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Third Session

REPORT

OF THE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

ENTITLED

"THIRD MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION"

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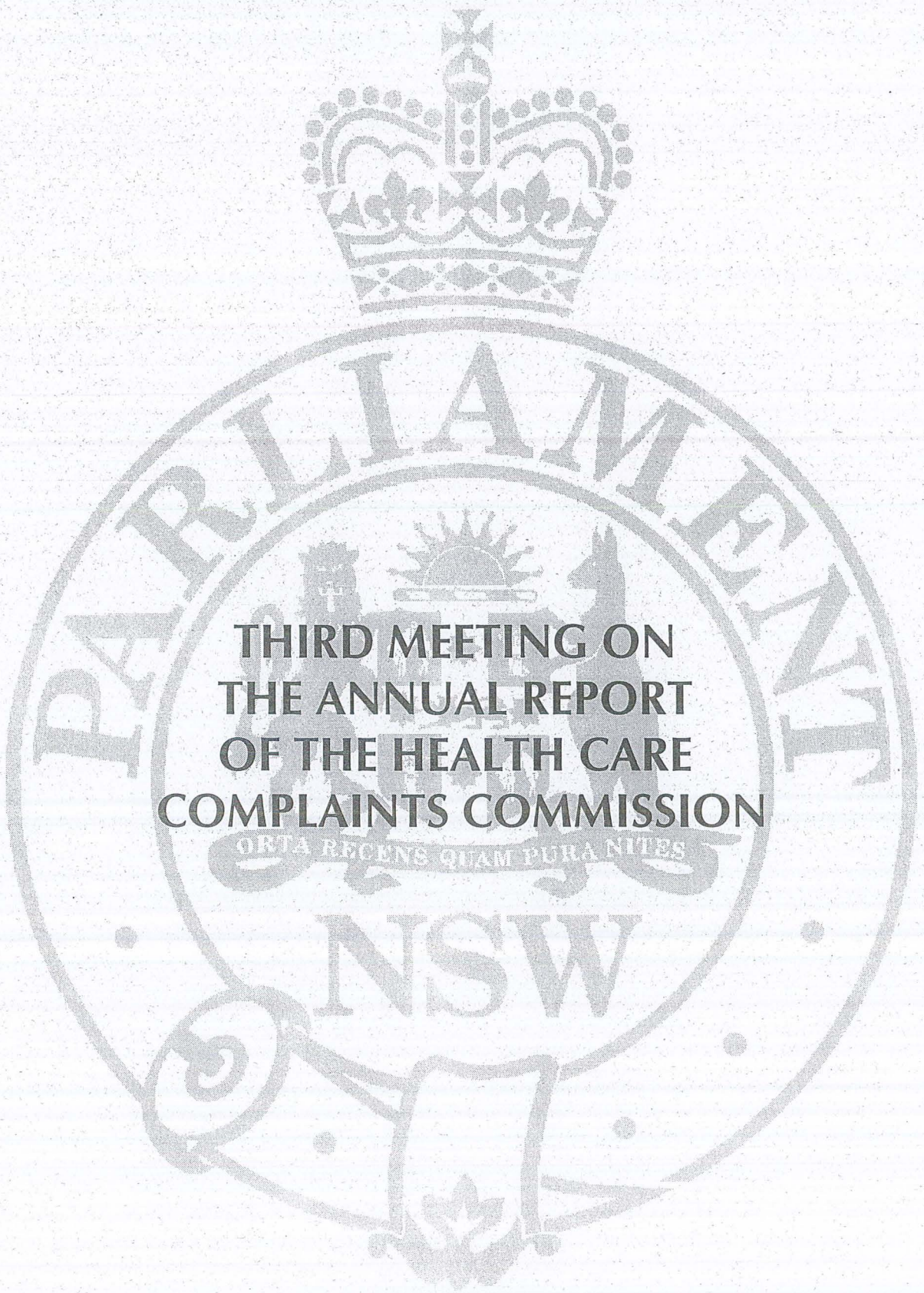
REPORT OF THE JOINT COMMITTEE
ON THE HEALTH CARE COMPLAINTS COMMISSION



THIRD MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

MAY 1998

JOINT COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

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FUNCTIONS OF THE COMMITTEE

The Joint Committee on the Health Care Complaints Commission was appointed in 1993. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

COMMITTEE MEMBERSHIP

Legislative Assembly

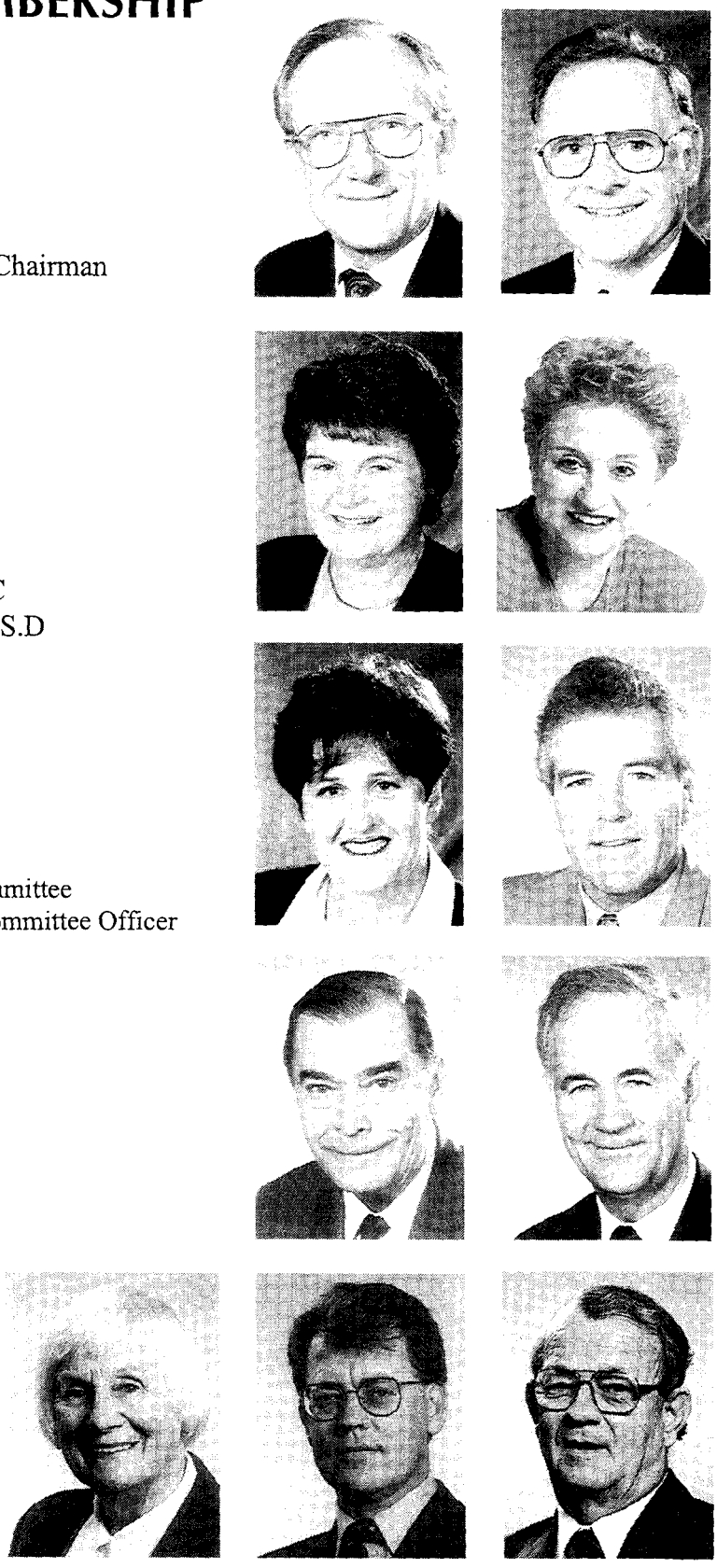
Mr John Mills MP - Chairman
Mr James Anderson MP
Ms Marie Andrews MP - Vice-Chairman
Ms Marie Ficarra MP
Ms Jill Hall MP
Dr Peter Macdonald MP
Mr Stan Neilly MP
Mr Bill Rixon MP

Legislative Council

The Hon Elisabeth Kirkby MLC
The Hon Dr B Pezzutti MLC R.S.D
The Hon John Johnson MLC

Secretariat

Ms Catherine Watson, Director
Ms. Susan Want, Clerk to the Committee
Ms Glendora Magno, Assistant Committee Officer



Joint Committee on the Health Care Complaints Commission (left to right)
Mr John Mills MP (Chairman), Mr James Anderson MP, Ms Marie Andrews MP (Vice-Chairman), Ms Marie Ficarra MP, Ms Jill Hall MP, Dr Peter Macdonald MP, Mr Stan Neilly MP, Mr Bill Rixon MP, The Hon Elisabeth Kirkby MLC, The Hon Dr Brian Pezzutti MLC, The Hon John Johnson MLC

Chairman's Foreword

Once again I am pleased to present the report of the Joint Committee's annual meeting with the Health Care Complaints Commission as required by Section 65(1)(c) of the *Health Care Complaints Act* 1993.

This is the Committee's third Annual General Meeting with the Commissioner to discuss issues arising from the Commission's latest Annual Report. It is a process which not only ensures greater accountability to the Parliament of New South Wales on the part of the Health Care Complaints Commission but also increases the Joint Committee's understanding and appreciation of the work of the Commission and the particular issues it faces in its day to day operations.

It seems that every year some of the key issues the Committee focuses on are: time taken for investigations; numbers of complaints being referred to conciliation; and budgetary and resource issues. These are all obviously extremely important to the effectiveness of the Commission and the faith of health consumers in the process and will continue to be examined by the Committee in future years. However, I would like to take this opportunity to congratulate the Commissioner on the many initiatives she has spearheaded during the past year.

I believe the introduction of the Patient Support Office has been a major success for the Commission and, as recommended in the Committee's report into local complaint handling, should ultimately be expanded to every Area Health Service within New South Wales. I would also like to congratulate the Commissioner on the work the Commission has done in relation to the establishment of a peer review reference panel to ensure the integrity of expert medical opinion. I am impressed by the consistent efforts of the Commission to raise the standard of clinical practice in New South Wales through competency based re-registration for physicians. I was part of a Committee delegation which last year examined what was being done in Canada in this area and would like to see it replicated here.

The Ministerial Review of the *Health Care Complaints Act* 1993 which was conducted by a Committee chaired by John Cornwall has recommended some important extended powers for the Commission and it is hoped that, if these are introduced, even better outcomes and time frames for investigation may be achieved by the Commission in the future.

Lastly I would like to thank the Health Care Complaints Commissioner, Ms Merrilyn Walton and the Deputy Commissioner, Ms Sigrid Higgins for their attendance. I also thank the Committee Secretariat for their efforts in the preparation of this report.

John Mills MP
Chairman

Summary of Key Issues

1. Standards of Health Care

The Commissioner emphasised that under the current legislation the Health Care Complaints Commission is limited in what it can do pro-actively in this area given that it only becomes involved in this issue after an adverse incident has occurred and is then restricted to the individual complaint and the outcome.

A Ministerial Committee was established in 1996 to advise the Minister on how to improve the quality of health care. An interim report has been prepared and is currently with the Minister. Three subcommittees have been established to investigate appropriateness of care, safety of care and consumer participation and consultation. The Commissioner is a member of the latter two subcommittees. In regard to safety of care, the focus has been on putting into place some systemwide procedure for incident monitoring and adverse event monitoring.

In relation to addressing adverse events in hospitals, the Commissioner believes that two issues need urgent attention: the hospital credentialling process and the problem of maintaining performance and competency. Both these issues need to be addressed by the Colleges.

