PARLIAMENT OF NEW SOUTH WALES

REPORT OF THE JOINT COMMITTEE
ON THE HEALTH CARE COMPLAINTS COMMISSION

5th Meeting on the Annual Report of the Health Care Complaints Commission and Final Briefing from Commissioner Merrilyn Walton

April 2000

REPORT OF THE 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 Jeff Hunter MP - Chairman
Ms Marie Andrews MP – Vice-Chairman
Mr Wayne D Smith MP
Mr Peter W Webb MP

Legislative Council

The Hon Dr Brian Pezzutti, RFD, MLC
The Hon Henry Tsang OAM , MLC
The Hon Dr Peter Wong AM, MLC

Secretariat

Ms Catherine Watson, Director
Mr. Keith Ferguson, Project Officer
Ms. Susan Want, Committee Officer
Ms Glendora Magno, Assistant Committee Officer

Joint Committee on the Health Care Complaints Commission (left to right)
Mr Jeff Hunter MP (Chairman), Ms Marie Andrews MP (Vice-Chairman)
Mr Wayne D Smith MP, Mr Peter W Webb MP
The Hon Dr Brian Pezzutti RFD, MLC
The Hon Henry Tsang OAM, MLC, The Hon Dr Peter Wong AM, MLC

Chairman's Foreword

I am pleased to present this report of the 5th Annual General Meeting with the Commissioner of the Health Care Complaints Commission as required by Section 65(1)(c) of the *Health Care Complaints Act 1993.*

This report marks my second annual general meeting as Chairman of the Committee and the final meeting with Ms Merrilyn Walton as Commissioner.

The 5th Annual General Meeting not only allowed the Committee to discuss the 1998/99 Annual Report and the Commission's efforts to achieve its statutory obligations and internal objectives, but also provided an opportunity to discuss with Ms Walton the challenges, successes and frustrations she experienced as Commissioner of the Health Care Complaints Commission since its establishment in 1993.

The report summarises the key issues raised during the meeting including options for resolving complaints, indicators for measuring the Commission's performance, consumers' awareness of their right to complain and the collection of statewide complaints data.

This Committee, both under the previous Chairman and since I became Chair last year, has met regularly with the Commissioner in order to fulfil its own statutory obligation to examine each annual and other report of the Commission and to report on any matters appearing in, or arising out of these reports. At all times the Committee has appreciated Ms Walton's considerable knowledge and willing cooperation. The Committee relies on a good relationship with the Commissioner and the Commission's staff in order to fulfil its prescribed functions.

I would like to thank Ms Walton for her attendance before the Committee, to congratulate her on her new appointment and to wish her well in the future.

I thank the Committee Secretariat for their efforts in the preparation of this report.

JEFF HUNTER MP
Chairman

Summary of Key Issues

Options for resolving complaints

The Commissioner advised the Committee that the new management structure of the Commission which replaced the position of Deputy Commissioner with two senior positions – the Director Complaints Resolution and the Director Investigations and Prosecutions - had achieved the objective of shifting the emphasis in resolving complaints from investigation and prosecution to the wider range of options available.

The Commissioner believed that the new structure will enable this change in emphasis to continue to develop. However, education of the community about the various options for resolving complaints is essential. Recent research conducted by the University of New South Wales showed that complainants wanted disciplinary action to be taken against the provider. However in many cases this course of action is not appropriate. The community needs to understand that there are acceptable alternatives to investigation and prosecution and that there are benefits to resolving complaints quickly and without the use huge resources.

As an alternative dispute mechanism, the Patient Support Office has been very successful. In 1998/99 it assisted more than 2,500 consumers and has had the positive impact of reducing the number of complainants who have been referred for conciliation following initial assessment. The Commissioner advised that surveys of complainants indicate that many people want the Commission to remain involved in the resolution of their complaint. The Patient Support Office is an alternative to complaints being referred to an external body for conciliation.

Currently, the Commission refers parties to a complaint assessed as suitable for conciliation to the Health Conciliation Registry, a section of the New South Wales Health Department. This requires consent from both parties. Those complaints which do not warrant investigation by the Commission or conciliation through the Health Conciliation Registry are referred to the Patient Support Office for direct resolution.

The Commissioner advised the Committee that trends were showing that the conciliation model currently in place in New South Wales is fast becoming redundant. The Annual Report indicated that 43% of complaints originally assessed for conciliation were not referred to the Health Conciliation Registry because one or both parties failed to consent for the complaint to be referred. The Commissioner advised there was also a significant drop out rate due, in her opinion, to complainants wanting the Commission to remain involved in the resolution of their complaint.

The Commissioner was of the view that the Commission should have a conciliation role as happens in other jurisdictions such as Victoria and Queensland. The Commissioner is of the opinion that if the Commission was to have conciliation as well as investigation and prosecution powers it could develop a better alternatives for resolving complaints. This model is currently being implemented in the Australian Capital Territory.

Performance Measures

NSW legislation explicitly requires that every public sector organisation is accountable for its performance and is required to meet all of the relevant legislative requirements.

One of the key principles of the move toward greater performance accountability is the use of performance indicators. Performance indicators are not an exact measure of achievement, but should indicate the level of effectiveness and efficiency of the primary objectives of the public sector organisation.

In response to a question concerning the Performance Measures in the Annual Report, the Commission conceded that the Commission could better report its performance.

The Commissioner provided the Committee with detailed business plans for each division within the Commission. These plans outline such things as specific goals to be achieved, action required, personnel responsible and time frames. The Commissioner agreed that an abridged version of the business plans would better document the performance of the Commission and satisfy its annual reporting requirements.

As well as statutory requirements for performance accountability, the *Health Care Complaints Act 1993* prescribes time frames within which the Commission must perform certain activities. The Commissioner advised that the Commission meets with these time restrictions. For example, 100 percent of notifications must occur within two weeks, and 100 percent of complaints are assessed within 60 days.

Statewide complaint data

The Annual Report states that the Commission, the Department of Health and the Area Health Services had agreed that statewide local health complaint data be collected. The data collection would provide the Commission with a better picture of complaints made at the local level and allow it to perform its function of reporting to the Minister on all complaints made within the public health system.

The Commissioner advised that as a result of discussions with the Director-General and Area Health Services, a working party was established to develop protocols for the complaints data collection. However, discussions concerning the de-identified

information that would be provided to the Commission had delayed implementation of the project. Currently, a Memorandum of Understanding between the three parties is still to be signed as the Commissioner remains concerned that the de-identified information to be passed to the Commission is not comprehensive enough.

Currently, complaints that are made directly to an Area Health Service are not automatically referred to the Commission. It was the Commissioner's view that it was essential for the Commission to be aware of complaints made about particular departments of hospitals in order that the Commission be able to identify problems and trends. It was the Commissioner's view that the public is entitled to know the total body of complaints against a particular facility.

Consumer awareness

The Committee queried the continuing low number of complaints being made to the Commission concerning unregistered health practitioners which suggests that the public largely remains unaware that complaints can be made to the Commission concerning these practitioners. The Committee queried what the Commission should be doing to better inform the public of their rights to complain.

The Commissioner advised that the Commission is embarking on a three-year promotions plan as a means to accessing those people in the community who do not know about the Commission. In the previous three months the Commission had distributed 90,000 rights and responsibilities brochures, 16,000 copies of the new complaints brochure and 1,500 copies of other brochures to multicultural centres in 15 community languages.

The Annual Report notes that another area where complaints appear to be particularly low was those complaints received from Aboriginal and Torres Strait Islanders. This was despite information received from the Aboriginal Medical Service which revealed consistent themes of discrimination and lack of access to hospitals. The Commissioner advised that a draft report has been prepared following these consultations which recommends that area health services improve access and that they involve aboriginal and Torres Strait Islander communities in the development of services for Aboriginal people.

It has been the Commissioner's experience that complaints made by Aboriginal communities were received by the Commission from the Aboriginal Legal Service rather than individuals and that Aborigines and Torres Strait Islanders tended not to complain. The Commissioner recognised the need for the Commission to make its service more accessible to Aboriginal and Torres Strait Islanders.

Language barriers have also been recognised as an impediment to consumer complaints. The Commissioner advised that the Ethnic Communities Council had identified the need for the Commission to specifically target communities. She

advised that the Commission is employing a consultant to look at a specific promotion strategy for non English speaking communities.

Ombudsman Style powers for the HCCC

The *Health Care Complaints Act 1993* prescribes an ombudsman style role in relation to the investigation of the care and treatment provided by health organisations but does not provide the Commission with the powers bestowed upon the Ombudsman. The Ombudsman Act provides that the Ombudsman may conduct an investigation into the conduct of a public authority whether or not a complaint has been made.

The Commissioner is of the view that the *Health Care Complaints Act 1993* could be amended to provide the Commission with a monitoring power and the power to review the quality of an investigation conducted by another organisation such as an area health service.

This power would ensure that the Commission was aware of the quality of investigations, whether investigations revealed public health or safety issues and whether the results of an investigation highlighted any policy implications.

The Commissioner's reflection on her time at the HCCC

Two of the Commissioner's biggest challenges during the past 15 years was the period of transition when the complaint unit of the NSW Health Department moved to a statutory authority and the application of a very prescriptive and complex Act.

Another constant challenge had been managing the different expectations and agendas of stakeholders including consumers, professional groups, registration boards and the Joint Parliamentary Committee and remaining neutral and free from capture from any one group.

The Commissioner said that she believed that:

> *The integrity of the place depends on not becoming an advocate for patients, not becoming an excuse for the profession, and not becoming bureaucratic in our response to the problems of the health system.*
>
> *Transcript, 25 January 2000 p.25*

The Commissioner said her biggest frustration had been a poor understanding of the Commission's jurisdiction exacerbated by the fact that professional board membership regularly changed. The lack of public involvement and debate about

many of the issues confronting both the medical profession and health had also been frustrating.

The Commissioner advised that the Commision had identified three "big picture" items it would focus on over the next three years: improving investigation time frames, improving the profile of the commission for alternate complaint resolution and improving feedback to the health system where deficiencies have been identified.

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

At Sydney on Tuesday 25 January 2000

The Committee met at 10.15 a.m.

PRESENT

Mr J. Hunter (Chairman)

Legislative Council	Legislative Assembly
The Hon. Dr B. P. V. Pezzutti	Mr W. D. Smith
The Hon. H. S. Tsang	Mr P. W. Webb

MERRILYN WALTON, Commissioner, Health Care Complaints Commission, on former oath:

CHAIR: I welcome Commissioner Merrilyn Walton to probably her last appearance before the Committee as Commissioner. Perhaps we will call on her in future for expert evidence, if she has no objection to appearing before the Committee.

Ms WALTON: I would be delighted.

CHAIR: We thank you very much for your co-operation with this Committee, even though we have not been up and running for very long. I am sure that Mr Mills, the Chair of the former committee, would like me to pass on his appreciation for your assistance during the term of the last Parliament. We wish you all the best in the future. We thought it best to ask you, rather than your successor, to review the Health Care Complaints Commission 1998-99 Annual Report, because most of the information in the report relates to work that you have undertaken. We are pleased that you could attend this week, which is your last week in the job. I will come now to some questions.

Ms WALTON: Before we do, I will table a summary of the annual report, which is in a more accessible form. I will also table the four issues of the *Health Investigator* that were published during the period of the annual report. Those documents will remain with the papers.

CHAIR: Is this abbreviated form of annual report a new initiative?

