ensured that staff are well equipped to provide health care consumers with useful and accurate referral information.

Activities to raise public awareness about the Office's newly acquired responsibility for disability service complaints, commenced with the appointment of an Investigation Officer whose duties include complaint handling and public awareness.

A Public Awareness Strategy prepared for the first year included design and publication of brochures and complaint forms and wide ranging promotional visits to service providers and advocacy groups.

The brochures have been made available in braille, on audiotape or in community languages on request. The Investigation Officer also spoke at a public forum on advocacy and complaints hosted by the Town of Vincent for Law Week in May.

Although the number of enquiries and complaints has increased over the past nine months, there is still considerable work ahead to raise awareness of the services available. The public awareness campaign will continue over the next twelve months with plans to visit country areas, to make contact with new and existing service providers, Local Area Coordinators, Aboriginal groups and non-government organisations and government agencies that have contact with people with disabilities and their families.

Prison Complaints

In the past 12 months there has been a steady increase in complaints to this Office about prison health care. However, taking into account the number of individual health services provided in the State's prison system and the number of complaints we receive across the health system generally, the level of complaints remains lower than might be expected.

I am concerned that the relatively low level of complaints is suggestive, at least in part, of a lack of awareness of the role of this Office among prisoners and prisoner support groups. Some prison health complaints are still being directed to the State Ombudsman, which perhaps reflects the greater length of time that office has been in existence and a greater familiarity by prisoners with its review functions.

It is incumbent on the Office of Health Review to do more to raise awareness in this area. With this in mind, I have initiated the development of brochures and posters, which are specifically intended for the prison population. Feedback will be obtained from prisoners and support groups on the most appropriate format for these publications and how best to disseminate them. I am also working with the Ministry of Justice to improve prisoner access to telephones to assist us in communicating with prisoners who have a complaint.

The Ministry of Justice has stated its commitment to ensuring that prison inmates are entitled to a standard of health care that is no less than that available to other citizens. Its Guiding Principles provide that:

> 'Every prisoner shall retain the rights of any member of society, except the rights necessarily removed or restricted by imprisonment'.

Our investigations in the last year have, however, revealed a number of significant factors that impact upon the Ministry's ability to achieve this objective. This should not be taken as a reflection on the calibre of prison health services staff. On the contrary, I have been impressed by their dedication, professionalism and competence. I believe that they are themselves often frustrated by the fact that, in the overall scheme of things, health services are often treated as secondary to the system's custodial requirements.

The following examples are illustrative of key issues that have emerged from complaints made by persons in custody.

Wait lists and the availability of transport

In common with many other members of the community, prisoners may be placed on a waiting list for elective treatment according to the urgency of their condition. An important distinction, however, is that when an appointment becomes available, most members of the community are able to make their own arrangements for transport to a public hospital. Prisoners have no choice but to rely on the prison transport system.

In August 2000, the Ministry of Justice decided to outsource the provision of prison transport services. There were a number of teething problems but these are to be

expected with any new system. I am concerned, however, at the continuing trend for prisoners' hospital appointments to be cancelled because transport is not available. I am particularly concerned that, often, the private transport operators are making such cancellations for logistical reasons rather than on the advice of the prison medical practitioner who actually referred the inmate for treatment.

In such circumstances, there can be no guarantee that prisoners' health needs are being properly assessed and addressed. In addition, cancellations are often made at the last minute. This effectively prevents hospitals from offering those appointments to other community members who are also wait-listed. I am continuing to monitor this situation to ensure that prisoners' health care is not jeopardised by the non-availability of transport.

Case Study

A prison doctor referred a prisoner to the Orthopaedic Department of a public hospital. The referral was made in May 2000 but, because of hospital wait-lists, the prisoner had to wait until December 2000 for an appointment.

The appointment was cancelled at the last minute because transport was not available on the day. Waiting lists already in place meant that a further appointment could not be scheduled until August 2001. The prisoner, who had waited 7 months for an appointment, now had to wait a further 8 months. Not surprisingly, he complained about the delay.

I wrote to the Ministry expressing concern about the delay and the obvious implications for the prisoner's health care. I also drew attention to the fact that whenever cancellations were made at the last minute hospital staff were denied the opportunity to offer an earlier appointment to other waitlisted patients. I put to the Ministry the view that, if an earlier appointment could not be scheduled, it should pay for the prisoner to be treated privately.

As it turned out, the prisoner's treatment in the public sector was able to be brought forward and carried out within a reasonable time frame. I hold to the view, however, that if prisoners are unfairly disadvantaged by unreasonable transport cancellations, then the Ministry of Justice should meet any costs involved in setting the matter to rights.

In the course of my investigation in this case, I recommended that the Ministry discuss with the Health Department's Central Wait Listing Bureau the possibility of prisoners being treated, where appropriate, at smaller hospitals in the metropolitan area. As a result, a number of prisoners have been able to have elective surgery performed earlier than would otherwise have been the case.

Nutrition in prisons

It seems to me that, where a prison medical officer identifies that a prisoner has special nutritional needs, those needs should be met without interference from custodial staff. Unfortunately, however, that is not always the case.

Case Study

A prisoner expressed concern at difficulties in arranging a low-fat diet as prescribed by one of the medical officers. I interviewed the treating doctor, who followed up to ensure that the prisoner's dietary needs were met.

He indicated, however, that he was aware of instances where prisoners on special diets were observed eating food from the 'normal' trolley. Since this amounted, literally, to 'double dipping', custodial staff sometimes responded by cancelling the special diet. He agreed with my view that such instances should be referred to medical staff, who should counsel the prisoner in the first instance. It is not appropriate for custodial staff to make such decisions when, presumably, there must have been sound medical reasons for prescribing the special diet in the first place. Behaviour or disciplinary issues should be dealt with quite separately from medical ones.