The Commissioner also believes that the health practitioner registration Acts are old fashioned and outdated when it comes to addressing changes in medicine, particularly technological. The Commission has made submissions to the review of the *Medical Practice Act* regarding the necessity to address continuing competency through the registration process. The legislative review will take place in 1998.

Dr Macdonald raised the issue of whether the Commission is constrained in addressing quality of care issues given that Sections 91 and 92 of the *Health Care Complaints Act 1993* prevent the Commission making any recommendations relating to resources and the allocation of resources as well determining or recommending general standards of clinical practice. The Commissioner answered that she would support the Commission, as a result of its investigations, being able to address gaps in services, even when this involves resourcing issues.

2. Patient Support Office

The Chairman raised two issues which had appeared in the Sydney Morning Herald suggesting the failure of public hospitals to promote the Patient Support Office and that the work of the Patient Support Office was being hampered by resistance from within the health system. The Commissioner told the Committee that the Commission had written to the CEOs of all hospitals and asked them to display the Patient Support Office brochures and posters in a prominent place. It was then decided to do an audit to check whether this had been done. The results were that there was very poor displaying of the information. The Minister for Health was approached about the issue in February 1998 and he agreed to contact the CEOs directly and remind them of their obligations.

The Commissioner also advised that the Patient Support Office has targeted divisions of general practice by addressing their divisional meetings and advising on what it can offer. From December 1996 to June 1997 Patient Support Officers handled 589 complaints, while from July 1997 to January 1998 they handled 965, which represents a 61 per cent increase.

3. Ministerial Review of the *Health Care Complaints Act 1993*

During 1997 the Minister established a Committee which was chaired by Mr. John Cornwell. The function of this Committee was to conduct a review of the Health Care Complaints Act 1993. The Commissioner advised that the Review Committee supported two rather controversial recommendations to extend the Commission's powers.The first recommendation requires mandatory attendance by respondents at conciliation conferences. The Commission has found that once a matter is assessed as suitable for conciliation and either party refuses to attend, in around fifty per cent of cases it is the respondent. The Review Committee considered that it was not appropriate for health care providers to be able to walk away from their responsibility to explain what happened and why or offer an apology where required.

The second recommendation involved the granting of an additional power to enable the Commission to compel the production of records in investigations conducted under Section 23 of the legislation. The Commission currently has to rely on search warrants or the consent of the relevant parties. It was agreed that this power should be appropriately circumscribed as to what information could be sought and the circumstances that can be invoked. The new power will be confined to medical records, medical reports and existing records that give information about the health care of the person and must relate to the substance of the complaint.

Penalties for failing to comply with the new power include, in respect of a registered health care provider such as a doctor, nurse or psychologist, a referral to the relevant registration board. In respect of a non-registered health care provider-such as a masseur or an iridologist, naming in the Commission's annual report.

Further, the Commissioner said that the Review Committee made significant recommendations for improving the conciliation process. As a result, the Commissioner has undertaken for a consultant to be employed to develop criteria for conciliation. A meeting was also recently held between the Commission, the Registry and the Department of Health to progress those recommendations relating to administrative matters which are not dependent on statutory amendment.

4. Complaint Handling Times

The Hon Elizabeth Kirkby MLC asked the Commissioner whether she considered that the average time taken to resolve complaints (318 days) was still extremely long, although it had reduced from an average of 365 days the previous year. The Commissioner agreed and said that length of investigations were a perennial problem for the Commission although a great deal of administrative energies had gone into improving them. She said that there are now externally set benchmarks for investigation times and it is accepted that 18 months is the

outside time frame within which the Commission can conduct an investigation for several reasons, including: the time frames prescribed under the legislation for respondents to comply; the fact that the investigation cannot proceed without a statutory declaration by the complainant; and the Commission's current lack of power to compel the production of records.

Further, the Commission now has an investigation committee with staff representatives on it which attempts to identify different ways to speed up the investigation process. Caseloads used to be capped at 140 files and are now capped at 40. In the past the Commission only substantiated around 30 per cent of complaints and they are now substantiating more than 45 per cent, which indicates that more complex complaints are being dealt with and more fairer outcomes are resulting for complainants.

5. Budgetary and Resources Issues

The Commissioner reported that in relation to matters like administrative costs and legal costs, the Commission is substantially more cost effective than other government departments. This is largely due to the fact that they do not pay senior counsel rates. The Commission has decided to pay no more than $2,000 whether they are briefing senior or junior counsel. It has found that most senior counsel will still work for this rate and therefore the quality of the Commission's legal advice has not been affected.

The Commission has also made savings by requiring only one peer review report instead of two and a prescribed flat fee is paid. The Medical Defence Union and the health registration boards have agreed to this approach and it has saved the Commission more than $250,000 per year.

The Commissioner also believes the Commission is carrying out more cost efficient investigations by identifying key problems sooner and quicker. Because 48 per cent of complaints currently investigated by the Commission are found to be substantiated, the Commission believes that it is getting better outcomes for complainants than ever before.

The Commission has undertaken an enhancement process to reduce the time frames for investigation. This involves two senior investigation officers and a hearing officer being trained to prosecute cases before the health registration boards. The Commissioner would like permanent funding for this position as well as funding for an officer to monitor trends in complaints and examine policy issues.

6. Peer Review

The Chairman raised the issue of the credibility of competing medical experts in medical negligence litigation and asked the Commissioner how the Health Care Complaints Commission works to maintain the integrity of the peer assessment process. The Commissioner said that she believed that the quality of the peer reviewers which the Commission uses is integral to its work and it is therefore the Commission's responsibility to ensure that these reviewers are well trained and that the system is transparent.

To become a member of the peer review reference panel providers must be in more than 75 per cent clinical practice; participate in peer review; participate in continuing education; attend a face to face interview with the Commissioner, Deputy Commissioner, head of operations or one of the Commission's medical advisers; and attend training seminars. Further, these providers should have no history of serious complaints against them.

The Commissioner told the Committee that there have been some difficulties with the effectiveness of the peer review system in hospital based complaints. This tends to occur when a series of departments or hospitals is involved and it is difficult to determine who is actually responsible for the substandard treatment. There is also a problem with the maintenance of the peer review system. The Commissioner has approached the President of the New South Wales Medical Board about funding a secretariat to establish an independent peer review panel. Such a panel would involve the respective colleges and may also provide an avenue for litigants involved in medical negligence actions to select a peer from an accredited peer review panel.

7. Sexual Misconduct

The Commissioner told the Committee that there is a developing concern about allegations of sexual assault that present when a gynaecological or rectal examination is being carried out by a provider. Medical Defence Unions advise practitioners to have a chaperone present when examining intellectually disabled people and young adolescent women. The Commissioner supports this but believes that there is resistence on the part of providers. Due to the increasing amount of complaints that the Commission is receiving in this area, it is trying very hard to be educative and has produced several pamphlets, one for providers and one for consumers. This is the type of case that the Commission tends to lose before the Medical Tribunal when the provider is able to provide an alternate explanation.

8. Consultative Bodies

Last year a Consumer Consultative Committee was established and first met in May 1997. Committee members include the Aboriginal Health Resource Co-operative, the Australian Association of Welfare and Child Health, the Australian Consumers Association, the Combined Pensioners and Superannuants Association, the Council for Intellectual Disability, the Council on the Ageing, the Mental Health Co-ordinating Council, the Network of Alcohol and Other Drug Agencies, the New South Wales Council of Social Service, People Living with HIV-AIDS, People with Disabilities, the Public Interest Advocacy Centre, the Women's Health Resource and Crisis Centres Association, the Youth Action and Policy Association.

The Commission has also established a Health Reference Panel which will consult with up to 100 key consumer organisations about issues arising from the Commission and standards of health care generally.

9. Conciliation

The Chairman asked why there had been a decrease of 30 per cent in positive outcomes achieved in conciliation conferences during 1996/97. The Commissioner was unable to

comment upon this as the Conciliation Registry does not provide this information to the Commission for confidentiality reasons. However, from recent discussions with the Registrar she believes that as of 2 February 1998, agreement had been reached in 80 per cent of all conciliation conferences.

10. Types of Complaints

The Chairman noted that the percentage of complaints against private hospitals had risen by 40 per cent in the last year. The Commissioner said that she considered that this was due to the fact that more attention is now being given by these hospitals to addressing patient concerns due to competition policy obligations for accreditation.

11. Request for Reviews

The Commissioner told the Committee that requests for reviews of investigations have increased by 10 per cent in the past year. She believes that complainants asking the Commission to rethink its decisions is ultimately a positive thing.

12. Local Complaint Handling

The Commission has begun to devote resources to monitoring the quality of the investigations being done by Area Health Services under Section 26 of the Act. Some have been found to be inadequate and the Commission has therefore taken over the investigation.

The Commission would like to provide appropriate training in this area but there is a reluctance on the part of the Area Health Services as they believe they will not retain the expertise. The Commission has considered doing the work under contract and is currently preparing a paper as to the feasibility of undertaking such a task.

THIRD MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

TRANSCRIPT OF EVIDENCE TUESDAY 03 MARCH 1998

2:00 PM JUBILEE ROOM PARLIAMENT HOUSE

MEMBERS PRESENT

Mr John Mills MP
Chairman

Legislative Assembly

Mr James Anderson MP
Ms. Jill Hall MP
Dr Peter Macdonald MP
Mr Stan Neilly MP
Mr. Bill Rixon MP

Legislative Council

The Hon Elizabeth Kirkby MLC
The Hon Dr Brian Pezzutti MLC

Apologies

Ms Marie Andrews MP
Ms. Marie Ficarra MP
The Hon John Johnson MLC

MERRILYN WALTON, Commissioner, Health Care Complaints Commission, before the Committee, and

SIGRID HIGGINS, Deputy Commissioner, Health Care Complaints Commission, sworn and examined:

CHAIRMAN: The Health Care Complaints Act provides that the Committee shall examine each annual report of the Health Care Complaints Commission and report to the Parliament on any issues that arise therefrom. This is an opportunity for members of the Committee to discuss the progress of the commission in the year under report and for the commission to tell the Parliament and, through it, the people of New South Wales, what the commission is doing. Do you wish to make an opening statement?

Ms WALTON: No, thank you.

CHAIRMAN: The *Sydney Morning Herald* referred last Friday to a 1995 report which stated that 18,000 deaths occurred in Australia each year from accidents in hospitals and other health care services, and claimed that nothing had been done about it. It reported that an expert Federal advisory committee was appointed in March 1997, and Professor Richard Day was reported to have conducted an independent investigation of some of the data. Given that the object of the Health Care Complaints Commission is to maintain and improve health care standards and quality, has the commission been involved in those investigations? Has the commission been consulted in any way? If not, why not? What gaps are there in our armoury of health care consumer protection and safety that would allow such a situation, if true, to occur? Our armoury includes the Health Care Complaints Commission, the Health Rights Commission, et cetera, in other States, medical boards, royal colleges, university education and a variety of peer review systems.

Ms WALTON: I would like to address that question in three parts if I may: what we can do under the Health Care Complaints Act in relation to systemic adverse events in hospitals; what this State is doing and our involvement in it; and identification of some areas that we think need urgent attention. The Health Care Complaints Act is a reactive piece of legislation that is dependent on a written complaint. If we receive a written complaint against a hospital in relation to an adverse event, we have the power to investigate and take appropriate action. When it comes to individuals, that disciplinary action is clearly prescribed under the various health registration Acts. When it comes to the system, we can only make recommendations in relation to improving the situation as we perceive it during the investigation.