Ms WALTON: We started it last year. It was very successful in getting information out to people, and a much more cost-effective way of informing the community about the work of the Commission without having to reproduce voluminous reports.

CHAIR: At our last meeting we discussed the restructure which resulted in the Deputy Commissioner position being replaced by two new senior positions—Director, Complaint Resolution, and Director, Investigations and Prosecutions. One of the benefits you saw of the new structure was to shift the emphasis in resolving complaints from investigation and prosecution to a wider range of options. Has that been achieved?

Ms WALTON: The short answer is yes, but I would like to add some comments. I think we have achieved it in terms of having a structure in place to enable those processes to develop. Page 19 of the annual report shows all the different assessment outcomes that we now are involved in. However, there is still an issue for the Commission in terms of educating the community about the desirability of looking at a range of options to resolve complaints. Last time you questioned me on research done by the University of New South Wales about complainants to the commission being unhappy with the outcome. Most complainants wanted disciplinary action to be taken against the provider. We need to change that perception of the Commission. That is a much harder task. The answer is yes, we

have the internal processes and the structure in place. The next phase is to educate the community about them.

Having said that, we have to remember and continually remind ourselves that the whole focus of the Act is to be a co-regulator with the other registration boards. Section 23 must still prevail, that is, a complaint which raises public health or safety or public interest issues must be investigated. We cannot bypass that and focus on the alternate dispute resolution. That is a live debate in the community because the Australian Medical Association—not all of the profession obviously—and other people would like us to focus purely on the alternative complaint resolutions. We need to educate the community about the desirability of having complaints resolved quickly and without having to use huge resources or create stress for the respondents. At the same time, we have to make sure that we get it right. We select those complaints that must be investigated and those that are suitable for the alternative methods. We are on a journey. We have set the structure in place and we now have to do some more work with the external stakeholders.

The Hon. Dr B. P. V. PEZZUTTI: In the foreword to the 1998-99 annual report you indicate that the patient support office [PSO] helped more than 2,500 consumers. Surely that alternative dispute resolution mechanism has been extraordinarily successful.

Ms WALTON: Absolutely.

The Hon. Dr B. P. V. PEZZUTTI: Would that success indicate why the number of people who have been offered conciliation has declined as a percentage?

Ms WALTON: Exactly.

The Hon. Dr B. P. V. PEZZUTTI: I noted in the table on page 19 a drop in the number of conciliations, which I suspected was due to the implementation of the patient support office. Has that initiative been very successful?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: I was subject to a complaint at Casino Hospital which was handled precisely in that way between the hospital Chief Executive Officer [CEO], the patient and me. That matter and a hospital matter that the patient complained about—not merely about me—was resolved by simply changing the way in which daily patients were admitted. The patient was extremely happy with the result, the CEO was happy and so was I. All the other anaesthetists who visited Casino Hospital were also happy because it had been a problem for all of us. That matter was resolved directly between the parties. Has that arisen because of the actions of these initiatives?

Ms WALTON: That is right. We are trying to encourage the people concerned to be the owners of the problem and to resolve it themselves. For those patients who have difficulty accessing those mechanisms, the patient support office is the vehicle.

CHAIR: There is a question to be asked later on the patient support office. However, while we are addressing the matter, I would like to ask a question. Did the Health Care Complaints Commission establish the patient support office?

Ms WALTON: Yes.

CHAIR: So it is part of the Commission's function. The January 2000 issue of the *Health Investigator*—which is the last issue to be printed and will now be published on the Internet—talks about the 1998-99 period and has a large feature on the patient support office and the conciliation or mediation process that is used. You say in your annual report that the number of people referred to the conciliation registry for conciliation has dropped because of the patient support office. In a sense, it is dealing only with those people in area health services, the public health system.

Ms WALTON: No, it deals with both private and public. For example, we resolve complaints with general practitioners through the patient support office.

CHAIR: You can refer a complaint that comes through the Commission to your patient support office?

Ms WALTON: It is routine policy that every complaint we are not investigating, apart from conciliation, is referred to a patient support office.

CHAIR: Does the Act say you can only refer a matter to the conciliation registry for conciliation at the beginning of your inquiries?

Ms WALTON: That is right. It is an assessment outcome. We assess a complaint on receipt for conciliation. The Act requires the Commission to obtain consent from both parties. There is no face-to-face involvement with the problem. It is just a matter of convincing people that this is the method we want to use. We get the consents and refer them to the registry. As you will see from the statistics, we have a drop-out rate because many people want the Commission to remain involved. However, we do not have any involvement, as you know, in conciliation, which leads to one of the other questions you have asked about why we want conciliation. We are selecting the patient support office as an alternative to conciliation.

CHAIR: Basically, it is another conciliation office, but within the commission?

Ms WALTON: It is, but we think it is more effective in the sense that it is more timely, it is local, the people own it and matters get resolved. It includes resolving policy as well as the individual complaint, as the Hon. Dr B. P. V. Pezzutti pointed out.

CHAIR: Do you find that patients believe they are still dealing with the Health Care Complaints Commission?

Ms WALTON: They know they are dealing with the Commission.

The Hon. Dr B. P. V. PEZZUTTI: The PSO does not actually bring the two parties together before it; the PSO helps to negotiate settlements.

Ms WALTON: Sometimes officers may attend with the patient if the patient is a bit vulnerable or not confident. If I could add, quite complex problems are resolved through the patient support office. Before the resolution meeting there might be two or three meetings with the hospital and doctors and two or three meetings with the complainant to try to get them to talk in the same language, so that when they meet it is a productive and satisfying result rather than them getting together and warring. The patient support office tries to sort out problems before they get together. A great deal of work is done by the patient support office.

The Hon. Dr B. P. V. PEZZUTTI: Many complaints are referred directly to the area health services, which then deal with them. The matter I referred to earlier was dealt with by the CEO at the hospital. Also, many complaints received by the Commission may be referred to a area health service.

Ms WALTON: In that case we would have advised the complainant that he or she could get the help of the patient support office and there would have been conversations about preparation, remaining calm, what the patient expects and so forth.

CHAIR: Do you think the conciliation model currently in place has worked effectively?

Ms WALTON: It is fast becoming redundant. That is not just because of our implementation of the patient support office. In some way, we implemented it having recognised the limitations of the conciliation functions. It also has something to do with how professions deal with conciliation. Section 23 means that if a complaint is not investigated everything-else we do is lesser. In a way, what doctors and nurses fear most is an investigation process. Once that does not occur, there is a loss of enthusiasm, if I could put it that way, for resolving a matter appropriately. They do not consent or when they attend they treat it lightly.

They are not using the conciliation functions as they do in Victoria and Queensland, where lawyers are involved and there is a lot more high level mediation. In this State it has more to do with the legal profession and the way we deal with medical negligence complaints, rather than the limitations of the Act that conciliation has not developed the way it has in Victoria and Queensland. I might add that the Australian Capital Territory, which has had a conciliation role similar to that in Victoria and Queensland, is now amending legislation to have exactly our prosecution and investigation powers. That means it will be both conciliating and investigating and prosecuting within the one piece of legislation, which is what we want. We think if we owned the conciliation then perhaps we can develop a better alternative to litigation down the track. However, it is not going to develop the way it is structured. It is in the Health Department, and I do not think it is driven or loved. I use that word metaphorically.

The Hon. Dr B. P. V. PEZZUTTI: It is just something that they own?

Ms WALTON: Yes. It is just located there.

The Hon. Dr B. P. V. PEZZUTTI: It is just located there? It is an independent group?

CHAIR: That leads me to my next question. Do you feel the legislative role of the Health Care Complaints Commission [HCCC], prosecutorial and focusing on section 23 complaints, creates inherent conflicts with the commission's role in conciliation?

Ms WALTON: No, I do not, there is nothing inappropriate about it. There are divisions within divisions. It is not like we are the decision maker. The other thing is, most of the complaints where you might want conciliation are on health facilities that are not prosecuted. They are more like systemic problems that we will do a report on. So, you could design legislation whereby we could conciliate and there would be no difficulty conciliating those matters within the commission's structure. In my view sometimes it might be appropriate after a prosecution that there be conciliation, because you want to bring the parties together to resolve it.

CHAIR: Can you explain to me the differences between the work of your patient support officers and the work of the Conciliation Registry?

Ms WALTON: Patient support officers are employed commission staff, so we can exchange information freely. We may get a complaint and decide that the patient support office will help the complainant. There will than be immediate contact between the parties and they will set about resolving it. With conciliation we have to obtain consent from both parties. With the patient support office we do not obtain consent of anyone to resolve it, we start resolving it. With the Conciliation Registry we have to obtain consent, which can take a lot of effort because most people want the commission to remain involved, and then we refer it and we walk away from it because the Act does not permit the commission to have any further dealings. Then someone else takes over, another person who has not participated in the private discussions takes over, and it becomes more of an administrative function: "Will you please attend for conciliation at 10 o'clock on Friday". If you have any particular problems it is very hard for the person to negotiate that process.

CHAIR: I mentioned the January edition of the *Health Investigator*. I was a bit confused by the figures shown for complaints resolved or concluded in 1998-99. On page 3 under "Outcome of all investigations completed in 1998-99, " it runs down a list and it states, "Transferred to Conciliation Registry 2.5 per cent." Will you explain what that difference is? I know you transfer a lot. It says "completed" so I presume that means you get thousands of contacts and you complete so many in the year?

Ms WALTON: Yes.

CHAIR: If you have nothing more to do with the complaints that go to the Conciliation Registry, why is it listed as two completed?

Ms WALTON: That is investigations. We have investigated but somewhere during the process we would have said: "There is nothing in this, let us conciliate it." The Act does not give us the power to do it but in my view, since it is a totally voluntary process, the Act in a way becomes irrelevant. So, if both parties want to conciliate it, let us facilitate that. We have said, "There is nothing in this", and have asked the complainant, "Would you like an opportunity to conciliate it?"Both of them have agreed and they have conciliated.

CHAIR: That is a conciliation that the HCCC has done?

Ms WALTON: Yes.

CHAIR: Because in your other figures—

Ms WALTON: No, we transferred it to the Conciliation Registry.

CHAIR: But you state in your annual report, "Offered conciliation, 146". Does that mean 144 were refused?

Ms WALTON: No, that is on assessment. This is an unusual peculiarity. These are just investigations. As an outcome investigation we rarely do it, but we have started to try to cull the numbers and decide what really needs investigating and what does not. The decision has been made that there is nothing in these two, let us get the parties together.

CHAIR: When earlier I said under the Act you can refer only after the assessment stage, in these cases you have moved partially—

Ms WALTON: The Act does not permit this, but it is all voluntary. If any of the parties had said no, we would not have referred it.

The Hon. Dr B. P. V. PEZZUTTI: As I understand it, you can refer to conciliation at any stage. When you first get the assessment over the phone and you say: "This is not a serious matter, we are not going to investigate it. Why not try conciliation? You can do that either through your patient support office or you might be able to get together with the doctor and talk this one out,"—rudeness, being late or whatever. This other group sounds a bit serious, so you investigate it. You cannot find anything in it so you refer it to conciliation. After your investigation do some of those go back to the patient support office?

Ms WALTON: They can but we have not developed that, basically because we figure the parties have been through enough.

CHAIR: It is the terminology we have to get clear. The terminology is you do an assessment and at some stage in that assessment refer it to the patient support office?

Ms WALTON: Yes.