In the course of my investigation, I noted that the order form for a special diet needs not only to be signed by a medical officer, but also has to be approved by the Assistant Superintendent. Since this is essentially a health issue, I can see no reason why the form needs to be approved (rather than simply being noted) by a non-medical officer. I have put this recommendation to the Ministry.

Resources and rehabilitation programs

Resources are finite in any system. It is nevertheless important that where a need for health care is identified, every effort should be made to meet that need.

Case study

A prisoner complained that he was refused admission to the Sex Offender Treatment Program without any alternative being offered. He had lost confidence in the prison medical services and felt any psychiatrist within the public system discriminated against him.

Following discussions with a senior mental health service provider in the Ministry of Justice, it was agreed that this Office would obtain an independent psychiatric opinion on the management of the prisoner's care. The Ministry of Justice agreed to meet the cost of the consultation and subsequent report. Both the Ministry and the prisoner were satisfied as to the independence of the private provider.

The independent adviser stated that for a number of complex reasons the prisoner was not suited to the Sex Offender Treatment Program. We sought his advice on other options and he recommended that intensive, one-on-one counselling and psychotherapy was more suitable in this instance. He made some suggestions as to how this might proceed, noting that one counsellor in particular had established a good therapeutic relationship with the prisoner and was appropriately qualified to work with him on an individualised program.

The Ministry of Justice implemented a specially designed program to meet the prisoner's particular needs.

The 3rd National Health Care Complaints Conference

In March this year myself and two other staff attended the 3rd National Health Care Complaints Conference in Melbourne. The theme of this year's conference was "Getting Better Together" and focused on how complaints could be used to improve the quality of health services.

The Conference was attended by health professionals, hospital complaints staff, registration boards, complaints organisations and legal practitioners. Participants had travelled from all states in Australia as well as from New Zealand.

Sessions at the Conference included the effectiveness of complaint processes and watchdog organisations, alternative complaint processes and risk management, roles and issues for registration boards and communication in difficult situations.

Office of Health Review staff presented a paper on impropriety and sexual misconduct, examining the obstacles complainants face when making such complaints and how providers can avoid such complaints. A copy of this paper is available from this Office on request.

Staff from the Office of Health Review also took the opportunity to attend a two-day investigation training course prior to the conference, which was conducted by the NSW Health Care Complaints Commission staff.

Mental health complaints

Some of the most complex complaints investigated by the Office of Health Review are received from complainants who suffer from a mental illness.

The *Mental Health Act 1996* provides the initial framework within which such complaints need to be considered. The Act outlines the basic rights of consumers of mental health services and also imposes duties on the providers of those services.

One of the important roles that we undertake is to direct complainants who have a mental illness to the best avenue for their complaint. For example, a number of complaints in the past year concerned the basis upon which patients were involuntarily admitted. The Mental Health Review Board more appropriately deals with many of these cases, particularly if the person is still an involuntary patient at the time the complaint is made. In such cases we refer the complainant to the Mental Health Law Centre whose solicitors can usually assist the patient in preparing an appeal.

Sometimes it is more difficult to decide what action the complainant should take. For example, where a complainant is concerned about the treatment they are being given as an involuntary patient, one option is again to refer them to the Mental Health Law Centre. The Centre can then assist the patient in obtaining the opinion of a second psychiatrist.

The Office of Health Review may also have a role to play in such complaints, however. In one case, the complainant was concerned about the side effects of the regime of medication he was required to take under a Community Treatment Order. The Office sent a copy of the complaint to the treating psychiatrist to verify the dosage of the medication as well as the steps that were being taken in monitoring any side effects. We then sought an opinion from an independent psychiatrist as to the reasonableness of the treatment being provided to the complainant.

As a result of the independent advice received, the Office was able to reassure the complainant that the regime of medication was reasonable for the treatment of the complainant's condition and that the side effects were being appropriately monitored.

A particularly challenging situation arises where a patient does not lodge an appeal with the Board during their involuntary admission, but after their discharge complains to this office that their treating psychiatrist incorrectly diagnosed them. It is often very difficult to reach an informed view about the reasonableness of such a diagnosis 'after the fact'. The very fact that the patient has been discharged suggests that their condition is likely to have changed significantly, meaning that a second opinion may not shed particular light on the reasonableness of the earlier diagnosis. Often our investigation is limited to checking the information contained in the medical record and whether the diagnosis made was consistent with that information.

Case Studies

Adverse outcomes

Some of the complaints dealt with by this office are the result of most unfortunate outcomes, such as permanent injury or ongoing pain. Fortunately, these cases are very much in the minority, but where they do arise our conciliation processes often provide an effective alternative to litigation that is far less stressful for all concerned.

In one case, a woman had surgery for removal of an ovary. The surgeon inserted a drain, which is normal for this type of procedure. The patient made several requests, postoperatively, that the drain be removed but each time was advised that it would fall out of its own accord after a period of time. In actual fact the drain had been stitched in place. Its continued presence for over two months had caused considerable pain and inconvenience for the patient. I referred the matter for conciliation with the consent of both parties.

Following conciliation, the complaint was settled by a payment of compensation.

In another case, a young woman complained about the management provided by her GP during her pregnancy. This was her first pregnancy and she was unsure what to expect. The GP took ultrasounds at each visit and told her that her baby would weigh about 8lbs at birth.

At about 38 weeks she experienced reduced foetal movement and an ultrasound confirmed her baby had died in utero. When the baby was delivered he weighed only 5lbs (significantly less than the estimated weight), raising concerns about the overall management of the woman's care.

We sought independent medical advice, which suggested that there had been an over reliance on the ultrasounds and that they appeared to have been misinterpreted.

The matter was referred to the Medical Board and is to be the subject of a formal inquiry.

Many complaints about fees could be avoided if patients were forewarned

A woman telephoned a dentist to make an appointment and was advised that the consultation would cost her $120.00. The appointment went ahead as arranged.