The Health Care Complaints Act, specifically under section 91 and 92, prevents the commission making any recommendations relating to resources and the allocation of resources, and we are also prevented under section 92 from determining or recommending general standards of clinical practice. The report that was published in the *Sydney Morning Herald* related to a study that was carried out of adverse hospital events, involving a number of hospitals throughout Australia, for the Tito Inquiry. There were no individual complaints referred to the Commission from that study. When we investigate we can identify a deficiency. We can only

recommend, under the Act, to a college, a health department or an area health service, and we do that.

In effect, the Health Care Complaints Commission comes into effect when the hospital system fails in a retrospective way. We are limited as to what we can pro-actively do. A ministerial committee was established by Dr Refshauge, and I table some information about that committee. The Commissioner is an ex-officio member of that Ministerial Committee. The other members of the committee are appointed on a time basis for two or three years. Dr Ross Wilson is the Chair of that committee. The committee started meeting in October 1996 and it comprises consumers, clinicians, health administrators and bureaucrats. Its job is to advise the Minister on how to improve the quality of health care. An interim report has been prepared and it is with the Minister.

Three key subcommittees have been established to investigate appropriateness of care, safety of care and consumer participation and consultation. I have been a member of two subcommittees on safety of care and consumer consultation. In regard to safety of care, the focus has been on putting in place some systemwide procedure for incident monitoring and adverse event monitoring. That is how this State is dealing with the broader systemic issues. It is a broad, consultative process. We have met with every area health service and we are meeting with services in rural New South Wales, the Ambulance Service, and correctional health. Funds have been provided to the committee to seek submissions for specific research projects. The representation of the committee is in my view appropriate. It has consumers and clinicians and is an independent body of the area health services. It is picking up where the study that was reported in the *Australian Medical Journal* left off, but this should be driven by the Commonwealth, not just the State system.

In relation to some areas that need urgent attention, which would lead to addressing some of the issues of adverse events in hospitals, I will comment only on things that are in the experience of the Commission. Two issues need urgent attention, one of which is the credentialling process in hospitals. The Commonwealth report on minimal access to surgery evaluated credentialling processes and made strong recommendations to colleges and the medical profession about the need to relook at how that process operates. The other issue, which I am already on record about is the problem of maintaining power and competence, and the lack of any provision in any of the health registration Acts to address performance and competency when they reregister each year. All the colleges have continuing education programs, a number of which are nearly mandatory. I say "nearly" because they are not mandatory at the moment. They are a voluntary schemes and no consequence flows if one does not participate in mandatory continuing education.

The registration Acts are old-fashioned and outdated when it comes to addressing the changes in medicine, like technology. This is not a problem for this State only or for this country; it is a problem throughout the world. Canada is the most advanced country in terms of its Medical Practice Act, which ties some audit process to registration. The Pew Inquiry in the United States recommended that all health registration boards address continuing competency and, indeed, the Federation of Medical Boards has accepted the recommendation and has in place a policy initiative to carry out the recommendation. The Medical Practice Act is under review this year, and in the preliminary first round the Commission made submissions about the necessity to

address performance and competence. The Commission does not have the answer. It obviously needs to be discussed broadly and debated within the medical and other health professions. They are the two areas that would rapidly address some of the deficiencies we are seeing.

Dr MACDONALD: You have opened up quite an interesting area. You point out that under Section 91 of the Act the Commission is not allowed to make recommendations inconsistent with the allocation of resources by the political process. It could be argued that the Health Care Complaints Commission is hobbled by political constraint. Would you like to see the Act amended in any way when it is reviewed? That is consistent with the view you put to the Cornwall committee, when you argued that the object of the Act, which is about maintenance of health standards, is not enough. You argued that there should be a role to improve health standards. As I read the Cornwall committee report, your recommendation will not be taken up because it believes the Commission already has adequate opportunity. One of the important roles of the HCCC is to get out of the political process and to make recommendations that may be politically uncomfortable for the government of the day, but which the Commission believes are appropriate to maintain and improve standards. For example, I would like to see the HCCC involved in the current debate about injecting rooms and heroin trials: a form of health service and saving lives, but clearly the Commission is not allowed to become involved because of the constraints placed upon it. Do you see this as opening up a broader debate? Would you support amending the Act in some way?

Ms WALTON: I would certainly support the Commission, as a result of its investigations, being able to address gaps in services. If that raises resource issues, the Commission should be able to deal with that. I do not have the appropriate wording, but as an example I, with a number of other health professionals, appeared before the World Bank Economic Committee that visited this State. I was asked a question about the results of the commission's investigations in relation to preventative health, which is clearly looking at where the resources go in terms of acute care and preventative health. Again, my answer was that we are limited to the individual complaint and the outcome. The Commission, when it makes recommendations as a result of a complaint about a district level hospital, has to bear in mind that it can confine itself to care issues only. My interpretation of that can be broad. It may involve a resource issue if there is not an on-site facility to get a second opinion, and that may well have to be addressed. But I address it through clinical issues. Yes, I think there is room for the Commission to be involved more broadly. I am not sure how it can be confined. I see a problem with an elected government having a mandate to do certain things with policies and with the commission being able to determine otherwise. I am not sure of the appropriateness of that situation.

Dr MACDONALD: I do not see any conflict in your role of speaking out on behalf of adequate health services and criticising rogue governments if they are not providing it. At the moment we could not accuse governments of that, but the day may come when rogue governments are not putting in resources. Surely, as Commissioner of the HCCC, you would not want to see services reduced and patients die? You would feel compelled to criticise?

Ms WALTON: Absolutely. I agree. Perhaps it is the system. Perhaps the Act could be reviewed to consider a pathway for that to occur rather than just a blanket statement. At the moment there is no avenue other than to report to Parliament through a particular section of the Act. But, again, that has to be based on a particular complaint.

Dr MACDONALD: I do not have the file with me, but I have a vague recollection that I wrote to the upper House committee about the concept of a health commissioner. This is a role that could ultimately be taken on by the HCCC. I did that because I am concerned that in the next 12 months we will have a war of words about who will provide the most resources for health, how long the waiting lists are and whether we are really getting value for money, et cetera. We need a body or a commission outside the political process that can tell the public the truth. That is really what I am getting at in my line of questions.

Ms WALTON: Are you talking about report cards on health services?

Dr MACDONALD: Yes. Why not?

Ms WALTON: That is certainly on the agenda with the ministerial committee. It is considering introducing publicly available report cards on health services. The evidence coming out of the *New England Journal of Medicine* and the United States is that report cards on individual practitioners, even with risk-adjusted information, have not affected patient choice.

Dr MACDONALD: They have not?

Ms WALTON: No. But I believe it is appropriate to provide as much information as possible to the public so that the public can make an informed choice.

The Hon. ELISABETH KIRKBY: I would like to take it from the opposite position, not so much the complaints made to you by concerned people and those who believe the health service has not done what it believes it should have done, but from the point of view of complaints made against your Commission, in particular to the Ombudsman. The Ombudsman's annual report contains 14 complaints relating to the Health Care Complaints Commission. Half of them resulted in the complainant needing assistance from the Ombudsman to resolve the complaint. To compare the complaints, the Department of Community Services, which has been very much in the press recently, had only one more complaint than your commission. The private operator of the Junee Correctional Centre—

CHAIRMAN: I must interrupt. I was asking for questions in the broad area of deaths in the public and private health care system. There will be plenty of opportunity to raise that question later.

Dr MACDONALD: Could you tell the Committee in what way you believe the work and the recommendations of the HCCC have resulted in systemic improvements to the health system? I want to explore that line, rather than individual complaints and management of those complaints.

Ms WALTON: For each individual complaint in which the Commission identifies a deficiency in the health system—and it can be in either a triage policy at a district level hospital through to an infection control policy of that hospital—the Commission, under the Act, has to give the facility an opportunity to reply, which it does. The Commission then makes recommendations to the Director-General of the Department of Health or the appropriate body. That appears in the annual report in relation to policy outcomes, but it is the only pathway the commission has to improve health services. That is how the problem is remedied when a specific complaint is made and the organisation accepts the complaint. If the organisation chooses not to follow that path the

Commission has the opportunity to approach the Minister for Health. If the Minister does not take sufficient action to address the issue, the Commission can then go to Parliament. I draw the Committee's attention to the inquiry in relation to the treatment of people with mental illness in emergency departments, which is the result of the Commission's concern about a number of complaints dealing with the misdiagnosis and incorrect treatment of people who presented. A working party was set up, and a document was sent to all chief executive officers of hospitals to ensure that their services were changed to meet the recommendations of the committee, which include psychiatrists being available on call 24 hours a day, no matter where you are, as well as many other recommendations.

Dr MACDONALD: I was inviting you to give the Committee an oversight of the triumphs that have occurred in the last 12 months for which you might like to take a victory bow.

Ms WALTON: The triumphs will take a bit longer than 12 months, unfortunately, given the fact that the boarding house report is now 18 months old and that the current state of play is that the Ageing and Disability Department and the Department of Health have embarked on a project to assess every individual in a boarding house to determine their appropriate accommodation and health needs and to provide support. That process may be completed in three years, so we are looking at a five-year time frame before we can say that as a result of those investigations by the Commission—

Dr MACDONALD: I understand.

Ms WALTON: The Commission has concurrently disciplined nine practitioners in relation to their prescribing for those residents.

CHAIRMAN: I would like to raise the patient support officer program, which is new this year. I am sure members of the Committee have a great interest in it. It is certainly well highlighted in six to eight pages of the report. You will realise from the Committee's investigation and report last year that the Committee supported that office. I refer in particular to an article in the *Sydney Morning Herald* of Monday 9 February, headed "Snubbed health unit defends patients' right." The journalist stated that hospitals have been reluctant to promote the PSO program and that the work of PSO staff has been hampered by resistance within the health system. What steps have you taken to try to resolve those problems? Are you aware whether the Minister for Health and other responsible people have also taken steps to resolve those immediate problems only 12 months after the program started?

Ms WALTON: When we were about six months into the program we wrote to all the CEOs and asked them to display posters and brochures in key places in the hospital. We then decided to do an audit of whether they had been put up. The patient support officers went to every hospital and facility and the results of the audit show that there was a poor display of our information. As a result I approached the Minister and expressed my concern about the lack of response to a service that is in everyone's interest. The Minister agreed to directly contact each CEO through his officers and he instructed that they be more cooperative and responsive, and that has happened. We have not done a follow-up audit because this happened only in the last month.

CHAIRMAN: The manager of the office, Bruce Greetham, was quoted in the article as saying that there was an enormous need for patients to be advised of their health rights and to increase providers' awareness of those health rights outside the hospital. What steps do you

think should be taken to achieve that objective for the better information of providers and patients?

Ms WALTON: We targeted divisions of general practice when we first set up and we are now retargeting divisions of general practice specifically to be more concrete in what we can offer them—that is, a speaker to address their divisional meetings. The Commission is ensuring that all the hospitals, nursing homes, private hospitals and day procedure centres are on our mailing list and are part of the information flow. The problem we identified was not so much with the private sector—even though we have only so many resources and so many places that we can stretch at one time—but the concern that the public hospitals did not have ready information for people who need help when they are receiving care.

Ms HALL: Is the information sent out? Quite often patients like to get their information from a familiar environment, such as their local general practitioner or community health centre. Is that information available in those sorts of places? Are the brochures sent out to the surgeries of all general practitioners or other places where people can access them, other than public or private hospitals?

Ms WALTON: I know that all patient support officers identify key health providers in their area. I will have to take on notice whether they have contacted every general practitioner in their area. To my knowledge, we would target divisions. I met with the college and it, through its newsletter, has circulated information, and the contact person for the college has a list of the patient support officers. With respect to writing individually to the 20,000 registered doctors in New South Wales, no we have not done that.