CHAIR: Then you move on from assessment and say, "This needs to be investigated." In the early stage of the investigation, if there is consent from both sides, you can send them to conciliation, even though the Act technically does not permit it. In this instance, because there was agreement between the parties, you have done that with two?

Ms WALTON: It has been accepted that in the review of the Health Care Complaints Act that will be made clear, that the commission can refer to conciliation

at any stage during the investigation. That was accepted by everybody and I imagine that will come before the Committee in the form of a draft bill.

CHAIR: Later we will be asking you for your thoughts on future inquiries, but arising out of the Committee's current inquiry into malpractice I believe there is a great need for the Committee to inquire into conciliation, to make it more clear.

Mr SMITH: My question refers to the performance measures set out on page 8 of the annual report.

Ms WALTON: I suppose, when I look at page 8, it is really a summary of our main achievements. I think that heading is a bit misleading. We will fix that. We have many benchmarks or indicators of performance and they come within our business plans. I am not sure whether I have tabled our business plans for different divisions of the commission. To give you an example, the headings are: The Goal, The Key Initiatives, Actions Required, Responsibility, Product Required, Time Frame and Performance Measures. In respect of every function the commission has to achieve what the Act requires.

I can table this for the Committee but, for example, for investigations and prosecutions we have a clear initiative, "Review the case allocation process and identify relevant factors for consideration." The performance measure would be the completion of guidelines. There are time frames for all of that. We break it down for the division of complaint resolution and executive support. I will table those, because they better reflect the performance of the commission. We could, in the next annual report, look at some abridgement of these documents to make it clearer. We should probably call that a summary of achievements and then, in the investigation and prosecution section, have key targets, key performance indicators and output. I do understand why that is a bit misleading. I will table those two.

The other thing we have done recently in relation to performance targets is an internal-directed self-assessment of the commission's processes. Coming out of that was further refinement to the target and performance benchmarks, if you want to call them that. They had just recently been incorporated in the final stages and I will table that also. Just generally, the issue of targets is a difficult one because no other statutory body—such as the Independent Commission Against Corruption or the Office of the Ombudsman—specifically nominates a target for the year.

We are quite process-driven. We cannot say we want to prosecute 200 doctors next year. That is not what we do. I can see Dr Pezzutti smiling. We need to be successful in proving the particulars in 75 per cent of cases that we prosecute, so there are different performance indicators. I think we do it as well as anyone does. There is no group in Australia similar to the commission. The commission is actually used as the benchmark for other organisations. They come and want to look at our process—does anyone else use your organisation as a benchmark? This is a continual process of quality improvement. I agree with Mr Smith that we should report it better. We are just not good at reporting it.

Mr SMITH: Do you envisage one fundamental measure of the commission's performance?

Ms WALTON: No, I do not. The Act is so prescribed. The Act says, for example, we have to do things within certain time frames, and I can say yes, we meet that measure; that 100 per cent of our notifications occur within two weeks; that 100 per cent of our complaints are assessed within 60 days. They are straightforward. With regard to whether the commission is successful, its continued existence could be an indicator of its success. I do not know. You should be the ones to answer that.

The Hon. Dr B. P. V. PEZZUTTI: Would you agree, though, that the assessment of the commission's performance would be improved confidence in the provision of health services?

Ms WALTON: I am just not quite sure what evidence we would need to sustain that.

The Hon. Dr B. P. V. PEZZUTTI: Ignore the fact about getting evidence, your main focus is to improve the quality of health services delivered to consumers in New South Wales?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: Not to prosecute doctors. That is all part of it?

Ms WALTON: That is right.

The Hon. Dr B. P. V. PEZZUTTI: That is the regulatory part of it. The main focus is to improve the quality, not just in terms of whether patients did better or not, but the quality of interaction between clients and the provider? Whether we worked out a measure for doing that or whether you do it with a survey is a different matter, but the fact that you have only 5,000 or so complaints—I do not know how many complaints you receive.

Ms WALTON: Two thousand written complaints.

The Hon. Dr B. P. V. PEZZUTTI: You advertise widely. People know you exist because you have conducted surveys on your profile. People know where to go if they want to complain. In a system where the number of consultations is huge, 2000 complaints is not very many.

Ms WALTON: Except we are not the only place where you can make a complaint. We get probably the minority of the complaints in the health system but, having said that, there is no evidence that complaints are an indicator of anything. It could be an indicator that this is a highly informed community that knows how to assess its rights.

The Hon. Dr B. P. V. PEZZUTTI: It is.

Ms WALTON: But it does not go on and say therefore we have a fabulous health system. I might personally think that, but I am not sure a complaint body in

itself will ever be able to gather sufficient evidence to say anything about the quality of the health service.

The Hon. Dr B. P. V. PEZZUTTI: Would it be possible to change the name of the commission from that of a complaints body? The word "complaints" actually helps people to find you. If I want to complain I will go to the complaints unit. It does not really describe what you do or what the Act says you ought to do.

Ms WALTON: That is right, but there have been consumer surveys of the names of other commissions around Australia which use words such as "health rights" or "health services" and consumers prefer the word "complaints".

The Hon. Dr B. P. V. PEZZUTTI: I know the word "complaints" is much better because they can find you and that tells them what you do: you help them to get over their problems.

Ms WALTON: You are right. We are more than a complaints body, that is for sure.

Mr SMITH: What are some ways to measure consumer confidence? The Hon. Dr B. P. V. Pezzutti mentioned a survey but are there other techniques?

Ms WALTON: We certainly have a consumer satisfaction survey, which we need to further refine, that we use to improve our own process. The difficult area of a complaints body is, from a consumer's perspective, to separate expected outcomes from the process. We could have a fabulous process but an unhappy consumer because they did not get what they wanted. If we got whatever the consumer wanted we would not be a complaint body, we would be lawyers, a firm of solicitors, an advocacy service or something else.

Our big problem is how to get the process right and how to match it with patient or consumer expectations. That just says to me that we still need to do a lot more work in the community in relation to its expectations about a complaints system. Recently, we did that by rewriting our complaint brochure. If you look at the new one we have recently published we distinguish medical negligence from complaints, we talk about the difference and we talk about expectations and time frames.

Mr SMITH: Do you think consumer expectations are unrealistic?

Ms WALTON: Not in every case but sometimes they are. Clearly, the commission has a small percentage of people who probably write to you and to others who have expectations that we are in the doctors' or the hospitals' pockets even though we try to convince them that we are not.

The Hon. Dr B. P. V. PEZZUTTI: Can you investigate a complaint against a public hospital without the approval of the director-general?

Ms WALTON: Yes we can but we need a complaint.

CHAIR: In many of the other jurisdictions the medical board or complaint agency really acts as an advocate for the patient in conciliation. Does our very neutral system create an imbalance between the patient, the practitioner or the provider?

Ms WALTON: Is this about conciliation? Do you mean that in conciliation the doctor has the Medical Defence Union or someone there to help them?

CHAIR: No. I must say when I first came into this position I seemed to think the medical board may be pro doctor but the more medical boards that I visit it seems as though they are very supportive of the complainant.

The Hon. Dr B. P. V. PEZZUTTI: You are absolutely right, it is outrageous.

Ms WALTON: I have no experience at all of that. The New South Wales Medical Board operates under its legislative powers to protect the public so it refers stuff to us. It has never been pro patient in a sense.

CHAIR: In Victoria when they go into conciliation they have all the records. During the conciliation process the Health Services Commission might say to the patient in one instance or to the doctor in another, "Everything is stacked against you" . whereas here at the registry that information is not available.

Ms WALTON: No. We made strong recommendations that there should be a case manager in the conciliation registry who can get peer opinion, can harness all the reports and have an informed position when they undertake conciliation. That does not happen at the moment.

CHAIR: Overall, are patients satisfied after they have been through conciliation or are they just going there because no other recourse is open to them?

Ms WALTON: Certainly there is no recourse after you refer conciliation to them. But we would not know because what we get back from the conciliation registry is a form stating that agreement was reached or not reached. Most of them state "agreement reached", but that does not mean the complainant is satisfied, it just means that in the conciliator's view the matter has gone as far as it can.

CHAIR: Can they come to an agreement in the conciliation registry on a monetary fund?

Ms WALTON: The Act prohibits that, as it does in Victoria. I think they can come to an agreement outside. There have only been a couple, but that is mainly because the Medical Defence Union is not allowed into the process and therefore prohibits its members from entering into any financial arrangements.

The Hon. Dr B. P. V. PEZZUTTI: Page 23 of the report states that 146 complaints were assessed as being suitable for conciliation, but that the Health Conciliation Registry provided the commission with feedback on only 46 cases in which an outcome had been achieved; three conciliations were cancelled; 41 parties reached agreement; and two parties did not reach agreement. That means that 100 or thereabouts did not even reach conciliation because they did not want to.

Ms WALTON: Because they dropped out.

The Hon. Dr B. P. V. PEZZUTTI: There were 146 assessed as suitable for conciliation. Having investigated or not investigated them, 46 went in the door and 41 came out in agreement which is not bad?

Ms WALTON: I will qualify that because I do not know what "reached agreement" means.

The Hon. Dr B. P. V. PEZZUTTI: It is a black box but it does mean that 48 reached agreement. That says an awful lot for the conciliation process inside the black box but it also means that a large number of people who were assessed as being suitable for this formal process of conciliation said that they would not bother. Only one-third went through the process. In respect of that one-third that went through the process it was not a bad outcome.

I do not necessarily agree with Merrilyn that the process should be managed by the commission or that the commission should allow the conciliator to have background briefing notes that would sway the conciliator's view. At the moment both parties go in cold. They tell the conciliator what they are concerned about, the doctor or the nurse responds and they try to work out a way between them. The conciliator has none of the results of the investigations that Merrilyn has done. Nothing is there except for the two parties themselves. In Victoria it is a guided conciliation.

Ms WALTON: In Victoria they say that they have peer review that says, "You really stuffed up", and, "I would settle if I were you."

The Hon. Dr B. P. V. PEZZUTTI: At the moment we have a purely independent conciliation process. Merrilyn is talking about a more guided process, as in Victoria, with which I would not disagree.

CHAIR: On page 19 under "Outcome of assessment of all complaints 19996-97—1998-99" the number of those who were offered conciliation in 1996-97 was 218 or 14 per cent and in 1997-98 it was 264 or 14.4 per cent, and then it drops massively. That is a accredited to the fact that we now have a patient support officer. In a way the easy-to-resolve matters—conciliations—are being handled by the patient support officer.

The Hon. Dr B. P. V. PEZZUTTI: Maybe.

CHAIR: Maybe the harder ones go to conciliation. Once again they need to be provided with more information.

The Hon. Dr B. P. V. PEZZUTTI: They may, but only one-third decided to proceed down that track even though they were offered an opportunity to conciliate.

Ms WALTON: At the time of the report a number were waiting to obtain consent, so there is that body. The problem for the commission is that because that patient support officer is so successful with very difficult matters as well as with

minor matters, it is an effort for the commission to put our complainants and respondents through quite a long and difficult process to resolve a complaint that we feel more confident will be resolved in all the issues through our patient support officer.

That says to me that we have to change the system. You cannot have an underutilised structure in place, because there are more viable processes. I agree with the Hon. Dr B. P. V. Pezzutti that we need to have case-managed complaints and we should target those where there is perhaps some alternative to medical negligence. Not all complaints would go down that pathway. It might still be a small percentage but if you are dealing with 20 big medical negligence cases—Victoria might only conciliate 15 a year, not the hundreds that we have here—there may be developed in this State a viable alternative that needs to be thought through.