One can imagine her surprise when, following the consultation, she received an account for $1200. On querying the account she was advised that she had received additional treatment during the consultation resulting in an increased fee.

In the course of our investigation, the dentist conceded that he did not advise the patient that the treatment she received would cost more than the initial quote. He accepted our recommendation to waive the outstanding account of $1080.

In another case, a patient at a private hospital was quoted $1648 as the full cost of surgery. He paid the account up front, only to receive an additional account of $806

for the surgery. The hospital explained that an item number had been changed, which meant he had to pay more.

On examining the admission documents we noted that the surgeon had listed the correct item number but this had been misread by the hospital when issuing the final account.

We arranged for a refund and an apology to be issued. In addition, the hospital revised its procedures to avoid a recurrence of the problem.

Often, health practices and procedures are improved as a result of complaints made to this office. Everyone in the community stands to benefit from such complaints.

In one case, a six-year-old was admitted to a public hospital with burns. After a short stay, he was discharged with a prescription for morphine for short-term pain relief.

The medication supplied to the boy's mother by her pharmacy was labelled *to be taken as directed by your doctor*, but the treating doctor had not discussed the dosage with her. Unsure as to what to do, the mother asked the pharmacist to ring the hospital. The pharmacist did so and a nurse at the hospital provided advice about what she thought was the correct daily dose.

The mother was concerned that this dose appeared to be too much for a small child and reduced the dose herself.

In response to her complaint, we obtained a copy of the original script from the pharmacy and confirmed that the script did not contain specific instructions. This contravened the hospital's own protocols, which stipulated that each prescription should contain clear directions and, specifically, that the words 'use as directed by your doctor' be avoided.

Fortunately, the dosage advised by the nurse was in fact within acceptable levels for a six-year-old child, but even so the doctor's failure to follow established protocols was a significant omission.

At our recommendation, the hospital strongly counselled the doctor concerned and used this case to reinforce with all staff the importance of following the correct Poisons Act protocols.

In another case, a man was admitted for day surgery in a public hospital. He was interviewed by the attending doctor, who sought information about his previous medical history and current medication. He complained about a lack of privacy and because the interview was conducted in a waiting room occupied by other patients who could hear other patient's consultations.

In response to the complaint, the hospital set up a special interview room to enable patients to be interviewed in private.

A number of complaints have concerned denial of access to public hospital treatment contrary to the Australian Health Care Agreement. The Australian Health Care Agreement is an agreement between the Commonwealth and the States which makes it clear that all patients requiring emergency treatment are entitled to be treated as public patients, including those who have private health insurance.

In one such case, a man consulted his GP about a broken bone in his foot and was advised to attend the nearest private hospital that afternoon, to have the foot plastered. The hospital account was fully covered by the patient's private health insurance but he only received a partial rebate for the doctor's account, leaving him $75 out of pocket. He complained that, because he had private health insurance, the GP had automatically assumed that he would prefer to be treated privately and had thus denied him the option of being treated free of charge at the Regional Hospital.

In response to the complaint, the practice decided to waive the outstanding account. They reminded all staff that in such cases patients are entitled to elect to be treated as public patients. They also advised us that some doctors at the practice had been under the impression that they were entitled to nominate the hospital where patients would be treated. The practice manager thanked us for advising her of the rights of all patients and assured us that the problem would not happen again.

In addition to this, the practice manager telephoned the complainant and apologised for the incident, and for the misunderstanding. The complainant was happy with the outcome. It is nonetheless disturbing that not all GPs are aware of patients' rights in this area. This office continues to work in conjunction with the Health Department to ensure that these rights are known and observed.

Not all complaints are able to be substantiated

There are times when a complainant feels aggrieved and complains to this office, but on investigation we find that the provider has not acted unreasonably. We have an obligation to both complainants and providers to provide a full explanation of our findings in such cases.

One man, in his early 70's, developed a range a symptoms for which he was treated at a public hospital over a period of 3 months (both as an inpatient and outpatient). He was eventually diagnosed with cancer of the tongue and was concerned that hospital staff missed the diagnosis at an earlier stage.

This Office obtained independent advice from a senior medical practitioner who advised that, given the patient's presenting symptoms, he would not have diagnosed tongue cancer any earlier than was the case. He also noted that arrangements had been made for a CT scan, videofluroscopy and review by a speech therapist, with instructions for the patient to return if the symptoms worsened. In addition, the case had been discussed with the patient's GP both before and after a presumptive diagnosis had been made and further investigations arranged. He stated *this management cannot be faulted*. He further advised that this was a rapidly growing lesion and, in his clinical opinion, would not have been apparent for some time.

On this basis then, we were able to reassure the complainant that his initial diagnosis and treatment had been reasonable.

In another case, a woman complained that a tooth on which she had root canal treatment subsequently became infected and had to be extracted.

Our investigation established that a temporary covering had been placed over the tooth. The cover was not intended to protect the tooth in the long term and the patient had been advised of the need for a permanent restoration to be applied at a later date. She did not attend for further treatment, even after a reminder letter being sent. The tooth had been open to infection for some months and could not be saved once it became infected. We concluded that the problem with the tooth had occurred because the patient did not return to have the treatment completed, despite being advised of the need to do so.

Providers often respond generously to a complaint

A man made a complaint to this Office on behalf of his wife who was a resident at a nursing home and unable to complain on her own behalf. His wife had been admitted to hospital for hip surgery which was scheduled for the following day. The surgeon who was to perform the surgery visited her on the evening of her admission, but the anaesthetist made no contact with the husband, who was the carer and responsible for the account. The first the complainant became aware of the anaesthetist's fees was when he received the bill. The complainant was concerned that he had had no opportunity to discuss the fees with the anaesthetist beforehand.

The anaesthetist advised this office that the procedure had been scheduled at short notice because of the urgent need for treatment. He had in fact carried out a pre-operative assessment of the patient the night before. He had also attempted to contact the patient's husband prior to the surgery, but was unable to do so.