Ms HALL: You would not have to write to 20,000 registered doctors because I am sure that there are not that many practices.

Ms WALTON: No, there are about 12,000 practices.

Ms HALL: I assume that the place where I would access such information most readily would be different to where John would access that information most readily. That information needs to be available to people where they can access it. It is good that it is going to all the divisional associations and other areas, but if there were a way to broaden that it would be good.

Ms WALTON: We will take that on board. I will take that question on notice and give you a detailed response of who we have contacted.

Ms HALL: My next question relates to the article to which John referred. Has the commission gone into any of the institutions and spoken to the staff to see what sort of acceptance level there is or has it sent out questionnaires to the staff?

Ms WALTON: The manager of the Patient Support Office and the patient support officers regularly talk to the staff in seminar meeting situations. We are currently planning the evaluation of the service, and clearly focus groups of health providers will be undertaken to ascertain their views.

Ms HALL: I will be interested to see the results of that.

Dr MACDONALD: What sort of evaluation indicators are you going to use—there are seven at the moment, is that right?

Ms WALTON: Yes, that is right.

Dr MACDONALD: Is this a pilot? On what basis will you work out whether they are successful in resolving matters before they have been advanced? Will you measure it against a control group or something?

Ms WALTON: We have been doing individual patient satisfaction contacts with every patient support officer, which will be separately evaluated. That is continuously evaluated now. There is no other such scheme in Australia. We might be able to benchmark against New Zealand in terms of what it does, but essentially the question we would be primarily asking is: is the service worth it? That would happen through focus groups with consumers and providers.

I refer to the evaluation proposal terms of reference. We are asking the consultants, or the people who evaluate it who will be independent, the appropriateness and relevance of the aims and objectives of the service, and whether they remain current; management systems and practice, with particular reference to staff recruitment, which is administrative stuff; impact on client group and appropriateness of service; accessibility of the service; and work processes. We have not done it as a pilot in the sense that there seems to be overwhelming support for it and there has been a request from everyone for more of it not less. It certainly makes people who come to the Commission happier with us because we just do not say, "We are not investigating your complaint" and we resolve it for them elsewhere without full investigative resources. For us it is an additional service to the public of New South Wales.

Dr MACDONALD: Do you anticipate that it will reduce the number of formal complaints to the Health Care Complaints Commission because of early intervention?

Ms WALTON: It could well do.

Dr MACDONALD: How will you measure that? Would it not be difficult?

Ms WALTON: Section 23 of our Act says what we must investigate; if it needs investigation we should do it. If getting a second opinion at the time prevents something dramatic or drastic happening, you could say that it has worked, but we would not know, would we?

Dr MACDONALD: No, I do not think you will. If the Patient Support Office is provided with information regarding a matter that should be dealt with under section 23, does it say to the complainant or to the patient, "Look, I cannot help you with this; you must go straight to the Health Care Complaints Commission"?

Ms WALTON: They do.

Dr MACDONALD: And they have?

Ms WALTON: Yes. They are obliged to help the person make a complaint. Our Act requires the Commission to provide any assistance necessary to facilitate the complaint being

written.

The Hon. ELISABETH KIRKBY: Commissioner, your report makes it clear that the Patient Support Office cannot investigate complaints; that it can only assist a consumer to resolve his or her concerns. The report also states that there are seven staff in the Patient Support Office. According to the figures, they deal with 522 clients, which works out at about 65 clients each every year. Do you believe that they would be more effective if they had the ability to investigate complaints? Do you think people feel it is waste of time going because they think they cannot do anything for them and they will not be able to investigate their problem? I believe that 65 clients a year is a small workload.

CHAIRMAN: These officers were appointed for about half a year, maybe a bit less, at the time of this report.

Ms WALTON: I have some up-to-date figures. From December 1996 to June 1997 there were 589, but from July 1997 to January 1998 there have been 965—a 61 per cent increase. We are not getting the complaints from people who go to the Patient Support Office and say that they want an investigation; we are not getting that feedback. They want to resolve the complaint. My view is that they should not be investigators because that confuses roles. There are a lot of natural justice and procedural issues that we need to be acutely aware of when we investigate complaints, and that needs to be closely supervised and monitored. The idea of the Patient Support Office is to avoid getting into those long investigations, if it is not a matter that should be; it is to help people resolve the matter there and then and to avoid a complaint.

The Hon. ELISABETH KIRKBY: Would it not be possible to assist those people through your conciliation registry? After all, the conciliation registry has been established to assist consumers to conciliate.

Ms WALTON: Once we get a written complaint we consider whether it is appropriate to go to conciliation or whether it can be dealt with by the Patient Support Office. We consider the appropriateness of that for every complaint, bearing in mind that the ones the Patient Support Office sees are usually matters that we never hear about because they are getting referrals from the local area, people read their name and number on a brochure and ring them, or they ring our telephone inquiry office.

Dr MACDONALD: Would it be worth considering the PSO having a role in some sort of exit process when the patient leaves the hospital? A discharge form is filled out, and perhaps there needs to be a box that asks whether the person is satisfied and, if not, whether he or she would like to report it to the PSO. There could be an opportunity for the person to comment about standards of care. That information would be directed to the PSO, which might get an overview of what is happening in that institution.

Ms WALTON: I can see the advantage in relation to continuity of care for the patients.

Ms HALL: That is an excellent idea, having some sort of a questionnaire, survey or a box.

CHAIRMAN: Everyone who leaves a hospital signs something.

Dr MACDONALD: In my professional experience people go to their general practitioner afterwards and say, "The nursing care was useless, but there is no way I am going to complain about it." The PSO should be the eyes and ears of that sort of operation. If it sees a recurring complaint it would be in the interests of health care to report it to the executive level.

Ms WALTON: I could ask the manager of the Patient Support Office to develop a proposal—such as a strategic focus on how we could use discharge planning to improve the system—and I will send it to you for your comments. We are happy to do that.

Ms HALL: That would increase the accessibility of the patient support officer and increase the community's awareness of the role and availability of such an officer.

Ms WALTON: Being mindful that the system can flood us if we target every discharge in the hospital. We need to look at it carefully, but it is a good idea.

CHAIRMAN: A health worker said to me recently regarding his local Patient Support Office, "It takes weeks to get anyone to answer the phone or to get answering machine messages responded to. However, once you get through the service is excellent." How stressed or overworked are the patient support officers now? Have you considered whether the PSO could be given secretarial help or mobile phones so they are easier to reach?

Ms WALTON: They have mobile phones. I would be concerned about that and I think the support office would like that information so it can follow up on it. In relation to the stress or overwork, it is a—

CHAIRMAN: It was not a complaint about a particular officer, it was merely that the phone was engaged too often.

Ms WALTON: That is a problem. The other issue may well be having a second phone number to take the flow-over calls, but we would need to consider that. We have made an application in the enhancement budget for two additional patient support officers to join the seven we have. I thought it was a bit unrealistic to actually make application for another seven at this stage.

Mr RIXON: Do you have seven or eight patient support officers?

Ms WALTON: Eight including the officer who is relieving.

CHAIRMAN: This Committee recommended that there should be a patient support officer in all areas. It may be that we should remind the Minister of the Committee's recommendation.

Ms WALTON: We have reminded Treasury of your recommendation.

CHAIRMAN: My next question relates to last year's ministerial review of the Health Care Complaints Act, the Cornwall report. By way of preface last year you discussed with the Committee the difficulties faced by the commission in accessing documents necessary to carry

out and complete investigations properly. I am aware that that is one of the topics covered at the ministerial review. Will you tell the Committee what you consider to be the significant recommendations for amendments proposed by the Cornwall committee of which you were a member?

Ms WALTON: I think there were two quite controversial recommendations, although there was consensus by the committee at the end of the day. The first one deals with conciliation and the committee has recommended mandatory attendance for respondents to conciliation. The premise on which that has been successfully debated and accepted is that most health care providers belong to a registration board and there are complaints systems in place to ensure that they maintain standards. It is not appropriate to be able to walk away from one's responsibility to explain to people what happened and why it happened, and indeed to offer an apology.

Once we have assessed a matter for conciliation, about 50 per cent involve refusal to attend by the respondent and 50 per cent involve refusal to attend by the complainant. If complainants do not proceed, they have an opportunity to ask for a review of the assessment decision so that there is a mechanism for them. We do not want mandatory attendance for consumers because it is their right to seek to have a matter explored, or not to do so. I think that will be controversial even though the Australian Medical Association and the Nurses Association supported it at the end of the day. I do not think it was a minority recommendation. The other issue that generated considerable debate related to an additional power to enable the commission to compel production of records.

Dr MACDONALD: Which recommendation are you referring to?

Ms WALTON: It is recommendation 37 on page 37. The recommendation is that the Act be amended to grant the Health Care Complaints Commission a new power to compel the production of information in the course of an investigation. The power should be appropriately circumscribed as to the information that can be sought and the circumstances in which it can be invoked. A penalty should apply to a failure to comply with the request made in accordance with this power. The reason we want that is that unless we use our coercive powers, our search warrant powers, no other avenue is available to get information from a provider.

We can obtain a search warrant power if it is an extremely serious matter and we appear before a magistrate and provide evidence that it would warrant a finding of professional misconduct against a provider. We also have a power to get access to records with consent, but both powers involve the Commission going to some other place and exercising the power. What we want is a power which asks people to deliver records to the commission. It is not an invasion of anywhere: it is to be confined to medical records, medical reports and existing records that give information about the health care of the person; and it must relate to the complaint. It cannot be a fishing expedition, looking for general information about someone's practice. As you might imagine that was hotly debated, but at the end of the day I think it was accepted by the Committee.

In relation to penalties, in respect of a registered health provider—such as a doctor, nurse or psychologist—the penalty for failure to comply is a referral to the board so that the board will deal with it. In respect to a non-registered health provider—such as a masseur or an iridologist—we want a power to report their names in the annual report. It is a bit like a shaming technique and I know that that is archaic, but I think it is not a bad thing to do in our area. At least

we can direct the public to read the annual report and see if they have been named in it. We have no other power.

There was discussion about fines. I am not sure about the difficulty involved with that. The commission does not want to become a collection agency for fines and get into arguments about who keeps the money and so forth. I believe it would cost us more to collect than we would benefit from it. They are the two controversial aspects, if they can be called that. Most other investigative bodies, indeed the Legal Services Commission, all have powers to compel production of records. We are the only investigative body that does not have such a power. Every other commission throughout Australia—even though they do not prosecute—has power to do much more invasive things than we do.

We have argued very strongly that this would reduce a lot of the angst that the commission has in trying to cajole people to provide information. At the moment we get medical records from doctors in specific categories of complaints. This really came about as an agreement we have with the AMA and the medical defence unions to provide medical records with the report from the doctor. We do that only when we have a patient complaint and the writer of the letter of complaint is the person it concerns. The AMA has agreed that is sufficient authority for them to give information to us. They provide the records if they choose to do so. However, if we ask for them and they do not provide them, as we all know that is probably an indication that there is something in them and that we should proceed to investigate it.

The Hon. ELISABETH KIRKBY: You suggested a few moments ago that you were the only investigative body that does not have power to subpoena documents. However, given the type of documents that you would want to subpoena, do you not believe it would be more appropriate that the medical board be given power to subpoena documents, rather than the Health Care Complaints Commission?

Ms WALTON: It would not be a matter of subpoena documents because we are not into legal proceedings at this stage. It is like a power to produce: it is a production power. The issue of whether the registration board should have the power was canvassed, but at the end of the day the medical board could see problems with that because they would need a power to pass on to the commission the information they had; and whether they would want to police that rather than be the body to deal with the appeal. At the end of the day they did not push that they have that power. Indeed, that still does not deal with the problem of unregistered health providers and hospitals or other facilities from whom we seek the information. If it were merely doctors we were talking about, one might be able to say it should be given to the medical board with a power to allow the board to give it to us. But the system is pretty complex when we have to deal with all those people about whom we have complaints.