The Hon. Dr B. P. V. PEZZUTTI: Under the table on page 23 in the second column, the report states:

The Final Report of the Health Care Complaints Act Review Committee found that parties were refusing consent in 50% of complaints. While the Commission assessed fewer complaints for conciliation—

there was 146 versus 264 before—

it has referred a greater proportion of those complaints than previous years.

Ms WALTON: We were more successful in getting the consent.

The Hon. Dr B. P. V. PEZZUTTI: So that of the 146 you assessed—

Ms WALTON: A higher number agreed.

The Hon. Dr B. P. V. PEZZUTTI: It must be the case that in the past even less than one-third of cases was assessed.

Ms WALTON: I thought it was 50 per cent. I thought half dropped out.

The Hon. Dr B. P. V. PEZZUTTI: It is only one-third now.

Ms WALTON: That is better.

The Hon. Dr B. P. V. PEZZUTTI: No, one-third continue now. There were 46 out of 146 that went ahead. In the top column on page 23, of the 146 offered only 46 reports were received. That means that each one that went to the registry would have to have a report.

Ms WALTON: Except the issue there is those we assess. You have got a record there on page 23, the outcomes of complaints received and referred. In the columns "No agreement reached" and "Consents not yet obtained or agreement not yet finalised" there were 100. It is not just two figures of what was referred. There is a body of complaints in there that have not yet been finalised.

The Hon. Dr B. P. V. PEZZUTTI: Then you state on page 23:

The Commission expends considerable resources in trying to persuade the parties to attend conciliation.

Is it a waste of money?

Ms WALTON: We think we have got more effective use of our resources, yes.

The Hon. Dr B. P. V. PEZZUTTI: Do you think you are flogging a dead horse?

Ms WALTON: Yes. We have recommended under a review of the Act, which was accepted, that the registry gets the consents. We just do pure assessments, send everything off and they start from the beginning.

The Hon. Dr B. P. V. PEZZUTTI: That is an excellent idea. In other words, if you think a matter is suitable for conciliation you send it to the registry to be worked out.

Ms WALTON: It does all the work. It makes the first contact.

The Hon. Dr B. P. V. PEZZUTTI: "Your complaint has been assessed as being suitable for conciliation" et cetera. The registry can then refer back to you the ones for which it cannot get consent. At the end of the day if you say a matter is suitable for conciliation, and the people are refused conciliation, you have got to close the file.

CHAIR: Page 23 of the report states:

Complaints where parties failed to consent were re-assessed by the Commission and the outcome of the re-assessment is contained in the table below. In these circumstances additional information may be available to the Commission either from the complainant or the respondent.

It has in the table "Discontinue dealing with" 28 or 44.4 per cent and "Refer to another body or person" six. What is the other body or person?

Ms WALTON: The area health service or the patient support officer.

CHAIR: It says "Refer back to conciliation" one. Those people who did not agree, one of them was still sent to conciliation.

Ms WALTON: We have just gone back and tried harder.

CHAIR: Under "Refer for investigation" there were five, so you have moved into an investigation process to satisfy them, I suppose and "Refer for direct resolution" is that your patient support officer?

Ms WALTON: If you combine "Refer to another body or person" and "Refer for direct resolution" the patient support officer is involved in both of those cases.

The Hon. Dr B. P. V. PEZZUTTI: Often they simply say, "That's it, we have tried our hardest, we are not going to do any more of this and we will close the file". Then we get the letters.

Ms WALTON: Can I go back and refer to the conciliation registry to let them do everything, our Act gives a review provision to complainants. In the future the only difference if that were implemented would be we would not refer immediately. We would wait for the period of review time to expire where a complainant is unhappy about being referred for conciliation. If they have not done that we will refer it and it really would not come back to the commission. They have had an opportunity to say they do not want to go to conciliation. We have given them the 60 days. It goes to conciliation and then it stays there because the trade-off was to have all respondents to attend mandatory conciliation. That was accepted even by the Australian Medical Association in the review of the Act. The trade-off is that no matters come back to the commission. We have to get it right in the first place.

The Hon. B. P. V. PEZZUTTI: You would not get it right.

Ms WALTON: No.

The Hon. B. P. V. PEZZUTTI: Because five of them came back to you, did they not?

Ms WALTON: There needs to be more information.

The Hon. B. P. V. PEZZUTTI: Four matters were reopened for investigation. During the conciliation process, the conciliator could say,"Gee, this sounds pretty awful." He or she could say that it was not suitable for conciliation and send it straight back to the commissioner. The conciliator could state that, as a result of the investigation, the matter was not suitable for conciliation because in the middle of the discussion it was found that there was a lot more to the complaint than met the eye.

Ms WALTON: They have done so, but none of the matters would have amounted to anything.

CHAIR: I note that under "Future Plans to improve conciliation" on page 24, you refer to advertising the fact that people can refer complaints about the Health Conciliation Registry to the Health Commission and you can investigate them. That is very interesting. I think we could spend a lot of time on this but, as I indicated earlier, I think the next avenue for this committee, as soon as we conclude our investigation into the issue about mandatory reporting negligence, would be to investigate this whole issue of conciliation, the role of the commission and the role of its registry- Patient Support Office-. The Committee could spend a lot of time on that.

The Hon. B. P. V. PEZZUTTI: It is barely 146 out of 3,000 complaints and I, too, think that we could waste a lot of time looking at the registry.

CHAIR: The commissioner has set up her own conciliation registry within the Health Care Complaints Commission which is doing most of the conciliation registry's work and maybe in a much better way. Whether that is actually allowable

under the Act is something we will have to examine. We have to look at it to see whether it needs to be formalised. My final question is: Do you believe that the practitioners and the providers will ever support the Health Care Complaints Commission moving to conciliation in-house?

Ms WALTON: No. I think it is a Government decision, basically. I think any move to give to any body what is perceived to be additional power—and I can assure you there is no additional power in this because it is just more effective—will not be supported. If we look at the other States, as I said, it happens. The Australian Capital Territory will be undertaking both the conciliation and investigation/prosecution processes, and that is another body to look at. In the past we have had no other commissions combining the functions and it would be hard to argue in support of that, even though we have had other statutory bodies with combined functions, such as the Environmental Protection Authority [EPA]. I think it will become obvious, but I just think that, historically, I cannot see the professions supporting it. It is not necessarily a fight that the commission is keen to put a lot of energy into, either.

The Hon. B. P. V. PEZZUTTI: Nor should we.

CHAIR: I might come back to you later after your next career move and get some information. I believe, though, that there could be some changes to the structure within the Health Care Complaints Commission which would see that as more of a separate entity from the patient support office.

The Hon. B. P. V. PEZZUTTI: You cannot bludgeon people into conciliation. Conciliation requires consent at all stages, otherwise you are looking at mediation.

CHAIR: The commissioner has said that a lot of people are reluctant to go to conciliation because they still want the Health Care Complaints Commission to be involved. That is why the commissioner set up the patient support office which is doing the role of the conciliation registry, maybe we just need to formalise it.

Mr WEBB: One of the key issues raised at our last annual meeting with you was the collection of statewide complaint data which would provide the commission with a much better picture of complaints made about the health system. Page 11 of your annual report states as a strategic initiative a memorandum of understanding between the commission and the Department of Health and its area health services is yet to be signed. You also mentioned today that the commission is yet to be satisfied that data will be provided in a form that will actually allow it to perform its function of reporting to the Minister about complaints relating to the public health system. Can you elaborate on the situation?

Ms WALTON: Yes I can. Maybe it is important also to give a little bit of background to this. The issue has now been on the table for over three years. It came up as a result of discussions I had with the Minister when I said that we could not fulfil our obligations to the Minister in terms of compliance because we do not have any information from the area health services. The Minister gave a direction that the Department of Health was to co-operate with the commission and develop a modus operandi to collect data. We also set about writing to all the area health services and said, "Give us what you have", and what we got was pretty well useless.

As a result of that, a working party was set up to develop protocols for the complaints data collection and that progressed very well. The Department of Health put in quite a significant number of resources and we now have a prototype of complaint data that has been collected. The reason that I will not sign the memorandum of understanding [MOU] is because the Department of Health has suddenly owned this project even though it was a commission initiative. Suddenly it is owned by everyone else and their view initially was to prohibit us from even getting access to the data.

The Hon. B. P. V. PEZZUTTI: Typical.

Ms WALTON: That was resolved and the MOU came about with this working party saying, "We are entitled to de-identified generic data like metropolitan hospitals or rural services." My view is that that is too broad a category on which to do any analysis or make any recommendations about trends and complaints. What we want is all complaints about X hospital, right down to that level, but de-identified. The Department of Health and the working party from the areas said, "No." It has been stymied for 12 months. On Friday, the director of complaints resolution, Miss Julie Kinross, is going to address the senior executive forum of the area health services and I am going to go on—but it is really in Julie's hands now—to try to convince them about the benefit of transparency and that these things should be on the public record. This is a debate that we had ten years ago.

The Hon. B. P. V. PEZZUTTI: You prepare a lot of other reports that you pass to the Minister for Health but they are never tabled in Parliament.

Ms WALTON: The reports we have given to the Minister have never been under section 23 which refers to reports to table in Parliament. The ones we have at the moment on that pathway are ones of which you are aware on HealthQuest. That is on that pathway but most reports are not. We have not really given reports to the Minister on trends and complaints because we have our annual report but, as you know, that does not say anything.

The Hon. B. P. V. PEZZUTTI: But you table that through the Minister for Health.

Ms WALTON: Yes.

The Hon. B. P. V. PEZZUTTI: So there are other complaints that the Minister for Health may ask you to investigate, but he does not have to table those, does he?

Ms WALTON: No, because we did it under section 53 of the Act, not under section 23. But, going back to the Statewide data, we are trying to break the stalemate. My view is—and I do not know whether the new commissioner will have the same view—that we hold out until we can actually access the data for which we have asked and that is why we have not signed the MOU. Hopefully, Miss Kinross' skills of advocacy will convince the senior executive forum on Friday that this is inevitable and they should co-operate and agree to give it to us.

The Hon. B. P. V. PEZZUTTI: If a complaint goes to an area health service, you do not necessarily get it.

Ms WALTON: No, no.

The Hon. B. P. V. PEZZUTTI: A complaint against me by a patient at the Casino and District Memorial Hospital to the chief executive officer [CEO]—and I am baring my soul—may never be received by you.

Ms WALTON: We would not receive it, unless it has been referred to us by the area health services or the Minister, or the patient or someone has complained to us. We still do not want knowledge of that individual complaint, but we would like knowledge of the collection of complaints.

The Hon. B. P. V. PEZZUTTI: That has happened, and it might be that everybody is complaining about the Northern Rivers Area Health Service and various doctors there, but you are not getting those complaints because they are being resolved.

Ms WALTON: For example, we would like to know all the complaints about the emergency department at Broken Hill. If that has one complaint, that is nothing; but if it has 80 per cent of hospital complaints in emergency departments and we compare that with the other States, it might tell us that there is a real problem with the midnight shift in emergency departments. It is that level that we need to look at.

Mr SMITH: Did you also say that you wanted that information de-identified?

Ms WALTON: Yes.

Mr WEBB: The information is there, hopefully, so that the Department of Health can provide a better health service to the people of New South Wales. That is why you want to collect it. I cannot believe that the situation is as you have described.

The Hon. B. P. V. PEZZUTTI: It is exactly that. The Department of Health is very secretive. It is the most secret department in entire State.