Nevertheless, as a gesture of goodwill the anaesthetist offered a discount on his fees which the complainant happily accepted.

A young mother contacted this Office as she felt a social worker at a community health agency had offered her patronising and unhelpful suggestions in relation to the care of her child, with whom she was having great difficulty. In response to the complaint, the manager of the agency contacted the mother and offered her a further appointment with a different social worker. The mother accepted.

Ultimately, the second assessment of the child's needs was identical to the first, but was communicated to the mother in a much more sympathetic and helpful way. The manager followed up by arranging an appointment for the mother with a clinical psychologist and senior paediatrician, to discuss options for her child's future treatment. This was a pro-active and very helpful response to a difficult complaint.

Part of our role is to assist providers to develop and improve their own complaint procedures and to suggest ways of avoiding complaints in the first place

A man complained that an elderly relative had not received proper treatment from a home care agency. He had previously complained directly to the agency but was not satisfied with the response.

We contacted the agency, which acknowledged that, in this instance, there may have been a breakdown in communication and undertook to implement the following procedural changes. They introduced strategies to work more closely with both the carer and the referring doctor in assessing and delivering the patient's needs. This would improve the level of service and hopefully avoid such complaints. In the event that complaints did arise, however, the Manager would take personal responsibility for meeting with the family to discuss and address their concerns.

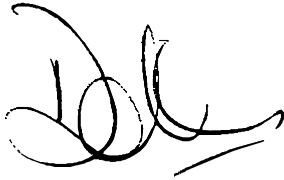
In another case, a woman consulted a chiropractor for the treatment of a sore back. She states that during each appointment the chiropractor repeated the same manipulation which gave short relief but no longer-term recovery. Following a number of appointments, the complainant felt that the chiropractor was deceiving her by taking her money for treatment that would not have a long-term benefit.

In response to the complaint, and as a gesture of goodwill, the chiropractor refunded his patient the money she paid for each consultation with him, the cost of x-rays he ordered and the fees she was subsequently charged by a second chiropractor who she had consulted.

Whereas the complainant had initially expressed misgivings that her concerns had not been taken seriously, she now felt reassured that her complaint would serve to benefit all users of the service.

Certification of Performance Indicators

I hereby certify that the Performance Indicators on page 23 are based on proper records and fairly represent the performance of the Office of Health Review in the financial year ending 30 June 2001.



David Kerslake
Director
Accountable Officer

30 August 2001

AUDITOR GENERAL

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2001

Scope
I have audited the key effectiveness and efficiency performance indicators of the Office of Health Review for the year ended June 30, 2001 under the provisions of the Financial Administration and Audit Act 1985.

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

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

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

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the Office of Health Review are relevant and appropriate for assisting users to assess the Office's performance and fairly represent the indicated performance for the year ended June 30,2001.

K O O'NEIL
ACTING AUDITOR GENERAL
November 28, 2001

Operational report

Outcome

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

Performance indicators

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

Efficiency indicators		**2000-2001**	**1999-2000**
a)	Cost per finalised complaint (based on the accrual costs for the period 1 July 2000 to 30 June 2001)	$646	$565
b)	Number of days taken to finalise a complaint (taken from the date of receipt of the complaint form to the date of closure of the file)	118 days	103 days
Effectiveness indicators			
a)	Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations.	42	46
b)	Percentage of complaints finalised this year (The percentage of complaints closed reflects the overall effectiveness of the OHR in dealing with a complaint)	99%	98%

Enabling legislation

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

Mission statement

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

General Objectives

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

Operations

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

- To undertake the receipt, conciliation and investigation of complaints and to perform any other function vested in the me by this Act or another written law;
- To review and identify the causes of complaints, and to suggest ways of removing and minimising those causes and bringing them to the notice of the public;
- To take steps to bring to the notice of users and providers details of complaints procedures under this Act;
- To assist providers in developing and improving complaints procedures and the training of staff in handling complaints;
- With the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;
- To cause information about the work of the Office to be published from time to time; and
- To provide advice generally on any matter relating to complaints under the Act, and in particular –
  (i) advice to users on the making of complaints to registration boards; and
  (ii) advice to users as to other avenues available for dealing with complaints.

Ministerial and parliamentary directives

Under s.11 and s. 45 of the Health Services (Conciliation and Review) Act*,* the Minister for Health may give directions to me as Director of the Office of Health Review for complaint matters to be investigated. No directions were given during the year ending 30 June 2001.

Under s.56 of the Act, I may make reports to Parliament, or at the request of Parliament. No reports were requested or made during the year ending 30 June 2001.