Dr MACDONALD: Does that mean that you would exercise such a power only in investigations under section 23?

Ms WALTON: Absolutely. Indeed, I strongly argued that it should be available to us from the receipt of a complaint, to help us to assess the complaint and decide whether we need to investigate. At the end of the day I compromised and agreed, on the basis that we could get some consensus, that it would be only during investigation.

Dr MACDONALD: What implications does this have for the legal rights of the

provider? If this comes before Parliament in the form of an amendment to the legislation the civil libertarians, lawyers and the medical defence unions will jump up and down and refer to the Evidence Act and other legislation and say that they are giving away material that might compromise them in terms of subsequent prosecution.

Ms WALTON: Bear in mind that we are not asking them to produce reports that they have given to their lawyers. We are seeking actual medical records, pathology reports or X-ray. They would not be compromised, except that they could hide from us of course. I think the circumstances under which we can do this would have to be prescribed. At the moment we can obtain a search warrant to do it, but it has to relate to a serious matter. We may ask for it with consent, but that does not generate a lot of success. It is only with hospitals that we successfully exercise that power. As I said, the Ombudsman and other bodies have power to require people to produce in certain circumstances. That is the balance I suppose that Parliament weighs up, the public interest and the individual interest.

CHAIRMAN: Do you wish to mention any other aspect, apart from the two controversial recommendations? I believe that having a support person at the health conciliation registry to enable a number of people to feel more comfortable about the process is an important recommendation.

Ms WALTON: Significant recommendations for improving the conciliation process have been made. Many of them are administrative and involve both the commission and the health conciliation registry. I did not push for the registry to become part of the commission. The recommendation is that they remain separate. A subcommittee of the Review of the Act Committee examined the issue of improved conciliation and mediation and, as a result of that, I have given a commitment that we will arrange for a consultant to work to develop criteria for conciliation. We do not think it is appropriate that the commission get the consent of the parties. That should be done by a case manager in the conciliation registry. That has all been supported. Two weeks ago a preliminary meeting was held with the conciliation registry and the Department of Health to progress the administrative recommendations that are not dependent on statutory amendment.

The Hon. ELISABETH KIRKBY: May I recap briefly. There seem to have been a great many complaints to the Ombudsman about your commission and the complainants have needed assistance from the Ombudsman. By comparison a department which is very much under fire at the moment, that is, the Department of Community Services, has had only one more complaint than the Health Care Complaints Commission. More complaints have been made about the Health Care Complaints Commission than have been made about the private gaol in Junee. In fact, only 23 complaints have been made about the entire New South Wales Department of Health; and only 18 complaints about the Legal Aid Commission, which has a staff of 624. I believe your staff numbers 61 but, for reasons that I find difficult to understand, 14 complaints have been made to the Ombudsman relating to your commission. Are you able to explain how that could have happened?

Ms WALTON: I am. Indeed, if you went to all those organisations and asked them what information they give to people about how they can complain about their services, you might get the answer. We give every complainant a written indication that they may complain to the Ombudsman about us. We give them information about how to do that. I do not think there are a lot of complaints to the Ombudsman but the Ombudsman has not proceeded to investigate those

14 complaints and they have been resolved with a phone call. Usually the complaints are about outcomes of our investigations or outcomes of our decisions rather than the process. We should be mindful of the fact that for every complaint to the commission there is an unhappy person. We tell them the avenues open to them to complain. Organisations that have numbers of complaints should not be punished for telling people to go and get a second opinion about how to act. It is our job to be open and forthright with consumers.

The Hon. ELISABETH KIRKBY: Would you not agree, however, that the average time to resolve complaints is still extremely long? According to your report it has only been reduced from 365 days to 318 days. People complaining are obviously in a highly emotional state about some medical accident. It is a long time to have to wait 319 days for a resolution.

Ms WALTON: I agree with you. A perennial problem of the commission is the length of time investigations takes. The commission has spent all its administrative energies going into how to improve investigation time frames. I might add though that 80 per cent of the complaints get dealt with quickly. I am talking now about those that are into investigation. We had external evaluation. We now have benchmarks for investigations and it is accepted that 18 months is the outside time frame within which we can do an investigation for many reasons. For instance, the time frames we have to give respondents under the Act to reply; not being able to proceed to an investigation without a statutory declaration and the amount of time that takes to get one; and no power to produce records during an investigation.

We now have an investigation committee with staff representatives on it to try to identify different ideas about how it can be progressed. Caseloads used to be around 140 and we have now capped them at 40. In the past we substantiated approximately 30 per cent of complaints and we are now substantiating more than 45 per cent of complaints, which means they are probably more complex and we are better at them so we are getting better results for people—fairer results indeed. The short answer is, yes, we do take too long and we are all very aware of that. We are aware of the distress it causes everybody and we are trying our best to manage that. It is not only the Commission that has this problem; it is a perennial problem when one gets into legal systems and administrative procedural issues.

CHAIRMAN: A 15 per cent reduction in time is worth achieving even though in absolute terms it is still a long time. The 15 per cent reduction in average time is a feather in the cap of the Commission for this past year.

Mr ANDERSON: Could the report give a fairer reflection of the times taken to resolve complaints, to break the figure down a little more rather than having that overall figure? For instance, it could state that such and such a percentage of claims are resolved within a certain time frame.

Ms WALTON: Yes, I agree with you. That is why we introduced the new category "average time to investigate" rather than other categories of complaints.

Mr ANDERSON: I am sure that the majority of your complaints are resolved fairly quickly. It could be shown at a glance that a few complaints are more serious in nature and take a lot longer to resolve.

Mr RIXON: A distribution graph could show what is happening. One or two

difficult cases to solve could skew your final result.

Ms WALTON: These are the perennial arguments of how it is measured in the commission. If there is one case that is four years old for many reasons that could skew it. This graph shows the closed and received complaints for this half year. We are pretty constant with the complaints we have received. We are continually closing more investigations than we open, thank goodness.

Dr MACDONALD: Is that an inherent problem because of the nature of the work that you do? Is it because of a need for operational streamlining or do you need more resources?

Ms WALTON: It is yes to all of those. We have made a submission for more investigation officers in our enhancement bid. We can always use more resources. But I am also mindful that we have to compete for those along with everybody else. It is the nature of complaints, especially when you do not know what you are going to uncover in an investigation. Investigations can blow out or not comply with the investigation action plan that everyone has. There are many reasons why that just does not follow suit. For instance, the tardiness of a peer reviewer when you ring him or her every month to say, "You said you would get it back." That can draw out to three or six months.

Yes, we can still improve. The approach of the commission is one of continuous improvement. If someone has a good idea we are encouraged to try it. Now the deputy commissioner chairs an investigation committee on which are the heads of each team plus a staff representative from each team. One suggestion I have asked them to examine is to actually have a current caseload for everyone. When a case exceeds the prescribed time frame we give it a different status and transfer the file out so there is some meaning to a delayed file. That is one option, and I am happy to receive staff suggestions. At the end of the day staff have to manage the cases and we need to support them to do it.

Dr MACDONALD: The role of the Committee in my view is to be an advocate for the Health Care Complaints Commission. As well as having a critical role it should be supported. You have put in a budget bid for additional resources and I feel that this Committee should have some role in evaluating whether that is justified. Are there any other organisations that you could measure yourself against to determine whether you are really doing the job well?

Ms WALTON: I appear before the budget officers group—before whom all the CEOs appear in relation to benchmarking of complaint handling.— I am part of a national group of commissioners. We have got Commonwealth funding. We are now attempting to benchmark complaints so we will be able to get some information in the future. In relation to other matters like administrative costs, legal costs, we do much better than any of the other government departments primarily because, say, with legal fees we will not pay excessive senior counsel rates. We will not pay more than $2,000 whether they are senior or junior counsel. That has not affected the quality of the legal advice we are getting, and most silks will do work for us on that basis.

We also used to have two peer review reports to whom we used to pay VMO rates. We have worked with the colleges and now we get one peer review. The Medical Defence Union, the medical board and the other boards agree with this approach because we want to stop the shopping around approach. We now pay a flat fee of $305.50 or whatever. That has saved us more than a quarter of a million dollars. We are doing a lot of productivity savings inside our

organisation, in my view, to justify a request for enhancements. There is just no fat in our place.

Mr RIXON: Are you your own worst enemy when applying for extra funds? From looking at that graph you gave us earlier you are completing more cases each year than you are actually receiving. You will have a hard argument if you say that you need more staff.

Ms WALTON: We are doing a better investigation, identifying the problems sooner and quicker. Indeed the investigation time frames used to be more than five years, if some of you recall, four or five years ago. Forty-eight per cent of the complaints have been substantiated. That is a very high percentage of any caseload which means that we had to cross the t's and dot the i's and we are maintaining our prosecution rate. It is not as if the work is dwindling away; the outcomes are still more significant than they were. We are being better assessors of investigation; we are doing it better; we are getting a better outcome in terms of substantiation; and we are maintaining prosecution, so we are getting better at our job.

Mr RIXON: You are getting better but you still want to get better?

Ms WALTON: We did an enhancement process to get the time frames down for investigation. The enhancement is for two senior investigation officers and a hearing officer. We have funded the hearing officer position out of a vacant investigation officer position because the medical board and the other boards wanted us to have one person—not allowed to be a lawyer—to prosecute the case so that he or she gets used to the procedures. To fund that we needed to find the resources and we have done that. Everyone thinks it is a very cost-efficient way of doing it. We now want some permanent funding to do it so I can go back to putting on the staff member we always had that we could not use. The same applies to policy operations. We need to have a person to monitor trends in complaints and look at policy issues. We have used a grade 7-8 investigation position to do it but now we do not have any more savings to do it. My argument to the Treasury is that since we started we have had no major enhancements to our core funding, apart from the patient support officer, and we need some support now.

The Hon. ELISABETH KIRKBY: You said that you have had no increase in your funding. I realise you are dealing with Treasury officials who are very hard headed and do not like giving out money. However, on your own figures in 1995-96 you had 23 people dealing with complaint investigations. In 1996-97 there was a drop in staff to 20 but in 1995-96 that staff complaint ratio was 9.8 complaints for each member of staff. I cannot believe that any Treasury official is going to look at that figure and say that you need more money. It appears that the workload may be lengthy and I agree that some of these complaints will take a long time for you to reach an outcome. However, a complaints ratio of 9.8 for each member of your staff would not be considered by many people, certainly not by Treasury, as an overwhelming workload.

CHAIRMAN: Where is the 9.8 figure in the annual report?

The Hon. ELISABETH KIRKBY: The total number of complaints in the report is 1,551 and the total number of complaints actually under investigation is 487. That is a large increase because in the previous report there were only 227 investigations. Staff numbers have gone up. I am not taking into account the patient support officers because, as the report says and as the commissioner has explained, they assist members of the public—they are not investigators.

CHAIRMAN: I know we had the other figure of investigation officers and their workload capped at 40 cases, so there is a big discrepancy somewhere.

The Hon. ELISABETH KIRKBY: Take the number of complaints and divide it by the number of staff.

CHAIRMAN: You may wish to comment, Commissioner.

Ms WALTON: I will read from the table. Which page of the report are you referring to?

Mr NEILLY: A summary of staff is on page 72 and page 90 gives staff details.

Ms HALL: Also, page 16 has the total number of cases and the total number of complaints lodged and under investigation.