Mr WEBB: The information is going to the department, not the commission, and never the twain shall meet.

Ms WALTON: I think the public is entitled to know the total body of complaints against a particular facility. The facility should be reporting that in its own annual reports.

The Hon. B. P. V. PEZZUTTI: I am getting a copy of the annual report because I do not think it has that information in it.

Ms WALTON: Some do, but they do not transfer information to us.

The Hon. H. S. TSANG: The committee has received a departmental report that reviews the patient support office which also raises the issue of complaint data from area health services. It is noted in the covering letter that action is planned to respond to the issues raised and the recommendations of the review. Has the commission formulated any plans for addressing these issues?

Ms WALTON: There are two questions in there. The first one is the provision of information to area health services. We have implemented the annual reporting of complaints to the area health services. In the last year when I have met individually with the CEOs, there has been a separate patient support office report and the CEOs have valued that information. We are going to do that on an annual basis so there is reporting annually, but there is the opportunity to meet more frequently, if the need arises, on trends or whatever happens.

In relation to the plans for addressing the issues relating to the patient support office, we have developed a strategic plan. I will table that document. It has target time frames, action required, and recommendations arising out of the report. This is the report: Action Arising from the Review: External Evaluation—Promotion of Patient Support Office. There are three activities in that section. For example, review of promotional material—that is to be done by March 2000 and the steps are outlined; the accessibility of the patient support office to clients—and that is to be completed by March 2000; the impact on client group and appropriateness of service which is to be done by March 2000; efficiency of work processes—there are number of elements there; and suitability of locating patient support offices in area health services or hospital facilities. That was a recommendation we looked at elsewhere. We are not actually sure about that because putting offices in, say, shopping centres is sometimes a bit remote.

What the patient support office has recommended is that we remain within the host facility but it has stressed our independence in a lot of promotional strategies. Indeed, the evidence is that people accept our independence. There is no confusion about where the patient support office sits with the area health services. I table the report. There are a number of issues such as computers and management systems that I mentioned, but there are strategies with the time frames as well, and responsibilities are identified.

The Hon. B. P. V. PEZZUTTI: I come back to the issue of area health service complaints. The complaints set out on page 13 of the Northern Rivers Area Health Service annual report, which I received only two days ago, indicate that for the 14 hospitals there were 171 complaints about hospitals services out of a total of 264 overall complaints. The remainder of complaints, that is, the remainder of 264 minus 171, were divided between mental health, dental health, Isolated Patients Transport and Accommodation Service [IPTAS], other community health services and renal services. All complaints were promptly acknowledged and 124 of the complaints received were resolved within 21 days of receipt. Another 76 were resolved within 35 days. It also states that, of 43 complaints which took in excess of 35 days, 21 remain unresolved. It does not say that any of those complaints were referred to the commission.

Ms WALTON: We received seven complaints about northern rivers.

The Hon. B. P. V. PEZZUTTI: But none of those necessarily was referred by northern rivers to you.

Ms WALTON: No.

The Hon. B. P. V. PEZZUTTI: And they had received an extra 264. You received seven, so there are an awful lot of complaints that you do not see. The one to which I referred earlier at the Casino and District Memorial Hospital was a significant matter for the patient. I did not deal with her personally except by her agreement that she would speak to me. But that means that approximately 90 complaints were not about hospital services so there are a lot of complaints that are made about area health services. Northern Rivers would be one of the better ones because it topped the State for consumer satisfaction. Across the board, it was the best area health service in consumer satisfaction surveys which were done independently by the Health Department. There are a lot of complaints made that we simply do not see. If they are serious matters they have to be referred to you.

Ms WALTON: Just recently I noticed a sudden increase in referrals of serious complaints to registration boards and the commission. Basically, the two registration boards are the commission.

The Hon. Dr B. P. V. PEZZUTTI: From the area health service?

Ms WALTON: I think it is because of the circulars. We have just finalised the protocols for area health services on who refers what to where.

The Hon. Dr B. P. V. PEZZUTTI: If there is a serious matter—say, for example, a patient complains to an area health service about a doctor's sexual assault—surely that matter would come to you?

Ms WALTON: We are notified about most of those.

The Hon. Dr B. P. V. PEZZUTTI: Are you notified, or is the matter referred to you? It might be inappropriate for the area health service to investigate something like that.

Ms WALTON: I totally agree. The Department of Health has its own investigative unit which is headed by a former police investigator who has done some investigations. Matters are then referred to us. There has been some discussion about the appropriateness of that, especially if the complaint is about a registered health practitioner. But we sort them out when they occur.

The Hon. Dr B. P. V. PEZZUTTI: That would be a much more valuable area for us to investigate—we are talking about large numbers—to determine what sorts of things an area health service is investigating and resolving itself, in-house so to speak, and obviously to everybody's satisfaction. There are many more complaints in this area as the Northern Rivers area comprises basically 5 per cent of the State. That is a large number of complaints. That would represent at least another 1,000 complaints.

Ms WALTON: In the preliminary data we have been given from the statewide collection the commission's complaints are about 4 per cent of all complaints. So it is tiny. But of the category of complaints across the State we can say that they have identified communication problems focused on clinical treatment—the second most complained about category. So they are doing quite serious investigations. I suppose that that is why we recommend that the Committee look at section 26 and at our monitoring powers. A complaint could be referred to an area health service and it could bypass the commission. The area health services would do the investigation. We might read about it in the papers or hear about it but we have no power to review that investigation. That is why we thought there was some public interest in giving the commission power to look at other peoples' investigations.

The Hon. Dr B. P. V. PEZZUTTI: I strongly urge the Committee to have a good look at giving the commission the power, even if it just does an audit, for example, of the 264 complaints for the Northern Rivers Area Health Service, to determine what sorts of complaints they are. If the commission is interested in some of those complaints it might then look at the nature of the investigation and determine whether or not it is happy with the procedure. That would be made possible under section 26 of the Act.

Ms WALTON: That is similar to section 13(1) under the Ombudsman Act where the Ombudsman, on his or her motion, can look at complaints.

The Hon. Dr B. P. V. PEZZUTTI: That might be something that could be discussed. I was surprised at the number of complaints. I was intimately involved with one complaint, which was nicely settled. However, if the complaint had gone to the commission and I had been approached by the commission I am sure that the matter would have been dealt with in the same way and the same outcome would have been achieved. However, the commission would not have been able to direct the area health service to arrange the physical changes to the consultation area—changes that the area health service was more than happy to make in resolving the problem itself. There was tripartite discussion.

CHAIR: It has been pointed out to me that the Committee has already conducted an investigation into local complaint-handling procedures. I am quite happy for the secretariat to review that report. You may wish to have a look at that report to determine whether we need to go further into that matter. We can then look at that matter at a later date. But you have certainly dominated question time today. I will now get other Committee members to ask questions. After they have asked their questions we can move on to more questions from you.

Mr SMITH: My question relates to unregistered health practitioners, a matter which is highlighted on page 16 of the annual report. In 1997-98 we had 20 complaints and in 1998-99 we had 11 complaints. My question is in two parts: First, are there reasons for that drop and, second, what should the commission be doing to better inform the public of their rights to complain?

Ms WALTON: I have no intelligent response to the reason for the drop, except to observe it. It is very small. I am not sure why. But the question relating to us better

informing the public is a good question. I suppose that my response will be both general and specific. Generally, the commission is embarking on a three-year promotions plan; it is doing that right now. So that will cover a lot of people in the community who do not know about us and, believe me, there are a lot. Specifically, we can target the professional associations. We can inform them and get them to put information into their newsletters and brochures. But it is really a matter of priority and resourcing for the commission. Because it is such a small complaint category, it comes into the unmet need category, which is about future planning and putting our resources into it to gee it up. But most of our energy goes into dealing with the complaints that we have. So it is a matter of the commission prioritising.

In the last three months we have distributed 90,000 copies of our rights and responsibilities brochures; 16,000 copies of the new complaints brochure—which is a big input—and 1,500 copies of other brochures in 15 community languages were distributed to multicultural centres. They could well be a group that uses alternatives, like Chinese medicine and so forth. But at this stage we are really focusing on commission-wide promotions. Within that I am aware that we have not really done anything for alternative health care. The commission has a bit of a problem though and this might explain it a little. The problem might disappear when I go because it might be my problem. Evidence-based medicine is the way of the world. We have a view that, if your health treatments are not evidence-based, it is quackery. But here we are actually the authority responsible for quackery. So if we get a complaint, for example, against an iridologist who did not do the right reading, I, as commissioner, cannot legitimately and in good conscience go to another iridologist and ask him or her, "What should have been the right reading?" That is a personal dilemma for me and for a lot of other people in the commission. It is a funny thing. We need to examine that and find out where the commission stands on a lot of these issues. I do not think that I am the person to do it. There is a free choice in the community and consumers are able to go where they want. It needs promotion and I suppose that I am not about to promote it.

Mr WEBB: Would you make recommendations to the Department of Health that that is its bailiwick, or would you suggest that there is a problem? Alternative medicine is really on the increase in society, so the problem will be ongoing.

Ms WALTON: That is true. The problem for the commission is that it is getting complaints about alternative medicine from traditional or orthodox health services. So it is investigating more direct complaints from patients than it is receiving.

Mr SMITH: How do these quacks come to light? Do you simply receive a complaint from somebody, or does somebody from the service ring you up?

Ms WALTON: Often another health provider gives us information or encourages a complainant to come forward. I also think it is a different environment, as your inquiry showed. Someone who goes to an iridologist or a masseur will probably not complain to the commission. We probably will not direct our resources into establishing whether someone was rude or someone did not perform a proper technique unless someone was harmed. It is just a balancing of our resources and the public health and safety. Whilst we need to inform people about their rights to

complain, that is more of a promotional activity. If we had hundreds and hundreds of complaints I wonder how we would investigate them.

Mr WEBB: Let us say that a serious complaint was reported to you involving someone practising alternative medicine. You said earlier that you cannot go back to the peer organisation. How would you deal with such a complaint?

Ms WALTON: We have investigated them. We had an allegation of sexual conduct by a masseur. We investigated it and substantiated the complaint. We have no power to refer it to any board, hence our recommendations relating to getting some umbrella in the legislation. We have referred one such complaint to the police. Under section 39 we can refer complaints to the Director of Public Prosecutions.

The Hon. Dr B. P. V. PEZZUTTI: A sexual assault involving a masseur might be referred by the commission to the police. If the matter goes to court and the person is found not guilty that is the end of the matter. If a matter involving a medical practitioner goes to court and the person is found not guilty the medical board still has a crack at it. In other words, if you are charged, appear before the court, get through the court and are found not guilty, the Health Care Complaints Commission [HCC] can still prosecute that matter and the medical board can knock out that medical practitioner.

Mr WEBB: I suppose that a lot of it revolves around the future of health care in the State and in the educating of consumers.

Ms WALTON: Yes. With more experience the commission will be in a better position to look at how they are dealt with.

Mr WEBB: The commissioner referred earlier to an Ombudsman-style role for the HCC. In response to questions that were taken on notice at our last meeting on the annual report, you noted that the legislation prescribes an Ombudsman-style role for the HCC but it does not provide the commission with the powers of an Ombudsman. Specifically, you noted that the commission does not have the power to review other organisations' investigations. Would you like to tell the Committee today what specific changes you would like to see to the commission's powers in this respect?