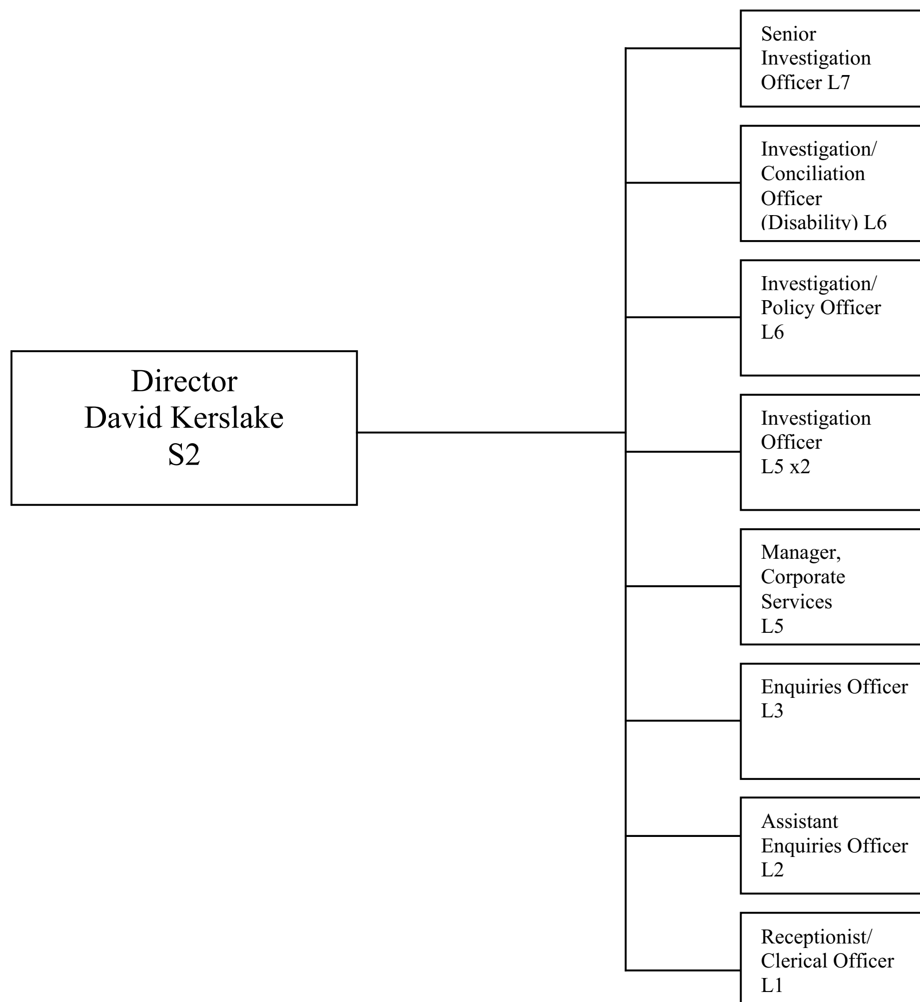
Administrative

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

The Office of Health Review staff numbered 11 as at 30 June 2001. There were 10 staff at the same time last year.

Two Level 5 Investigations Officers and a Level 6 Investigation/Conciliation Officer (Disability) were appointed during the year.

Organisational Chart



Promotions, publications and research

The Office of Health Review has not been involved in any research activities in 2000-2001. We promote our office through brochures and complaint forms that are distributed widely and available on request. Staff also attend various forums to promote awareness of the Office of Health Review.

Declaration of Interests

The Office of Health Review has no contracts in which a senior officer has a substantial interest or is in a position to benefit from the appointment of those contracts.

Subsequent Events

No events have occurred that may significantly affect the operations of the Office of Health Review since 30 June 2001.

Customer feedback

The Office of Health Review sends client survey forms to all complainants and providers at the conclusion of a complaint. These forms ask our clients to comment on our manner, promptness, impartiality and the overall effectiveness of our processes. We use the results of these forms to reinforce what we are doing well and to alert ourselves to any areas where improvements are required.

This year we introduced a new survey, which meant that some clients whose complaints were closed very early in the financial year would have responded using the previous survey form. Most questions were the same, but there are some questions in the revised survey that were not addressed previously. This means that some survey questions were not answered by about 24% of respondents.

Complainant responses

The vast majority of complainants appear to be satisfied with the manner in which their complaints were handled. 82% of those who responded to the survey agreed or strongly agreed that staff were prompt in responding to letters and telephone calls; and 83% agreed or strongly agreed that it was easy to contact the office. 89% agreed or strongly agreed that we were polite and 93% of complainants agreed or strongly agreed that the staff listened to what they had to say.

On the other hand, only 58% of complainants agreed or strongly agreed that we had satisfactorily resolved the issues raised in their complaint. The overall level of satisfaction obviously is related to whether people achieved the outcome they were seeking. In this regard, it is noted that 80% agreed or strongly agreed that we handled their complaint in an unbiased way.

Some comments from our complainants:

"I have been very pleased with the way your office dealt with my complaint and happy with the outcome."

"Issue could not be resolved due to lack of evidence, but I had expected this. I felt your staff handled this particular aspect well."

"Naturally I am disappointed with the outcome, but appreciate your efforts on my behalf."

"The initial response to my first phone query was very important – sympathetic, non-judgemental. Can only suggest more of the same."

Provider responses

More providers than complainants responded to our survey this year. 90% of providers who responded agreed or strongly agreed that the staff were polite and 92% agreed or strongly agreed that we handled the complaint in an unbiased way. 84% of providers agreed or strongly agreed that we listened well to what they had to say and 74% agreed or strongly agreed that we were prompt in responding to their letters and

telephone calls. 70% of providers agreed or strongly agreed that it was easy to contact the office and 81% agreed or strongly agreed that the issues of the complaint had been resolved.

Some of the comments received included:

“This process was exactly how such matters should be dealt with, very professional.”

“Thank you for the professional, courteous and efficient way you dealt with this complaint. OHR staff do a difficult job sympathetically, fairly and graciously.”

“It is good to have an independent office to assist our clients.”

“I think your staff do a difficult job well.”

“Keep up the good attitudes.”

Not all comments were positive. Given the contentious nature of some complaints and the unrealistic expectations of some parties, we cannot be expected to have positive responses from all respondents. For example, one provider stated that ‘My experience with the OHR was very disappointing’. All comments provide food for thought and are analysed and distributed to all staff. We provide both complainants and providers with a full explanation of our findings. If either party remains unhappy, we have an internal review process that allows for the decision to be reviewed by a senior officer not previously involved with the case. Aggrieved parties retain the right to complain to the State Ombudsman about the manner in which our investigation was conducted.

Statutory report

Workers Compensation

No workers compensation claims were made in 2000-2001.

Occupational Health and Safety

The Office of Health Review moved to new premises this year. At that time new office furniture was purchased. An Occupational Physiotherapist visited the Office and made recommendations to all staff members in relation to their specific ergonomic needs. She ensured all of the new equipment was adjusted appropriately for each staff member. This action was taken to increase safety for staff in the workplace and reduce the potential for workers compensation claims.