Ms WALTON: I have a table here that is not in the annual report but has been produced for today's hearing. It shows the number of investigation complaints open. As at January 1995 there were 1,507, January 1996, 1,219—so they are decreasing—January 1997, 864 and January 1998, 773. I do not know where the 200 investigations for 1996 come from that were just mentioned. Perhaps I need to take the question on notice because I am a little confused.

CHAIRMAN: Yes, because we need to know the source of the figures. The figure of 773 at 31 January 1998 is complaints under investigation at that time?

Ms WALTON: Yes.

The Hon. ELISABETH KIRKBY: Not closed?

Ms WALTON: They are open right now.

Ms HALL: They are not the ones that have been dealt with in the year. They are what you are looking at now?

Ms WALTON: Yes, as at 31 January 1998 we had 773.

Mr RIXON: Could some of those complaints date back a number of years?

Ms WALTON: I can give that breakdown. At 1998, complaints dating back under 18 months 551, 86 for two years, 92 for three years and 44 for four years, and none for more than four years. In 1997, six complaints dating back more than four years, 38 for four years, 164 for three years, 111 for two years and 545 for 18 months. I can give the figures for each year.

CHAIRMAN: Would you table the sheet that you are reading from?

Ms WALTON: Yes.

Mr NEILLY: I have had great difficulty in marrying up the individual tables in the statistical section of the report. An operating business would conventionally start with opening

stock, then add purchases, deduct sales and wind up with closing stock. But it is difficult to get any semblance of sequential numbers from what is contained in the report. To illustrate I refer to page 14 of the report, table 10, headed "Total complaints under investigation as at 30 June 1997 according to year the complaint was received". I presume that refers to the relevantly dated years in the table. At page 16, table 15 is headed "Types of complaints lodged in 96/97 under investigation according to type". In reality table 15 refers to the number of complaints under investigation according to type as at 30 June 1997 rather than the way it is headed, because you certainly had more than 487.

Ms WALTON: Yes, but they are only those complaints that are raised in that year. There were 227, so the total is 885.

Mr NEILLY: Strictly speaking, that table should be headed "complaints lodged in 1996 and remaining under investigation as at 30 June 1997". If it is taken in conformity with table 10 at page 14 it shows the same 487.

Ms WALTON: That is exactly right and the total of complaints under investigation as at 30 June 1997 is 885. The totals shown on table 10—52, 119, 227 and 487—are the total number of complaints under investigation.

Mr NEILLY: They are residual complaints from those years.

Ms WALTON: That is right.

Mr NEILLY: How do you integrate table 10 and table 16? Table 16 indicates that significantly more complaints are being finalised than are received.

Ms WALTON: They are closed. That is why they would not be under investigation.

Mr NEILLY: I realise that. But it is difficult for the uninitiated to sort out what complaints are received, how many are finalised and what is the residue. I have the explanation now. Looking at table 16 one would think that you are steamrolling through the complaints, which is not the reality.

Ms WALTON: No, because those 1,899 would be closures from not only that year but also from previous years.

Mr NEILLY: Yes. So all in all, there remained 487 as at 30 June 1997?

Ms WALTON: No, 885. That figure of 487 is the ones just received.

Mr NEILLY: If we aggregate those figures, you have resolved all complaints prior to 1994?

Ms WALTON: That is right. Table 10 shows complaints received in the years 1994, 1995, 1996 and 1997.

Mr NEILLY: I suggest that the heading could have been better worded.

Ms WALTON: I agree, we should have had an aggregate.

CHAIRMAN: I refer to the medico-legal conference that was held in Sydney a fortnight ago in which the Chairman of the Legislative Council's Standing Committee on Law and Justice, the Hon. B. H. Vaughan, is reported to have said that judges have stated that they cannot trust medical experts and that the credibility of competing medical experts was at risk. Can you comment on that from the point of view of the commission's work in prosecuting cases before tribunals and also from the point of view of the peer review and peer assessment processes that are at the heart of the commission's work in assessment and investigation of complaints?

Ms WALTON: Peer review is at the heart of our assessments. When consumers are unhappy with our investigation outcomes, 99 per cent of the time it has come down to the opinion of the peer being that the complaint is not sufficiently serious enough to take disciplinary action. That says to me that the commission has an obligation to make sure that the peer review system is transparent and has some integrity. That means that we have to train our peer reviewers, because some of the reports that we are getting whitewash the complaint. However, we are dependent on peer reviewers. Therefore, it is our responsibility to make sure that we do not get reports of insufficient quality.

I have talked to people at all the colleges that now support the peer review reference panel. To become a member of the peer review panel now providers have to be in, I think, more than 75 per cent full-time clinical practice; participate in peer review; be members of a continuing education program; attend a face-to-face interview with me, the Deputy Commissioner, head of operations or one of our medical advisers; and attend training seminars. Also, providers must have no complaint history that is sufficiently serious to expel them from the panel. Having said that, it still does not mean that we get the quality we need in 100 per cent of the reports. A peer review panel committee has just come into place which vets and evaluates our reports in a quality assurance way. Because, as I said, we have cut down from two peer reviewers, we have an additional obligation to ensure that we get it right.

There have been some difficulties with the effectiveness of the peer review system in hospital-based complaints. For example, we may receive a complaint from a person who has had a fracture of the neck, is misdiagnosed in X-ray and is eventually transferred to another hospital with dramatic consequences. When each of the segments is sent to a radiologist, a surgeon or somewhere else, they all say that for each bit of care the standard was not that bad. But commonsense would tell you that the hospital did not treat the person well. We are trying to grapple with this issue at the moment. How do we deal with peer review in that system? Who owns the problem? We have canvassed these problems with our peer reviewers. For every case study we give them, we receive six views about who should be responsible.

There is a problem with the maintenance of the peer review system. We are letting it work and we are bedding it down. But I have approached the President of the medical board to look at the possibility of funding a secretariat to establish a peer review panel that is independent from the commission. That is a longer-term project that I am looking at and I am getting the colleges involved. That may provide an avenue for medical negligence people to select a peer from an accredited peer review panel. People who want to be on that panel will be accredited and will receive appropriate training and education. At the moment our resources are stretched in

trying to do that.

CHAIRMAN: Does the Deputy Commissioner, with her legal background and experience, have any comment on this issue?

Ms HIGGINS: Not at this stage. The Commissioner has outlined the steps that have taken place in addressing the issues.

CHAIRMAN: At the same conference Chester Porter, QC, was reported to have told the conference that to avoid allegations of sexual misconduct male doctors might reinstitute the old practice of having a chaperone present when giving women internal examinations. In the report sexual misconduct is shown as a continuing problem. What countermeasures is the commission considering taking to reduce the incidence of that problem?

Ms WALTON: There is a developing concern about allegations of sexual assault that present when a gynaecological or rectal examination is being done by a provider—not only by doctors, because we have had complaints against chiropractors. Medical defence unions advise doctors to have a chaperone present certainly with intellectually disabled people and young adolescent women. There is resistance to doing that. I support the need for a chaperone in those circumstances. I do not think that there is any circumstance though that should prevent a doctor explaining to a person why he or she is doing an examination. Even if a chaperone is present, it does not mean that a provider should not explain the purpose of an examination, any discomfort that may be felt and ask for consent. Also, a provider could ask whether a sheet or gown is required, or whatever.

We are getting increasing complaints about this area, which is very difficult to investigate. For example, a provider may take a very long time to do a pap smear and the allegation may be that some sexual gratification is attached to it. In reality, it may be because of the provider's incompetent use of a speculum. It is an area in which we are trying to be educative. These are the types of complaints that we have lost before the medical tribunal—a doctor has given another explanation as to the examination, even though we think there was some sexual gratification from the examination. It is a difficult area. We have produced two pamphlets—one for health providers on sexual misconduct and boundary issues and one for patients and consumers—which I will make available to the Committee. I am surprised complaints are still coming in about sexual misconduct, in particular for medical practitioners. They are on notice; the medical board has issued a directive that it is professional misconduct to get sexually involved with patients. Basically we have to accept that it will occur and be really hard on them when it happens.

CHAIRMAN: Page 50 of the report refers to the establishment this year of the position of complainant liaison officer. Is sexual misconduct the main focus of the casework of that officer?

Ms WALTON: Yes, it is. We employed that person primarily because of complaints about the commission. We had to get into an adversarial situation, but complainants felt a bit isolated and that they were not part of the process. They wanted the lawyers who were preparing their cases to be available to them. In my view lawyers are compromised if they are counsellor and support person as well as prosecutor, so we introduced this position, which has

been very successful, and we sought funding in our enhancement package to make it a permanent position.

Mr NEILLY: The report refers on pages 50 and 51 to a 14-year-old girl who appeared before the medical tribunal. The commission made a comment at the conclusion of its report about the processes that have been put in place by way of recommendation to obviate such occurrences in future. No comment has been made about what the girl encountered when she appeared before the tribunal. Does the commission believe the tribunal handled the matter in the most appropriate fashion?

Ms WALTON: We are in a difficult position, being like a prosecutor before a court. We made submissions on behalf of the girl for a screen so she could be protected during her cross-examination, but that was refused. We made submissions to the medical board, which made written submissions on our behalf, about the delay in delivering the judgment. We protected her in cross-examination as much as the law permits. I am very vocal about the difficulties complainants have in going through an adversarial situation. She was a particularly young girl, which made it more gruelling. But it is equally hard for adult women. We do our best to prepare them. We take them to the tribunal room beforehand. I met with this young woman, because I know it was difficult for her, and I asked her if she would like to share her feelings. I said we would publish it for her as a salutary reminder to the bench, whom we would send it to. She did not write about it. We did not direct her what to write, we did not edit anything she wrote. We just said we would publish it.

Mr NEILLY: Do you believe any changes should be made to the format in which the tribunal conducts these hearings?

Ms WALTON: There can always be improvement, but I am also mindful of the rights of the provider, especially in sexual misconduct cases. This jurisdiction is not like the criminal area, even though many barristers who act for the doctors think it is the criminal area and try to move it into that arena. We fight very hard to keep it out of that arena.

Mr NEILLY: I am aware of a situation which involved a choice between proceeding on criminal charges or proceeding through the tribunal, and the choice was made to proceed through the tribunal. The doctor concerned got away with it, but was subsequently charged with criminal offences arising from another incident and was convicted. The procedure in the tribunal is almost like that in a criminal case.

Ms WALTON: It is very adversarial and it is fought very hard, and the tribunal is loath to strike someone off. It is not only on the balance of probabilities, it is much higher, to the criminal standard—the Brigginshaw test. The commission would like to hear about a doctor who is convicted of an offence.

Mr NEILLY: That doctor was struck off in Victoria before he came to New South Wales.

Ms WALTON: Is he still practising?

Mr NEILLY: He is no longer practising because he has been convicted and has now been struck off.

CHAIRMAN: Page 68 of the report outlines the establishment of the Consumer Consultative Committee during the report year. What are the terms of reference of that committee? Are members of the committee satisfied with their role on the new committee? Some members of the Consumer Advisory Committee, which was disbanded a couple of years ago, were disgruntled about their role on that committee.

Ms WALTON: I table the terms of reference and the code of conduct for the consultative committee. The new Consumer Consultative Committee first met on 6 May 1997. It subsequently held meetings on 5 August, 5 November and February, and the next meeting is scheduled for 6 May. Some of the issues we have discussed with them include the prisons strategic plan, the Aboriginal and Torres Strait Islanders strategic plan, the disability action plan, impotency clinics, review of mental health care in emergency departments, the management review that this committee organised through Coopers and Lybrand, review of the Health Care Complaints Act, sexual misconduct leaflets and distribution sources, revision of a patient rights brochure which we are about to print, the election of a Chair for the independent complaint review committee, the *Health Investigator* journal—I will table two of our journals, and we are about to publish a third—the statewide data modelling project and the ministerial committee on quality.