Ms WALTON: An easy way to answer that question is to direct the Committee to section 13(1) of the Ombudsman Act, which provides:

> Where it appears to the Ombudsman that any conduct of a public authority about which a complaint may be made—

and the conduct refers to a provision—

> the Ombudsman may, whether or not any person has complained to the Ombudsman about the conduct, make the conduct the subject of an in investigation under this Act.

We do not want that exactly; we want the monitoring power and we want to be able to review the quality of an investigation. A good example is the Hunter area food poisoning matter. No complaint was made to us. We had absolutely no entry point from which to review that matter, look at it, or do anything. It might well be a fabulous investigation, but it might well not be; we would not know. There are many

area health service investigations and we do not know the quality of those investigations; we do not know whether they raise public health or safety issues; and we do not know whether policy recommendations have been picked up.

Whilst we ask a lot of area health services to report back to us on the matters we refer to them, we have no specific power to do that. It is really done through co-operation. The only way we can do it is to cajole them. If we are not happy we sometimes say, "We will investigate it", and we go back to the Act. But I do not think that that is actually clear. I do not think that the Act allows us to reassess a section 46 complaint as a section 23 complaint. Sometimes we get area health services to refer matters back to us if we are unhappy. So that is the reason.

The Hon. H. S. TSANG: You also suggested that a possible line of inquiry for the Committee might be the consideration of the suitability of the commission conciliating complaints involving health organisations. At the moment it has no prosecutorial role. Could you expand on that suggestion?

Ms WALTON: This leads on from our earlier conversation about conciliation. Basically, I do not think there is any rational, legitimate, legal reason to keep the conciliation functions outside the ambit of the commission. For historical reasons, though, they are separate. I think it is because of the perception that the commission will have too much power, or there will be what are called confidentiality breaches between the investigation section and the conciliation section. Because of the way in which our Act is constructed—we must consider investigations first—this just does not arise. Other commissions do it. So it is really to save the Government some money and to streamline the process. If there are concerns about our prosecutorial role and there is confusion between conciliation and investigation, we do not prosecute health facilities. Even for health facilities you could do it and there would be no argument. I suppose a compromise position may be that we should be able to conciliate any complaint about a public facility.

The Hon. H. S. TSANG: During your time as commissioner what were your greatest challenges?

Ms WALTON: My answer depends on the period your question refers to. If you are asking about when the complaint unit was moved to a statutory authority, I would have said that that was the most difficult period I had had in 15 years. Most people had told me that they had never heard such a debate about a bill. Whilst I did not like it at the time, I wish we had had such a debate about a lot of health issues. When I speak about my frustrations I will tell you about that. I suppose one of my two biggest challenges were making an Act, which is very prescriptive and quite complex, translate into practical, workable actions. That was a very big challenge, which we accommodated and achieved very early in the life of the commission.

The second big challenge was to turn the complaints unit into an institution which was to survive. Today there is no debate about whether the commission should continue. We certainly debate about how we do things, and that is healthy. We do not debate whether we should exist, even though I note that the Australian Medical Association [AMA] has called for the abolition of commissioner and wants that position replaced with three commissioners; I suppose I should be flattered. I also

think it is about devolving power and fragmenting an efficient organisation. That is part of a healthy debate. That was a big challenge.

The constant challenge has been managing the different expectations and agendas of the stakeholders. I include consumers in that because some consumer groups have very strong views about the role of the commission which are at odds with the statutory legislative provisions of the Act. Managing different professional groups, the registration boards and the joint parliamentary committee is a constant challenge for the commission. It tries not to let one group gain dominance and that leads to the biggest challenge for the new commissioner; to try to remain neutral and not be captured by any one group.

The integrity of the place depends on not becoming an advocate for patients, not becoming an excuse for the profession, and not becoming bureaucratic in our response to the problems of the health system. My biggest frustration is a poor understanding of the jurisdiction. It is a complex area and part of the problem is that the registration boards change membership every two or three years. We are continually having to educate people and by the time we just get them to a position where we can progress we are back to square one. That is a frustration.

The lack of public involvement and debate about many of the issues confronting both the medical profession and health is frustrating also. We have such poor community and consumer involvement in health issues. In a way, the commission becomes a bit of a lightning rod when issues are articulated, but we need many other mechanisms outside the commission to involve consumers in health care. There is an embryonic movement, but the frustration is the poor level of debate. In response to the article which I had published about continuing confidence was an anecdote from a surgeon in a theatre in which the anaesthetist, or someone, said "Oh, there is Merrilyn bashing us up again." The surgeon replied, "Well, that is that headline, she is not the subeditor of the *Sydney Morning Herald*. Have you read it?" The anaesthetist said, "I will read it", and after reading it said, "No, she is not bashing us up." We need to lift that perception and get people to look at the real issues. I have just rolled three questions into one.

Mr WEBB: You have referred to what you think will frustrate your successor and it is apparent that, having gone through the annual report, the Committee is concerned with obvious errors. You have expressed your concern about future directions. Do you think it will be more of the same? Perhaps there will be three commissioners. How do you think these challenges will be faced?

Ms WALTON: The commission has identified for the next three years the three big picture items we need to focus on and all staff have been involved in the process. Basically, they are to speed up the investigation time frames, to actually improve the profile of the commission for alternate complaint resolution, and to improve our feedback to the health system where we have identified deficiencies in health improvement. We have developed strategies to achieve those three big items.

I imagine that the new commissioners would be delighted to come with that already set out and give them time to get on top of it. It will take three years to get on top of much of the jurisdictional matters. Hopefully, steady as it goes for those three years to achieve those things. The commission is a dynamic organisation and has to

be flexible, sometimes on a weekly basis. Whilst there has been criticism of me in the past, because of changed priorities, that is the nature of the game.

CHAIR: On page 56 of the report you refer to a number of consumer groups that you are consulting with. As part of the Committee's current inquiry into mandatory reporting negligence, we met with a newly formed group, the Action for Victims of Medical Accidents of Australia. That group was launched by a gentleman from the United Kingdom, Arnold Simanowitz, and is now incorporated and official. Previously it had run for two or three years in a very small way. Mr Webb, the director and myself met Mr Simanowitz in the United Kingdom. He works very closely with the British Medical Association, and attends colleges and lectures on complaint resolution and so forth. Instead of being adversarial, he is working with the doctors.

There was some apprehension on the part of doctors initially, but he is there to advise patients on how they can resolve matters and on legal action. Although the Action for Victims of Medical Accidents of Australian is not listed amongst the consumer groups you are consulting, the Executive Director, Lorraine Irene Long, said that she would be pleased to meet with the commission. On the day she was here, the AMA was represented and I introduced her to those representatives and also to Dr Tjiong from the indemnity fund. I am hoping to set up, in the next month or two, a round-table discussion on that inquiry.

I know that you are moving on it and I hope that the other members of the Health Care Complaints Commission who are in attendance take note of that lady and that organisation. Lorraine Long had some complaints about the time taken by the commission to handle complaints. She said that most people who go to her do not want to go to the commission because it takes too long to resolve complaints. If we could set up a dialogue with that group it may be quite helpful in resolving some of the problems, if they follow the United Kingdom model. The Committee will give you her name and address; could you include her in your consultation?

Ms WALTON: Yes.

CHAIR: On page 49 under "Legislative review", you refer to the Health Care Complaints Amendment Bill, which is being reviewed. What stage has that review reached? Also, do you know what stage the review of the Medical Practice Act has reached?

Ms WALTON: I enquired of the Minister's office about that two weeks ago. I was told that a draft bill had been prepared, but I have not seen a draft bill of the Medical Practice Act. Regarding the Health Care Complaints Amendment Bill, late last year I met a number of times with the parliamentary draftsmen, but I have not seen a document. I believe it is to have further consultation. That is all I can report.

CHAIR: On page 61 you list overseas travel, and that is very impressive. I recall reading the ICAC report in which the ICAC commissioner noted some of his travel. You have expanded on the details he gave of his travel. Members of Parliament now report on their overseas travel. On page 64 you referred to motor vehicle claims. Underneath the chart you stated:

The Commission has reduced its fleet of motor vehicles from three to two i.e. one SES and two pool vehicles.

At present the SES vehicle is leased and the two pool vehicles are owned by the Commission. A review obvious situation will be made in the near future for the purpose of determining practicality of replacing the Commission vehicles with leased vehicles.

It has been brought to my attention that this is happening throughout the public service. Instead of buying and trading-in after 40,000 kilometres we are actually going towards leasing. Have you investigated that concept? I would have thought that leasing would be less efficient. If you purchase a vehicle at a lower price, and sell it after 40,000 kilometres, would you not get a better return than with a leased vehicle? Has there been an instruction from Treasury?

Ms WALTON: It is a whole-of-government approach. The costs saved through leasing arrangements may offset each department's budget through Treasury purchasing capital, like cars. I will take that question on notice and will ask my director.

The Hon. Dr B. P. V. PEZZUTTI: The Treasurer confiscated $400 million worth of cars from New South Wales Health and then, as I understand it, supplemented the budgets of the area health services to pay for leasing. He actually got a capital injection of $400 million from that process. That was not identifiable in the area health service budgets, but was a whole-of-government approach to capital. Whether it is cheaper is a different matter. It is probably cheaper for each individual agency to turn over cars.

CHAIR: On page 62 you mentioned energy management plans. You stated:

The commission will consider:

- fuel efficiency when renewing its two fleet vehicles next financial year.
- energy efficiency ratings when replacing computers, and other office machines and equipment.
- energy efficiency went to photocopy machines are replaced next financial year.

Energy Australia and most other distributors have a program under which a group of people assess energy needs and uses, basically free of charge. They assess how energy can be saved. It is a special deal under which they work something out for future bills. I believe that the Hunter Area Health Service has been involved, and has introduced a number of changes whereby it can save many thousands of dollars on its energy bill. Although your organisation is not as large as that, EnergyAustralia would be able to look at the energy use of your office and suggest ways to save energy.

The Hon. Dr B. P. V. PEZZUTTI: I congratulate you on the annual report. The first question I would like to ask is about your foreword. How do you go about keeping the Government accountable for its provision of health services—given that, as you have said, apart from being invited by the Minister to investigate certain matters, such as the toxic injection at Canterbury Hospital, you do not really have any power to investigate matters? If you read about a matter in the paper you cannot investigate it.

Ms WALTON: We have no power on our own motion to do anything, let alone investigate.

The Hon. Dr B. P. V. PEZZUTTI: How did your investigation into skin care—which was a very good investigation—come about?

Ms WALTON: As a result of a complaint from a clinician.

The Hon. Dr B. P. V. PEZZUTTI: A clinician asked you to investigate?

Ms WALTON: A general practitioner who was treating the patient.

The Hon. Dr B. P. V. PEZZUTTI: And you made a more widespread investigation?

Ms WALTON: We had two complaints. I went to the Minister and said, "This is a trend." I think two complaints is a trend.

The Hon. Dr B. P. V. PEZZUTTI: You have no way of keeping the Government accountable for its provision of health services?

Ms WALTON: No, and the Act expressly prohibits the Commission from making any recommendation about resources, which underpins a lot of Government activity.

The Hon. Dr B. P. V. PEZZUTTI: Your report on skin care had some implications?

Ms WALTON: That was as a result of a complaint.

The Hon. Dr B. P. V. PEZZUTTI: In the third last paragraph on page 4 you say, "The Director General of Health has agreed to a joint sponsorship of a project to address continuity of care." What project is that?