Statement of compliance with Public Sector Standards

The Office of Health Review has complied with the Public Sector Standards in Human Resource Management, the WA Public Sector Code of Ethics and our Code of Conduct. No applications were made for breach of standards review in 2000-2001.

Advertising and Sponsorship

The Office of Health Review did not produce any advertising material in excess of $1500 in the 2000-2001 financial year.

Waste Paper Recycling

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

Information Statement

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

There were four Freedom of Information requests in the 2000-2001 financial year, all of which related to personal information. Two of the requests were granted full access and two were granted edited access. There were no reviews and no amendments. No one was charged for access. The average time to process an application was 30 days.

Evaluations

There were no evaluations undertaken by the Office of Health Review in 2000-2001.

Report on Customer Group Outcomes

Disability Services Plan

In the 2000-2001 financial year, the Disability Services Plan was updated in accordance with our new accommodation and changes we have made following the implementation of the last plan. The appointment of a dedicated officer for disability complaints has led to all staff having an increased awareness of the issues facing complainants with disabilities.

Plan for Women Outcomes

91% of the staff of the office are women and women occupy 75% of senior positions in the office.

Family and Domestic Violence Plan Outcomes

The Office has nothing to report against this requirement.

Equal Employment Opportunity Outcomes

Of the 11 staff employed in the Office on 30 June 2001, 10 were women. Two main ethnic groups are represented in the staff, with one staff member of a minority ethnic group.

Language and Cultural Diversity Outcomes

The Office has implemented the Language Services Strategy and we have signage to advise of the availability of translation services. In 2000-2001 the Office produced a multilingual guide, which provides information about the office and how to contact us in 14 languages other than English. These languages are Arabic, Bosnian, Chinese, Croatian, Farsi, Indonesian, Italian, Polish, Portuguese, Russian, Serbian, Somali, Spanish and Vietnamese. This list was compiled through consultation with the Translating and Interpreting Service, the Ethnic Disability Advocacy Centre, the Multicultural Access Unit at the Health Department of WA and the Office of Citizenship and Multicultural Interests.

Customer Focus Outcomes

I visited the Kimberley during the 2000-2001 financial year and spoke to health service providers and consumers in towns and remote Aboriginal communities in the area. I was interviewed on ABC Radio in Kununurra and Aboriginal radio in Halls Creek and Kununurra. The trip included visits to the remote communities of Warmun, Balgo, Imintji, Kulumburu, Ngallagunda and Kupungurri. During this trip I was able to become more familiar with the specific health complaints issues from people in the Kimberley region. I was also able to advise the communities of the role of our office and how we are able to assist with health and disability complaints.

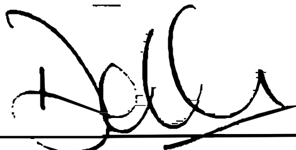
Office of Health Review

Certification of financial statements

For the year ended 30 June 2001

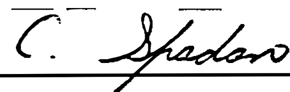
The accompanying financial statements of the Office of Health Review have been prepared in compliance with the provisions of the Financial Administration and Audit Act 1985 from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2001 and the financial position as at 30 June 2001.

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



David Kerslake

Director Accountable Officer



Charles Spadaro

Principal Accounting Officer

27 August 2001

AUDITOR GENERAL

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30,2001

Scope
I have audited the accounts and financial statements of the Office of Health Review for the year ended June 30, 200 I under the provisions of the Financial Administration and Audit Act 1985.

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

My audit was performed in accordance with section 79 of the Act to form an opinion based on a reasonable level of assurance. The audit procedures included examining, on a test basis, the controls exercised by the Office to ensure financial regularity in accordance with legislative provisions, evidence to provide reasonable assurance that the amounts and other disclosures in the financial statements are free of material misstatement and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Accounting Standards, other mandatory professional reporting requirements and the Treasurer's Instructions so as to present a view which is consistent with my understanding of the Office's financial position, the results of its operations and its cash flows.

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

Audit Opinion
In my opinion,

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

(ii) the Statement of Financial Performance, Statement of Financial Position and Statement of Cash Flows and the Notes to and forming part of the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and the Treasurer's Instructions, the financial position of the Office at June 30, 2001 and the results of its operations and its cash flows for the year then ended.

K O O'NEIL
ACTING AUDITOR GENERAL
November 28, 2001

Office of Health Review

Statement of Financial Performance

For the year ended 30th June 2001

	Note	2000/01	1999/00
		$	$
COST OF SERVICES			
Expenses from Ordinary Activities			
Salaries and wages		546, 160	522,917
Superannuation		47,862	35,827
Supplies and services		18,475	30,104
Repairs, maintenance and consumable equipment		130,334	52,564
Depreciation	2	17,668	17,465
Net loss from disposal of non-current assets	3	3,447	0
Other expenses from ordinary activities	4	190,878	130,440
Total cost of services		954,824	789,317
Revenues from Ordinary Activities			
Other revenues from ordinary activities	5	4,340	0
Total revenues from ordinary activities		4,340	0
NET COST OF SERVICES		**950,484**	**789,317**
REVENUES FROM GOVERNMENT			
Recurrent appropriation	6	900,000	872,000
Liabilities assumed by the Treasurer	7	46,403	35,827
Resources received free of charge	8	19,204	21 ,889
Total revenues from government		965,607	929,716
CHANGE IN NET ASSETS		**15,123**	**140,399**
TOTAL CHANGES IN EQUITY OTHER THAN THOSE RESULTING FROM TRANSACTIONS WITH OWNERS AS OWNERS		**15,123**	**140,399**