Committee members include the Aboriginal Health Resource Co-operative, the Australian Association of Welfare and Child Health, Australian Consumers Association, Combined Pensioners and Superannuants Association, Council for Intellectual Disability, Council on the Ageing, Mental Health Co-ordinating Council, Network of Alcohol and Other Drug Agencies, New South Wales Council of Social Service, People Living with HIV-AIDS, People with Disabilities, Public Interest Advocacy Centre, Women's Health Resource and Crisis Centres Association, Youth Action and Policy Association.

The committee has been working very hard and has provided written comments on most of our publications, and there has been absolutely no distraction from the task at hand. We have also created a health reference panel, which includes other consumers. The Minister will open our first meeting of the health reference panel on Friday, 27 March. It is open day for half a day at the Southern Cross Hotel from 9 o'clock to 1.15 p.m. We are inviting 100 consumer organisations to listen to a program about the commission and identifying key organisations like Diabetes Australia that they would like to be involved in terms of policy development. It is a much more considered approach to consulting with consumers. It is much more productive both for them and for the commission.

CHAIRMAN: Is the health reference panel a body which belongs to the commission?

Ms WALTON: Yes.

Mr NEILLY: Page 12 of the report refers to the development of the prisons strategic plan, and the number of complaints in respect of the commission's health service increased from six to 10. Prisoners know the ropes and they have generally better access to the Ombudsman than do most members of the general public. Have those complaints primarily been directed to the commission or have they been sieved through the Office of the Ombudsman to the commission?

Ms WALTON: The Office of the Ombudsman mainly refers complaints to us. As

a pilot scheme the Patient Support Office will conduct an outreach program like the Ombudsman's office one day a month or a fortnight at three prisons. At the moment we refer complaints to corrections health, but we have taken on board some broader policy issues on the standard of health care, say, for the women's prison at Mulawa. We rarely investigate those complaints in the commission.

We received a complaint from a prisoner support group or action group about the commission's access to that population, and we responded by discussing with the Ombudsman and corrections health a Patient Support Office outreach program to be run on a monthly basis. That has been well received and accepted by everybody. We can deal with counsellors who are employed by Corrections rather than the health system as well, because they come under our jurisdiction. At the moment we have about four serious complaints about psychologists who have been sexually involved with prisoners, so there is an issue of reminding them about professional ethics.

Mr NEILLY: Does the Office of the Ombudsman deal with complaints by prisoners in respect of medical services?

Ms WALTON: Not to my knowledge.

Mr NEILLY: So the figure of 10 is indicative as a total, but there is a suspicion that there are more than 10?

Ms WALTON: That is correct.

CHAIRMAN: I refer to pages 36 and 37 of the report, in regard to conciliation. There has been a decrease of 30 per cent in the number of outcomes of conciliation in the present year—from 122 to 82. Are you aware of any trends that might have been responsible for that decrease?

Ms WALTON: No, because the only information the conciliation registry provides to the commission is comments, agreement reached, or failed to reach agreement. When the parties fail to reach agreement there is an opportunity to find common ground, voice concerns, and obtain a clarification of the issues without necessarily reaching agreement on the matters in dispute. Where we have actually had "reach agreement", that does not mean they have reached agreement; it means they have got together and talked about it.

No clear patterns are evident in predicting the likelihood of a successful meeting or of anticipating that they would fail to reach agreement. The health conciliation registry conducts an evaluation of the parties to the conciliation after each meeting, and those results might assist in identifying it. From memory, after talking with the registrar there is more than 70 per cent satisfaction from both the parties. The current figures are better. As of 2 March 1998, agreement was reached in 80 per cent of all conciliations. That is an improvement from the 68 per cent in the earlier reporting period. Twenty per cent failed to reach some agreement. In 2 per cent of cases the complainant failed to attend conciliation, in 2 per cent the complainant cancelled—and we are talking about two people—in 4 per cent the complainant withdrew the consent once it was referred, and in 3 per cent the respondent withdrew the consent once it was referred. In one case the parties came to their own agreement prior to the registry having to convene the conciliation. When the parties do not turn up or do not agree, they are referred back to the commission.

CHAIRMAN: I believe that of those surveyed regarding their unwillingness to enter conciliation, a majority doubted that the conciliation process would be able to assist or provide benefits. Is there any way to address that problem?

Ms WALTON: By the time a complaint reaches the commission many complainants do not want to talk to or see the person, they are so distressed, intimidated or annoyed. Those results, though, are not atypical of all conciliations. Forget health, if you look at industrial and other areas of mediation, the information provided to the Review of the Act Committee was that is not atypical.

CHAIRMAN: Table 6 on page 12 of the report shows a significant increase in the number of complaints about medical centres. Can you provide a breakdown of the nature of those complaints, or do you believe they follow the same pattern as other medically related complaints?

Ms WALTON: In terms of predominant category—clinical standards—they follow the same pattern. For example, 54 per cent of all complaints are about clinical standards, 5 per cent are about patient rights, nearly 3 per cent are about prescribing drugs, 24 per cent are about quality care and 11 per cent are about business practices. If we break down further the complaint type it is mainly incorrect diagnosis as a result of speed of consultation, not taking a proper history and not spending sufficient time with the patient. Subsequently the patient goes to another treating doctor and is properly diagnosed. The patient then becomes annoyed and complains about the quality of service given at the medical centre. In relation to medical centres, and it is not contained in a table, 102 complaints relating to general practice have been categorised differently because a complaint has been about a doctor and not about the medical: 102 doctors who were complained about work in medical centres. Three complaints related to obstetricians and gynaecologist, three to surgeons and one to a physician. In addition to the named medical centre, we identified other health providers working in a medical centre, so the problem is even bigger than the complaint against the medical centre.

Dr MACDONALD: Is it possible to pass some judgment on whether there are more complaints for services rendered in public hospitals versus private hospitals? Clearly the vast majority of complaints in the hospital system come out of public hospitals, but they treat a lot more patients and have a lot more beds. It would be interesting to break it down to determine whether the figures tell us anything about the two parallel systems. Perhaps some areas of the community make an assumption that more abuse occurs in private hospitals but in some way they are shielded against public scrutiny. That is not something I believe.

CHAIRMAN: If I could interrupt before that question is answered: the statistics may not be reliable enough—they may be too small—but the percentage of the total number of complaints in private hospitals has risen from 5.5 per cent in 1994-95 to 7.8 per cent of the total number two years later, which is a relative 40 per cent increase. I wonder whether that is a trend. That is basically the same question.

Ms WALTON: There are certainly no more private hospitals, so we cannot relate it to an increase in private hospitals. I think that much more attention is given to patient concerns in terms of making complaints and addressing problems when they occur. In keeping with the competition policy requirements for accreditation, the Private Hospitals Association has an agreement with all its member hospitals that they have complaint policies and that they refer to the old complaints unit, now the commission, certain categories of complaints.

CHAIRMAN: They may be giving better publicity to their patients' rights?

Ms WALTON: Some structural mechanisms are in place that are not as firm in the public system.

The Hon. Dr B. P. V. PEZZUTTI: Tables 6 and 7 refer to complaints received. On page 39, tables 35 and 36 refer not to complaints received but to what happens to them. In other words, 47 per cent—almost 50 per cent—of complaints that are investigated are not substantiated whereas all that is listed is what happens to the complaint and how many there are. Tables 35 and 36 indicate complaints you investigate and what happened to them. Of the complaints investigated 50 per cent were not substantiated. In table 6, how many complaints against various levels came to anything of substance, that how many were referred to the board or the professional body, or how many were substantiated? Could you indicate what the figures in table 6 might be if they were substantiative complaints?

Ms WALTON: Table 6 refers to complaints against health facilities.

The Hon. Dr B. P. V. PEZZUTTI: Yes. How many of those 299 complaints against public hospitals were substantiated after investigation?

Ms WALTON: I would have to get back to you on that and have a tabulation done on the computer.

The Hon. Dr B. P. V. PEZZUTTI: Could you give the Committee some idea of how many of those complaints were investigated, or did you send them straight back for local settlement?

Ms WALTON: If they comply with section 23 we would investigate them. Off the top of my head I cannot tell you how many investigations of public hospitals the commission carried out.

The Hon. Dr B. P. V. PEZZUTTI: That would be a key thing to know. Of the 299 complaints perhaps only 90 were investigated. If you look at the figures, only 40 would be substantiated. That would give the people a better understanding.

Mr RIXON: Could I seek clarification on that? From what you said earlier I understand that those two tables cannot be directly related in that way?

Ms WALTON: That is exactly right.

Mr RIXON: Table 35, the 336 complaints that were not substantiated in that time, could relate to two or three years previously, although unsubstantiated claims would probably be closed fairly quickly?

Ms WALTON: Not necessarily.

Mr RIXON: Whereas table 6 refers to complaints from that year?

Ms WALTON: Yes, that is exactly right.

The Hon. Dr B. P. V. PEZZUTTI: That is a problem I have always had with the figures that the commission adopts. Every year the annual report shows an increase or a decrease in the number of complaints against this person or that person. But it is only some years later that we find out how many of the complaints are real and problematical. It is important for the people of New South Wales to understand how the health system operates in relation to substantiated complaints when action is taken. I have a real problem with the presentation of the report. I would like to see a comparison of the complaints and how many were substantiated from the closed years, perhaps as far back as 1994.

Ms WALTON: We are happy to do that. We report what the Act requires us to report. The Act says this is the format it wants the information in: the number of complaints received, the number of complaints outcomes, the number of investigations. Over the years, as a result of this Committee, the commission has added additional tables, such as the number of years in which the complaints originated.

CHAIRMAN: That is a topic on which we could have an informal discussion at some stage rather than in this hearing. We can then develop ideas on how to find out the detail we seek. Is that reasonable?

The Hon. Dr B. P. V. PEZZUTTI: It is. All complaints that are published—299 against the public hospital system—may well turn out to be 35 of any substance that would effectively be of concern to the people of New South Wales. The number of complaints tells us a bit more about the system. Do you agree with that?

Ms WALTON: Yes. It may well be that we need to totally separate investigations and have a separate reporting section that analyses public hospital investigation outcomes, doctor investigation outcomes, et cetera.

Ms HALL: Similarly, you could find that certain types of complaints were all substantiated whilst others were only partially substantiated. A whole new reporting format may be needed, and that is something that we should discuss at a later time.

Ms WALTON: A lot of it is dependent upon the capacity of our computer.

Ms HALL: I am sure you remember that last year and the year before I asked about the cases that were reopened. I note that the report refers to 176 requests for review. At a glance I cannot pick up the reopened cases. Are the only cases reopened those that were reviewed, or is there a separate section with a table that tells me the number of cases that were reopened?

Ms WALTON: Can you remind me of the page number?

Ms HALL: I looked at table 16 on page 16, which talks about the total number of cases. Then I flipped over and the only place I could find anything that would mildly bring in line cases that were reopened was on page 47. The second paragraph refers to 176 request for review. I could not see anything that jumped out at me that showed me how many of the new cases were actually reopened. I thought that was something that would be recorded. Perhaps I have missed it.

Ms WALTON: Page 47 has two tables.

Ms HALL: Yes, I see those.

Ms WALTON: Table 46 shows that 28 cases were reopened for investigation, so that answers your question as to how many were reopened for investigation.

Ms HALL: That answers my question.

CHAIRMAN: While we are looking at tables, I refer to table 7 and Figure 8 on page 13, which are essentially the same information. I am concerned about the category "other" which contains one quarter of all the cases we are considering; in other words we are blind about one quarter of all the cases. The "other" category has increased dramatically from the previous year. Can you give me any examples of what might be under "other" in complaints against public hospitals?