Ms WALTON: We had about seven complaints from which it became evident the problem was not with the hospital and the community, where we often talk about continuity of care. The problem was within the hospital system with the development of sub-specialisations, the movement of the patient around the hospital and no one person being particularly responsible for the tests that were ordered, the review of the tests and the discharge of the patient. That became an issue.

I wrote to all the area health services to find out if they similarly identified that as a problem, and they did. I addressed the senior executive forum, and they did. They agreed with my suggestion that the Commission should develop a position paper. When we were in the process of doing that I thought that this is too big for the Commission to take on and the Department of Health needs to drive it. I met with the Director-General who agreed. He has now agreed to establish a working party to look at continuity of care, and that is where it is at.

The Hon. Dr B. P. V. PEZZUTTI: Does that come under whole-of-quality management?

Ms WALTON: It does. We can refer any complaint that raises other issues of health and safety. We did not do it formally under section 53, but the Director-General has agreed to take it on.

The Hon. Dr B. P. V. PEZZUTTI: For the Commission to take on something like that would require a huge injection of money and resources into your area?

Ms WALTON: That is right. We are doing it as co-sponsorship of the problem.

The Hon. Dr B. P. V. PEZZUTTI: The cosmetic surgery report is mentioned in your foreword, which gives me the ability to ask you questions about it. Did you get supplementation of your budget to do this report?

Ms WALTON: No Commission money went into this. The Health Department provided all the money for the cosmetic surgery report.

The Hon. Dr B. P. V. PEZZUTTI: It is fascinating. You may have seen an article in the *NSW Doctor* written by Dr Martyn Mendelsohn.

Ms WALTON: He was on the committee.

The Hon. Dr B. P. V. PEZZUTTI: Dr Mendelsohn, who is quoted extensively in the article, makes the point that out of an estimated 20,000 cases of cosmetic surgery only 20 complaints were lodged with the Health Care Complaints Commission last year and the incidence of medical defence claims is no higher than in any other area of medicine. Further, he said that the dollar amounts of settlements are generally lower than in other areas of medicine. Why was this report—which is not one of the best reports I have read—undertaken?

Ms WALTON: Because it was a ministerial inquiry. It was not a Commission investigation.

The Hon. Dr B. P. V. PEZZUTTI: The Minister directed it?

Ms WALTON: The medical profession itself requested this inquiry. I think that the potential risk to consumers is sufficient, with the knowledge that surgery is being done in rooms with improved sedation techniques without an anaesthetist. Receptionists are being used as assistants. The fact that we have no recorded death, I am not going to wait around for a royal commission and then do this report. It was a very proactive report.

The Hon. Dr B. P. V. PEZZUTTI: It may well have been. In spite of that, the main problem identified was advertising controls. In other words, what can be offered, what people can do, what people promote, consent and all those sorts of arrangements were not addressed effectively by this report.

Ms WALTON: They were addressed by the report. The Australian Competition and Consumer Commission [ACCC] and the Health Care Complaints Commission have circulated new advertising guidelines that are out there now. Basically, the

pathway is to educate the health profession about the guidelines. If the profession does not comply with the appropriate advertising guidelines—that is, to not use models, to not use before and after photos, to not make false and misleading claims—we evaluate that and get the evidence. That is the evidence we need to get the Trade Practices Act evoked to get a prohibition on advertising in specific areas.

We have been told that will not occur—we tried it with the impotence inquiry—until we have tried an education program. We are doing that right now. We have developed the guidelines, they are out there. If in 18 months we still see false and misleading advertising in these cosmetic magazines with 18-year-old models who have never had a procedure in their life, then, as we have been told by the ACCC and the Commonwealth department which is responsible for this area, section 61D of the Trade Practices Act can be used. That is a prescription which says they will not be allowed to advertise certain things. We will have evidence that the public interest needs protection. That is the pathway.

The Hon. Dr B. P. V. PEZZUTTI: The ACCC has the power to investigate complaints. If I complain 18-year-old models who have never undergone surgery are being used, then the ACCC can investigate off its own bat. I think the ACCC is part and parcel of the problem. The ACCC Act does not require this inquiry and public education. It can investigate there and then. Why has it not done that? Did it explain that during this inquiry?

Ms WALTON: Ask Commissioner Fels.

The Hon. Dr B. P. V. PEZZUTTI: It is not clear from this report that the ACCC used its powers, and therefore you had to undertake this report.

Ms WALTON: I will go back to Dr Mendelsohn. He has manipulated the data in that statement. Nowhere in the report do the statistics show what he says. He is one of nine clinicians and he is out of kilter with the others.

The Hon. Dr B. P. V. PEZZUTTI: Out of 20,000 cases, were more than 20 complaints lodged with the Health Care Complaints Commission?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: More than 20 cases in the year 1997-98?

Ms WALTON: I do not know, you would have to look. It was not just the Commission, there were other complaints.

The Hon. Dr B. P. V. PEZZUTTI: If you are saying that Dr Mendelsohn is wrong, that more than 20 complaints were lodged—

Ms WALTON: I think it is a manipulation of the data.

The Hon. Dr B. P. V. PEZZUTTI: What is the data then? Were there more than 20 complaints?

Ms WALTON: The cosmetic surgery inquiry was not a Commission inquiry. We reported on it in the annual report because it took my time away from the Commission. This was a ministerial inquiry done under the Health Administration Act.

The Hon. Dr B. P. V. PEZZUTTI: It was done by you as Commissioner, as mentioned in your annual report.

Ms WALTON: Because it was me and took away from my time as Commissioner administering the Health Care Complaints Act.

The Hon. Dr B. P. V. PEZZUTTI: You signed it as the Commissioner, Health Care Complaints Commission, Chairperson, Cosmetic Surgery Inquiry. You mentioned that it was a major focus throughout the year.

Ms WALTON: It was, of my time.

The Hon. H. S. TSANG: For someone who is not a doctor and reads these magazines, that provides good public education.

The Hon. Dr B. P. V. PEZZUTTI: Doctors are not the only people who are mentioned in this report. If there were only 20 complaints, was this a wise use of your major focus? You say, "Cosmetic surgery was a major focus throughout the year."

Ms WALTON: It was a major focus for me, not the Commission.

The Hon. Dr B. P. V. PEZZUTTI: This is the Commissioner's foreword.

Ms WALTON: I am the Commissioner and it was a major focus for me. It did not take up the Commission's resources.

The Hon. Dr B. P. V. PEZZUTTI: Were there more than 20 complaints?

Ms WALTON: I do not know what page it is on, Dr Pezzutti. You will have to look, I do not know. I was not prepared to answer questions on the cosmetic surgery inquiry.

CHAIR: The Commissioner said that she believed it was a manipulation of the figures.

The Hon. Dr B. P. V. PEZZUTTI: She cannot tell me how many complaints have been lodged.

CHAIR: As the Commissioner has mentioned in her annual report—and I believe our Committee is at liberty to investigate anything that is mentioned in her annual report—I expect that in the future we will review that report and conduct our own inquiry.

The Hon. Dr B. P. V. PEZZUTTI: It is not a report by her. From 1995 to 1999 the Health Care Complaints Commission received 54 complaints. In other words, far less than 20 complaints.

Ms WALTON: I am not arguing.

The Hon. Dr B. P. V. PEZZUTTI: You said it was a manipulation of the figures.

Ms WALTON: United Medical Protection gave evidence to the inquiry. Dr Tjiong came and said, "We are worried about cosmetic surgery. There is an escalation in the number of complaints." True, a less dollar amount is awarded in judgments and awards, but there is a growing concern about a number of people who are doing procedures and are not covered.

The Hon. Dr B. P. V. PEZZUTTI: In four years 54 complaints were lodged with the Health Care Complaints Commission.

Ms WALTON: I do not disagree. This inquiry was not as a result of complaints to the Commission.

The Hon. Dr B. P. V. PEZZUTTI: I am worried about the use of your resources and you as a person for an inquiry which was directed by the Minister, which the department could have undertaken.

CHAIR: We have the opportunity to review the report in the future.

The Hon. Dr B. P. V. PEZZUTTI: We do not really because it is a report to the Minister by a commission of inquiry. It is done by Ms Walton, not by the Commission.

Ms WALTON: No.

CHAIR: The way I read the Act our Committee has the right to investigate anything that is contained in her annual report or any other report that she tables to Parliament. She has mentioned it in her annual report, perhaps at the request of the previous Chairman, so we can investigate it at a later date. On our visit to Victoria we were told that although not many complaints are received there are concerns about one cosmetic surgeon doing deals with other cosmetic surgeons to fix up his mistakes and sort it out in-house. I know that the Health Services Commissioner in Victoria is concerned about the situation there because she discussed it with me just prior to Christmas. There is concern in other States and we should look at the concerns you have raised in the future.

The Hon. H. S. TSANG: This being the last inquiry with the Commissioner it would be more beneficial for the Committee to talk about the future challenges for the success of the Commission rather than focus on this.

The Hon. Dr B. P. V. PEZZUTTI: This is an ongoing issue. The reason I asked those questions was not to challenge the nature of the report but the fact that Ms

Walton said that cosmetic surgery was a major focus throughout the year. If the Minister asks the Commissioner to chair such an inquiry and it takes up a great deal of her time, the Minister should be providing more resources to the Commission so that Ms Walton's absence will not affect its workings.

Ms WALTON: Dr Pezzutti, my work was at night, it was additional hours on my days. The Commission's work did not suffer one iota because of my work on this inquiry.

The Hon. Dr B. P. V. PEZZUTTI: The reason for the questions was the small number of complaints and the fact that the Commissioner undertook the inquiry. The Commissioner is a senior public servant who oversees an important function. The Minister asked for this report; it was not directed by the Commission.

CHAIR: You have articulated your case in a detailed way and I think it is clear to everyone at the table that your line of questioning is political.

The Hon. Dr B. P. V. PEZZUTTI: No, it is not.

CHAIR: I think the Commissioner has handled the questions very well. Do you have anything else? It was antagonistic.

The Hon. Dr B. P. V. PEZZUTTI: It was not an antagonistic question. I object to that because it was about the Commissioner's resources. On the next page the Commissioner says, "Many Aboriginal communities told us about the problems they experienced, including discrimination and access to district hospitals." How do you undertake consultation with Aboriginal communities on these matters?

Ms WALTON: The Aboriginal medical service is the contact person for the local Aboriginal community. We do not go through the public health system at all or the Health Department. They organise different members of the community, either through the lands council or just family groupings, to meet and it is a very informal meeting where I meet and my colleagues meet. We usually provide morning or afternoon tea and we do an introductory section where we talk to about their rights to complain and do you know about us, and then they will share with us their experience. They are very astute in terms of the quality of the care they receive. There were some consistent themes and I have done a draft report to the Minister on those initial consultations with the Aboriginal community. Some consistent themes are discrimination in emergency departments, lack of access to hospitals—and that was a problem for a lot of the lower socioeconomic groups in smaller communities where hospitals have been closed down. They have to go to the district base hospital but no transport is available. So, in some small towns they have to walk for three hours to get a train, which is very irregular, to get to a hospital. One of our strong recommendations would be when closing services they have to provide some mechanism to access the system.

The Hon. Dr B. P. V. PEZZUTTI: I did not ask that as a political question. My question relates to page 10, where you state, "To make the commission's service more accessible to Aboriginal and Torres Strait Islander people." Can you tell us how many complaints you receive from Aboriginal and Torres Strait Islander people?

Ms WALTON: Yes I can, Dr Pezzutti. We have just started keeping data on cultural background, languages spoken at home, and page 27 states that 1.5 per cent of complainants identified themselves as an Aborigine or Torres Strait Islander.