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

Office of Health Review

Statement of Financial Position

As at 30th June 2001

	Note Number	2001 $	2000 $
CURRENT ASSETS			
Cash assets	9	388,512	357,399
Total current assets		388,512	357,399
NON-CURRENT ASSETS			
Property, plant and equipment	10	63,078	64,403
Total non-current assets		63,078	64,403
Total assets		**451,590**	**421,802**
CURRENT LIABILITIES			
Payables		1,533	3,664
Accrued salaries	11	15,781	11,546
Provisions	12	62,886	46,592
Total current liabilities		80,200	61,802
NON-CURRENT LIABILITIES			
Provisions	12	41,652	45,385
Total non-current liabilities		41,652	45,385
Total liabilities		**121,852**	**107, 187**
Net Assets		**329,738**	**314,615**
EQUITY			
Accumulated surplus	13	329,738	314,615
Total Equity		**329,738**	**314,615**

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

Office of Health Review

Statement of Cash Flows

For the year ended 30th June 2001

	Note	2000/01 $ Inflows (Outflows)	1999/00 $ Inflows (Outflows)
CASH FLOWS FROM GOVERNMENT			
Recurrent appropriations	6	900,000	872,000
Net cash provided by Government		900,000	872,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Payments to suppliers		(324, 082)	(192,383)
Payments to employees		(530,822)	(500,763)
Receipts			
Other receipts		5,807	0
Net cash (used in) / provided by operating activities	14	(849,097)	(693,146)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	10	(22,005)	(12,606)
Proceeds from sale of non-current assets	3	2,215	0
Net cash (used in) / provided by investing activities		(19,790)	(12,606)
Net increase / (decrease) in cash held		31,113	166,248
Cash at the beginning of the reporting period		357,399	191,151
Cash at the end of the reporting period	9	388,512	357,399

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

Office of Health Review

Notes To The Financial Statements

For the year ended 30th June 2001

Note 1 SIGNIFICANT ACCOUNTING POLICIES

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

(a) General Statement

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

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

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

(b) Accounting *for* the Goods and Services Tax

The financial statements have been prepared in accordance with Urgent Issues Group Consensus View Abstract 31 Accounting for the Goods and Services Tax. The operating cash flows are inclusive of all GST, including GST cash flows to / from the A TO and GST on investing activities.

(c) Acquisition of Non-Current Assets

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

(d) Leases

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

The Authority has no contractual obligations under finance leases.

(e) Depreciation of Non-Current Assets

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

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

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

(f) Payables

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

(g) Accrued Salaries

Accrued salaries represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year.

(h) Provisions

i) Annual and Long Service Leave

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

The liability for long service leave represents the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including related on-costs, experience of employee departures and periods of service. Expected future payments are discounted using interest rates attaching to national government securities to obtain the estimated future cash flows.

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

ii) Superannuation

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

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

The note disclosure required by paragraph 51(e) of MS30 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State Scheme deficiencies are recognised by the State in its whole of government reporting. The Government Employees Superannuation Board's records are not structured to provide the information for the Authority. Accordingly, deriving the information for the Authority is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

(i) Recognition of Revenue

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

(j) Appropriations

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

k) Resources Received Free of Charge or For Nominal Value

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

(i) Comparative Figures

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

Note 2 Depreciation

	2000/01	1999/00
	$	$
Computer equipment and software	12,993	12,918
Furniture and fittings	1,459	925
Other plant and equipment	3,216	3,622
	17,668	17,465

Note 3 Net profit loss from disposal of non-current assets

	2000/01	1999/00
	$	$
a) **Proceeds from sale of non-current assets**		
Proceeds were received for the sale of non-current assets during the reporting period as follows:		
Received as cash by the Authority	2,215	0
Gross proceeds from sale of non-current assets	2,215	0
b**) Loss from disposal of non-current assets**:		
Computer equipment and software	138	0
Furniture and fittings	3,309	0
	3,447	0

Note 4 Other expenses from ordinary activities

	2000/01	1999/00
	$	$
Workers compensation insurance	7,762	9,016
Other employee expenses	19,691	22,936
Motor vehicle expenses	2,187	1,815
Insurance	6,157	5,760
Communications	23,204	16,709
Printing and stationery	21,770	17,926
Rental of Property	2,479	1,001
Audit fees -external	11,000	15,000
Administration expenses (higher due to movement to new premises}	96,628	40,277
	190,878	130,440

Note 5 Other revenues from ordinary activities

	2000/01	1999/00
	$	$
Sale of sundry items	4,340	0
	4,340	0

Office of Health Review

Notes To The Financial Statements

For the year ended 30th June 2001

Note 6 Government appropriations

	2000/01 $	1999/00 $
Recurrent appropriation	900,000	872,000
Total appropriation revenue	900,000	872,000

Note 7 Liabilities assumed by the Treasurer

	2000/01 $	1999/00 $
Superannuation	46,403	35,827

Note 8 Resources received free of charge

Resources received free of charge has been determined on the basis of the following estimates provided by agencies.

	2000/01 $	1999/00 $
Office of the Auditor General -Audit services	11,000	15,000
Crown Solicitor's Office -Legal services	8,204	6,889
	19,204	21,889

Note 9 Cash assets

	2000/01 $	1999/00 $
Cash on hand	400	400
Cash at bank –general	388,112	356,999
	388,512	357,399

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

Note 10 Plant and equipment

	2000/01 $	1999/00 $
Computer equipment and software		
At cost	69,511	63,282
Less accumulated depreciation	(38,963)	(35,832)
	30,548	27,450
Fumiture and fittings		
At cost	18,074	20,091
Less accumulated depreciation	(2,854)	(3,664)
	15,220	16,427
Other plant and equipment		
At cost	35,269	35,269
Less accumulated depreciation	(17,959)	(14,743)
	17,310	20,526
Total of plant and equipment	63,078	64,403

Office of Health Review

Notes To The Financial Statements

For the year ended 30th June 2001

Payments for non-current assets

Payments were made for purchases of non-current assets during the reporting period as follows:

Paid as cash	22,005	12,606
Gross payments for purchases of non-current assets	22,005	12,606

Reconciliations of the carrying amounts of plant and equipment at the beginning and end of the current and previous financial year are set out below.