Ms WALTON: I can. I have a list of what "other" consists of. They are individual complaints of ambulance, anaesthesia, cardiology, community health, drug and alcohol service, gastroenterology, five for general physician, nine for gerontology, haematology, infectious diseases, intensive care, midwifery, neurology, nuclear medicine, ophthalmology, palliative care, paediatric medicine, pharmacology, physiotherapy, prosthetics and orthotics, rehabilitation medicine, respiratory, radiology, social and welfare work, and two for waiting lists.

CHAIRMAN: Waiting lists are already listed.

Ms WALTON: Yes. The "other" are those that comprise 1.3 per cent of a complaint. When I inquired about it this morning I was told that it would be meaningless to generate 1.3 of a complaint, so they have all been lumped together.

CHAIRMAN: Some 73 things comprise one complaint category?

Ms WALTON: From all those different departments, yes. Two from pharmacology, seven paediatric medicine. Next year we will have some examples of what comprises "other", which might help to explain it. We might even revisit that and if there are five or more complaints we might give them a specific category. Those under five will then be put in "other" with a definition that it includes less than five complaints and we will give examples.

Ms HALL: I should like to return to page 47. I did not ask how many cases that were asked to be reviewed were reopened, but does any section, other than this section, show the number of cases that were reopened and how many of the current cases reflect the number of cases that were reopened? I understand that that information was to be included in the report.

Ms WALTON: We would only ever reopen a file through a review process.

Ms HALL: That is the answer I need. They are the only cases that have been reopened.

Ms WALTON: Yes. It may well come from my interviewing the complainants, then we reopen the file or whatever.

Ms HALL: That is fine. That is the answer I wanted.

Mr NEILLY: It appears that reviews are running at about 9 per cent to 10 per cent of cases finalised. Is that trend consistent with previous years?

Ms WALTON: Increased requests for assessment reviews are a good thing because the Act is encouraging people and making it easier for people to ask the commission to think again. The figure has increased significantly. It used to be 1.5 per cent. The trend is to increase because the community wants the commission to investigate; that is the bottom line. People come to the commission expecting an investigation. When we put up other assessment options like the Patient Support Office, conciliation or, indeed, the area health service investigating the complaint I understand why they are concerned, but our resources just could not deal with it.

Mr NEILLY: I notice that in 1995-96 185 reviews were completed. You say it has increased. Is that since the inception of the commission?

Ms WALTON: Yes, we did not have a capacity to review then.

CHAIRMAN: Page 72 of the report refers to the national health care complaints conference that was held in Sydney. I compliment the commission on organising that successful national meeting, and I hope that there will be a follow-up conference in a year or two so that contact can be maintained between the State and New Zealand bodies involved in this issue.

Ms WALTON: The next conference will be held in Tasmania next year.

The Hon. Dr B. P. V. PEZZUTTI: The number of complaints, on page 10, has increased slightly over the years on average and the number of complaints against professionals has decreased. On page 39, table 36—I know they may be from different years—the types of complaints received and investigated was only 420 and you received 1,500 complaints. Are they comparable figures?

Ms WALTON: Page 14, table 10—there are some deficiencies with the table—outlines the total complaints under investigation, which is 885. We have 487 investigations arising in the year 1996-97, the subject of this annual report. Equally, the number of investigations—227, 119 and 52—is being investigated, but they arose in other years.

The Hon. Dr B. P. V. PEZZUTTI: The fact that the figure is 487 versus 420—

Ms WALTON: We take on only 25 per cent of all complaints.

The Hon. Dr B. P. V. PEZZUTTI: If someone complains and you say, "We have looked at this and we are not going to investigate it", how many ask for a review? When you then review them, how many do you investigate then?

Ms WALTON: Page 47, table 46, shows the outcome of investigations following a review, and table 45 is the outcome of review. In those you will see that 15 per cent went to investigation after we reviewed them.

The Hon. Dr B. P. V. PEZZUTTI: Is that only ones that beforehand you had said that you did not have the resources for?

Ms WALTON: We ask: does this meet section 23 of the Act? If it does not, what is the best way to resolve this complaint? We have a conciliation, patient support office or area health service investigate it. We will then do that. The complainants are told that they can have a review of that assessment. When we reviewed them, 28 went on to investigation because we had additional information or we thought longer about it and were convinced.

The Hon. Dr B. P. V. PEZZUTTI: And that would be included in the figure reported as types of investigations received and investigated?

Ms WALTON: If it is an open investigation it is captured then.

The Hon. Dr B. P. V. PEZZUTTI: So one in four or one in five get investigated.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: What happens with the other four out of five? You handle them all, you send them off to see someone or they get counselling. Does that mean that they are not serious problems?

Ms WALTON: No. When we refer them to an area health service for investigation under section 26 of the Act we ask for a report back. We are starting to put some resources into monitoring the quality. We have taken over and investigated a number of those because we think there is a still a problem. Some of them have been inadequate and instead of us taking it over we have said, "You have not done this and we suggest you do."

The Hon. Dr B. P. V. PEZZUTTI: If they do a good job and come back to you with an answer, do you say, "Based on your investigation, we believe we should take over this investigation"?

Ms WALTON: We will do that, yes.

The Hon. Dr. B. P. V. PEZZUTTI: Does that happen very often?

Ms WALTON: This year we have had two referrals from an area health service on assault allegations. They have done an investigation and notified us. We have said, "You complete it—because it was not a registered health provider—give us your report and then we will determine whether we need to get involved." If the system is doing it well, we want to encourage it to do it well.

The Hon. Dr B. P. V. PEZZUTTI: If they uncover a significant issue in the middle of the investigation, do they refer it back to you?

Ms WALTON: Very rarely. We might take it over and say that we will do it.

The Hon. Dr B. P. V. PEZZUTTI: You keep in touch with what is going on?

Ms WALTON: Yes. I suggested to the CEOs that in return for us referring matters to them that we provide training for them and a procedures manual, but some of them have raised the issue with me that they will never retain the expertise because the people responsible, such as the clinical directors, move on. It may be appropriate that, in a way, the commission does

them, but we look at some alternate resourcing of that by the area health services. We are preparing a paper looking at whether there are barriers to this.

The Hon. Dr B. P. V. PEZZUTTI: You would have investigations for hire?

Ms WALTON: Sort of.

The Hon. Dr B. P. V. PEZZUTTI: So if they wanted you, for a contract price, you could do the investigation?

Ms WALTON: The consumers would like that, but there may be conflicts of interest. We are exploring that.

CHAIRMAN: Are there any other pieces of information or statistics that you would like to table before the Committee?

Ms WALTON: Yes. I refer to the *Health Investigator*—the third one is at the printers. To date we have raised $6,000 from subscription fees from area health services—and Committee members get one free.

CHAIRMAN: How much is it?

Ms WALTON: It is $100 for one copy of four editions a year; $200 for five of these four times a year; and $300 for 10 copies of these four times a year. It has been well received by consumers and providers. It is the first of its type in Australia—we go into disciplinary cases, standards of care and peer review. We are seeking comments.

The Hon. Dr B. P. V. PEZZUTTI: Are you generally happy with professional boards, standards committees and tribunals? Are you comfortable with the results you are getting from your investigations and prosecutions? Do you think that the penalties are adequate?

Ms WALTON: We will always appeal them if we think they are not. We are successful in 95 per cent of prosecutions. The boards—other than the medical board and nurses board—need major work in terms of disciplinary structures. In fact, even the nursing and medical Acts need to be amended to bring them up to date with current issues. For example, we can deal with matters only retrospectively rather than look at proactive audits—not that the commission should do it; the board should do it.

The Hon. Dr B. P. V. PEZZUTTI: When the medical and nursing boards deal with things a lot of effort has gone into getting them right because they are the majority of providers against whom complaints are made. Are you happy with the end result—that is, the penalties for the proven offences?

Ms WALTON: Yes, I am.

Mr NEILLY: Page 13 relates to complaints alleging fraud but it does not typify the nature of the complaints. Can you give us an illustration of the sort of fraud involved?

Ms WALTON: Charging for services not rendered—such as medical services—and medifraud where it is referred from the review committee under the national health insurance legislation.

Mr NEILLY: So that is passed on federally and you act only as an intermediary?

Ms WALTON: If you get a finding of inappropriate treatment through that committee it is then automatically a reference to the medical board and to us.

Mr NEILLY: There are some high sentiments expressed in the report from consumers and on page 68 you have a consumer satisfaction survey. However, I cannot see a consumer dissatisfaction survey.

Ms WALTON: We report on them in terms of complaints against the commission. I think the commission's staff do a good job and if they can be congratulated for the work they do through individual statements it is appropriate to do so. It is not that we do not take on board our criticisms.

Mr NEILLY: I notice down the bottom that you suggest that comments tabled are published throughout the report, but you intend to revamp the report and give a bit more information.

Ms WALTON: Yes, we do.

Mr NEILLY: Page 72 details the staff profile. I tried to relate it to page 90, which is the staff of the commission. In respect of medical advisers there seem to have been significant changes over the three years. I presume that the temporary staff designated as medical advisers under the staff of the commission comprise on a part-time basis 1.2 persons.

Ms WALTON: Yes, it is four people now on a part-time basis.

Mr NEILLY: And they equate to 1.2 persons on an annual basis?

Ms WALTON: Yes.

Mr NEILLY: On page 86 there is a discussion and analysis on the financial statement. There is no comment made on the interest income and I do not know why. In 1997 $58,000 was derived from interest income. There is a comment made on savings from corporate services in relation to efficiency. Were there special circumstances to achieve that?

Ms WALTON: Yes, we out sourced a major part of corporate services and deleted two positions. I think the interest was as a result of too much cash being left in an account, and we have remedied that since then—of course, we have done so appropriately.

Mr NEILLY: Paragraph 3 of the analysis states:

> As there appears to be little likelihood of maintaining the level of legal cost recoveries achieved in 1996/97, alternative methods of recovering such awards will be explored during 1997/98.

I think the recoveries of 1996-97 are down on the preceding year. On savings in the ensuing column it is indicated that legal cost recovery has been identified as a means where savings could be achieved. There seems to be a little bit of a contradiction between what is stated in each column.

Ms WALTON: I can talk about cost recovery, but I am not sure whether that will answer your question.

Mr NEILLY: In one column you say that you do not expect to have the same level of recoveries and in the other column you say that you have identified recoveries as being a mechanism to finance something.

Ms WALTON: Historically, we have rolled it over and used it to fund our current functions. We have managed to achieve productivity savings through cost recovery and one peer review to fund some core functions. We cannot continue to do that because the cost recovered is diminishing. We out sourced cost recovery to a private legal firm on a contingency basis but it is not in its interests to chase doctors all over the world to recover the cost. We had substantial cost savings from recovery costs up until about a year ago—I think we recovered $150,000 last year. It is diminishing because there are smarter doctors—once they are before the tribunal they disinvest, leave the country, pass their assets over to others. Geoffrey Edelsten owed us $100,000 and we had to wipe that debt, which Treasury agreed to. Other doctors owe us $80,000.

The Hon. Dr B. P. V. PEZZUTTI: You did not identify your presentation to the College of Anaesthetists in the report.

Ms WALTON: It is a different financial period.

The Hon. Dr B. P. V. PEZZUTTI: It was in November last year. It was a good presentation.

Ms WALTON: The report goes to June last year.

CHAIRMAN: Thank you for appearing before the Committee today. We look forward to a similar process next year. I thank the staff of the commission who have been here today to see the process in action. I wish the commission well.

(The witnesses withdrew)

(The Committee adjourned 4.45 p.m.)