	Computer equipment and software	Furniture and fittings	Other plant and equipment	Total
	$	$	$	$
2000/01				
Carrying amount at start of year	27 ,450	16,427	20,526	64,403
Additions	16,229	5,776	0	22,005
Disposals	(138)	(5,524)	0	(5,662)
Depreciation	(12,993)	(1,459)	(3,216)	(17,668)
Carrying amount at end of year	30,548	15,220	17,310	63,078

	2000/01	1999/00
	$	$
Note 11 Accrued salaries		
Amounts owing for:		
7 days from 22 June to 30 June 2001 (2000: 6 days from 23 June to 30 June 2000)	15,781	11, 546

	2000/01	1999/00
	$	$
Note 12 Provisions		
Current liabilities:		
Liability for annual leave	47,000	45,644
Liability for long service leave	14,428	948
Liability for superannuation	1,458	0
	62,886	46,592
Non-current liabilities:		
Liability for long service leave	41 ,652	45,385
	41 ,652	45,385
Total employee entitlements	104,538	91,977

The superannuation liability has been established from data supplied by the Govemment Employees Superannuation Board.

The Authority considers the carrying amount of employee entitlements approximates the net fair value.

Office of Health Review

Notes To The Financial Statements

For the year ended 30th June 2001

	2000/01	1999/00
	$	$
Note 13 Accumulated surplus		
Balance at beginning of year	314,615	174,216
Change in net assets	15, 123	140,399
Balance at end of the year	329,738	314,615

	2000/01	1999/00
	$	$
Note 14 Notes to the statement of cash flows		
Reconciliation of net cash flows used in operating activities to net cost of services		
Net cash used in operating activities (Statement of Cash Flows)	(849,097)	(693,146)
Decrease / (increase) in payables	2,131	1,165
Decrease / (increase) in accrued salaries	(4,235)	(3,510)
Decrease / (increase) in provisions	(12,561)	(18,645)
Non-cash items:		
Depreciation	(17,668)	(17,465)
Profit / (loss) from disposal of non-current assets	(3,447)	0
Superannuation liabilities assumed by the Treasurer	(46,403)	(35,827)
Resources received free of charge	(19,204)	(21,889)
Net cost of services (Statement of Financial Performance)	(950,484)	(789,317)

Note 15 Remuneration of accountable authority and senior officers

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

	2000/01	1999/00
$130,001 -$140,000	0	1
$140,001- $150,000	1	0
Total	1	1
	$	$
The total remuneration of senior officers and members of the Accountable Authority is:	143,245	136,445

	2000/01	1999/00
	$	$
Note 16 Retirement benefits		
In respect of Senior Officers and members of the Accountable Authority, the following amounts were paid or became payable for the reporting period:		
Notional contributions to Gold State Superannuation Scheme and West State Superannuation Scheme	10,826	8,466
	10,826	8,466

Notes To The Financial Statements

For the year ended 30th June 2001

Note 17 Explanatory statement

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

Details and reasons for significant variations between actual results and the corresponding items of the preceding year are detailed below. Significant variations are considered to be those greater than 10% or $50,000.

	2000/01	1999/00	Variation
	$	$	$
Superannuation *The variance is due to the increase in Superannuation Guarantee charge rate from* 7% *to* 8%.	47,862	35,827	12,035
Supplies and services *The variance is due to less use of contractors and consultants in providing services.*	18,475	30,104	(11,629)
Repairs, maintenance and consumable equipment *The variance is largely due to increased cost of lease and maintenance of new premises and set up costs for accommodation.*	130,334	52,564	77,770
Other expenses from ordinary activities *The variance is largely due to increased initial administration costs as a result* of *movement to new premises.*	190,878	130,440	60,438

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

Section 42 of the Financial Administration and Audit Act requires the Authority to prepare annual budget estimates.

There are no significant variations between estimates and actual results.

Note 18 Expenditure commitments

	2000/01	1999/00
	$	$
Operating lease commitments:		
Commitments in relation to non-cancellable operating leases are payable as follows:		
Not later than one year	106,385	8,753
Later than one year, and not later than five years	408,100	0
Later than five years	111,798	0
	626,283	8,753

Note 19 Output information

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

Office of Health Review

Notes To The Financial Statements

For the year ended 30th June 2001

Note 20 Contingent liabilities

It is the Authority's policy to disclose as a contingency any material future obligations which may arise, due to special circumstances or events. At the reporting date the Authority is not aware of any such material future obligations.

Note 21 Events occurring after reporting date

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

Note 22 Financial instruments

a) Interest rate risk exposure

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

	Weighted average effective interest rate	Non interest bearing	Total
	%	$	$
As at 30th June 2001			
Financial Assets			
Cash assets	-	388,512	388,512
		388,512	388,512
Financial Liabilities			
Payables	-	1,533	1,533
Accrued salaries	-	15,781	15,781
		17,314	17,314
Net financial assets (liabilities)		371,198	371,198
As at 30th June 2000			
Financial Assets			
Cash assets	-	357,399	357,399
		357,399	357,399
Financial Liabilities			
Payables	-	3,664	3,664
Accrued salaries	-	11,546	11,546
		15,210	15,210
Net financial assets (liabilities)		342, 189	342, 189

b) **Credit risk exposure**

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. In respect of other financial assets the carrying amounts represent the Authority's maximum exposure to credit risk in relation to those assets.

c) **Net fair values**

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

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Estimates of Expenditure for 2001/2002

The following Estimates of Expenditure for the year 2001/2002 are prepared on an accrual accounting basis. The estimates are required under Section 42 of the Financial Administration and Audit Act and by instruction from the Treasury Department of Western Australia.

The following Estimates of Expenditure for the year 2001/2002 do not form parts of the preceding audited financial statements.

Revenue	**2001/2002**
Consolidated Fund	$1 001 000