The Hon. Dr B. P. V. PEZZUTTI: Yes, I saw that. Is that high? They represent 1.5 per cent of the population but they also represent, as you said, a very high percentage of the people in the Aboriginal and Torres Strait Islander group, which is a fairly disadvantaged group people. Coupled with the access to service question that is a relatively small percentage of the complaints.

Ms WALTON: I think it is very low. That is why we are starting to keep the data.

The Hon. Dr B. P. V. PEZZUTTI: Do they make more complaints? Most area health services have a Aboriginal person on the staff. I know Northern Rivers has two or three to help Aboriginal people when they come into the hospital, because they do not like to complain and they are very quiet. So, to get them out of their shells they have Aboriginal health workers in the hospitals.

Ms WALTON: That is true, but from talking with the Aboriginal communities they do not complain to the Aboriginal person at the hospital. In fact, many of them complain about the Aboriginal liaison officers in the hospitals. I think they tend not to complain generally, and the complaints we get usually come from the Aboriginal Legal Service.

The Hon. Dr B. P. V. PEZZUTTI: So, is there a way we can make the problems that the Aboriginal and Torres Strait Islander people have in accessing private services or hospital services or community health services or whatever, known to the doctors, the providers of the health care, so they know what the problems are? It is a real issue.

Ms WALTON: In the draft report I have completed—and I did it with staff who contributed to it—we have made recommendations to the area health service in every place we have visited to improve access and how they can involve the Aboriginal and Torres Strait Islander communities in the development of services for Aboriginal people. Having more Aboriginal faces in hospitals for a start. For example, far west now has an Aboriginal health west ward where the Aboriginal community actually controls general services, but even though they have a community centre where 80 per cent of the users are Aborigines there is not an Aboriginal person on the reception desk or employed in the centre.

The Hon. Dr B. P. V. PEZZUTTI: Is it possible for us to get some of those reports? I have no idea what people in the Aboriginal community complain about or worry about. Aboriginal medical services are now established in most major centres—Casino, Grafton and so on. Lismore has Aboriginal medical service but even when they access the Aboriginal medical service I do not know what they have a difficulty with.

Ms WALTON: The Aboriginal medical services themselves, through general funding, are having a difficult time. A lot of Aboriginal communities only access dental services through the medical service, and they are cutting down the dental service to a mobile unit once every three months. It is becoming so difficult to even provide services.

The Hon. Dr B. P. V. PEZZUTTI: The Aboriginal medical service at Casino, which was opened by the Minister during the election campaign, is funded by the area health service not by the Commonwealth. It might be with Commonwealth money but it is funded through the area health service. The big issue we all face in health, and which you would also face, is the concern in the broader community and in the Aboriginal community about their health care and the quality of the health of the people in the Aboriginal community. The standard of health care is probably the lowest in Australia. Part of the reason is that they do not access the services because the services are not right for them, or not in the right place or not provided at the right time and in the right way. It would be good if someone would produce a report that says these are the problems with the service you are offering. That might improve the services and improve the general health of the Aboriginal community. I have not seen figures on what is the problem with what is being provided.

Ms WALTON: That is a report on our consultations but it is not evidence-based. It is our perception but we think it is sufficient for people to take notice of. It will be going to the Minister within the next month. I will probably sign off on it on Friday. We have already sent it in draft form to those Aboriginal communities we consulted with and to the Aboriginal Health and Medical Research Council.

The Hon. Dr B. P. V. PEZZUTTI: We probably would not see that report until the Minister has received it.

Ms WALTON: Probably in the next annual report. I do not have a problem with giving access to a report we have done. In my view, I think the commission should probably publish it.

The Hon. Dr B. P. V. PEZZUTTI: That is a problem not so much with access but whether it is what they like.

Mr WEBB: I think we have touched on a much greater area than just health-care provision. Largely the Aboriginal and Torres Strait Islander people's unwillingness to complain is often a cultural thing, and unless the Aboriginal adviser in the health service or the people running the ward are culturally attached to those people they will not correspond with them. They will not speak with them or open up.

The Hon. Dr B. P. V. PEZZUTTI: I would be interested. Ms Walton has done the consultation; it would be great to have the information.

Ms WALTON: We have completed a third of the State. We have two-thirds still to do. The intention was to have a public report on those consultations. But to assist the Aboriginal community we now have little fridge magnets of the poster we have developed, and they have been distributed, just to let them know how to complain.

The Hon. Dr B. P. V. PEZZUTTI: Does the patient support office in the area health service have an Aboriginal helper it can use if an Aboriginal person wants to talk or be guided through the process?

Ms WALTON: We have one Aboriginal support officer who has contacts with the local Aboriginal community. Each patient support office has developed that locally.

The Hon. H. S. TSANG: Ethnic communities are unlikely to complain about the police or any services because of the complaint process of filling out forms. It is very hard to understand what to fill in. It takes time to fill in different forms and it is very frustrating because of different language barriers, and the time and skill required to fill in the form. Maybe the complaint process needs to be simplified.

. **CHAIR:** Following on from what Henry is saying, I see you list here, "Country of birth"and the percentages of complaints. The Philippines is 1.1, China is 1.1 and Lebanon is 1.5, the same as for the and Torres Strait Islanders. You have brochures in different languages, do you not?

Ms WALTON: Yes, 15.

CHAIR: I notice when you go through the list of the consumer groups I mentioned earlier about adding Actions for Victims of Medical Accidents [AVMA] to the list of the consumer groups that you consult with, you have the Aboriginal council on that list.

Ms WALTON: Yes.

CHAIR: Has consideration been given to getting these out to those ethnic communities, the Chinese community, the Philippines community, and conducting education campaigns? I agree with the Hon. Henry Tsang, we see a lower percentage because of language barriers.

Ms WALTON: He is right. The Ethnic Communities Council has identified the need for us to specifically target those communities. We do not want to do it on the run. We are getting a consultant in to look at a specific promotion strategy for non-English speaking communities, and that is a specific target requirement of the commission that we have undertaken to do with the Ethnic Communities Council.

The Hon. Dr B. P. V. PEZZUTTI: Page 10 refers to the number of telephone inquiries received, 5,497 and then to the number of complaints received. So, first there are inquiries and then you received complaints. Is that so?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: You received more complaints than during the previous year but I notice that the number of patient support officer clients was 2,842. How many of the patient support officer clients actually become complaints received?

Mr WEBB: They are carried over from the previous year, are they not?

The Hon. Dr B. P. V. PEZZUTTI: No.

Ms WALTON: No. Of that 2,052 there would be a small percentage of patient support officer clients, because we actually assess the complaint and refer it to the patient support office. But I think from memory about a third are referred from the commission. The number of formal complaints that arise out of those patient support officers is 5 per cent to 7 per cent.

The Hon. Dr B. P. V. PEZZUTTI: If someone goes to see a patient support officer, they do not necessarily make a complaint do they?

Ms WALTON: No.

The Hon. Dr B. P. V. PEZZUTTI: Are they similar to a telephone inquiry?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: A patient support officer might resolve an issue which is then not actually dealt with as a complaint?

Ms WALTON: No, it will be a patient support officer client.

The Hon. Dr B. P. V. PEZZUTTI: Do they just help them through a problem?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: But if the patient support officer was not there, the only access would have been for it to become a formal complaint?

Ms WALTON: Or a telephone inquiry.

The Hon. Dr B. P. V. PEZZUTTI: That would indicate to me that there are more avenues open for people to have their grievances—not necessary complaints—addressed?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: So your workload has substantially increased. The number of telephone inquiries has dropped off a little, but you now have the face-to-face process.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: I know in the Lismore Base Hospital there is a very good advertisement for the patient support office. You want to complain, everybody will send you off to see this person. That is a good process but it does increase your workload. Since the patient support office was established have you

received more resources or have you made savings within the organisation because of the work of these patient support officers?

Ms WALTON: We receive resources from Treasury every year for the patient support officers.

The Hon. Dr B. P. V. PEZZUTTI: But your budget each year has not necessarily grown by that amount?

Ms WALTON: In our budgeting process the patient support office has been a dedicated service with the initial grant. We have been able to add to that through not necessarily Treasury but the Department of Health or ministerial approvals for ongoing funding. For example, this Committee recommended an inquiry into local complaint handling. We have patient support offices throughout the State and we got approval to increase the numbers just in the past year. That will up the numbers but it does not take away from the funding of the commission.

The Hon. Dr B. P. V. PEZZUTTI: I received a question from the Ethnic Communities Council which was not included on the list. One of the things about which I have been impressed is the way in which you have been prepared to go out, not so much defend your patch but to promote the work of the commission at every opportunity. Has that been a valuable exercise for the Commissioner and for the work of the commission?

Ms WALTON: Yes, the Act requires me and the commission staff to do it. Yes, I do.

The Hon. Dr B. P. V. PEZZUTTI: Do you get positive feedback from when you appear at the College of Anaesthetists continuing education program?

Ms WALTON: Yes, always.

The Hon. Dr B. P. V. PEZZUTTI: What is the work of the complainant liaison officer? Should the work of the liaison officer continue?

Ms WALTON: The complainant liaison officer was a position that we established to help people, particularly those with complaints of sexual misconduct, through our own disciplinary processes to the prosecutorial role because that in itself is pretty horrible for the complainants. We have now passed on that role to patient support officers who will attend court and sit with the person and we have integrated it. The complainant liaison officer which is a dedicated position with the commission is now a resolution officer and helps with other work in the commission. It was really rationalising our resources, picking up on the expertise of the patient support officer.

The Hon. Dr B. P. V. PEZZUTTI: As set out towards the bottom of page 12 of the report, in 1998-99 the commission referred 22 complaints to the medical board, the board substantiated the vast majority of those complaints and counselled practitioners where appropriate. Does the board conduct investigations?

Ms WALTON: No, it does not. The Medical Practice Act—I think it is section 50—states that on receipt of a complaint the board may do the following things and it says counsel. The law as it currently stands says that if there is any inconsistency between a Health Care Complaints Act and any registration Act, the Health Care Complaints Act prevails. Our Act says under section 26 that we can refer a complaint for investigation to another appropriate body. We think a registration board should maintain some of those responsibilities and share the workload, basically.

With the nurses board, the medical board, and to a limited extent the psychologists board, we have got written agreed protocols about a certain class of complaints that might get bogged down in our system for 12 to 18 months which they could resolve very quickly and if there is a problem refer back to us. For example, last week the medical board referred two complaints back for investigation after interviewing the doctors on some initial complaint.

The Hon. Dr B. P. V. PEZZUTTI: For example, prosecutions before the board are entirely a matter for you. They cannot be resolved with counselling to their satisfaction and referred back to you for approval because you effectively have to approve that?

Ms WALTON: No, this is part of section 26. There is no law which says they have got to report back to us. They do because we are all aware that our Acts are so close, we have to get it right.

The Hon. Dr B. P. V. PEZZUTTI: It is part of transparency.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: Those investigations are still undertaken and, as a result, that is where the counselling process comes in?

Ms WALTON: The board does not investigate as we do. They write a letter, get the doctor's response or interview the doctor and that is it.

The Hon. Dr B. P. V. PEZZUTTI: The counselling process is quite a formal process is it not?

Ms WALTON: Not under that provision. During a fact-finding interview they will say that it does not seem right and really, "Do not do it again." "What are you doing?" "What is your continuing education program?" They talk and counsel them about how to avoid a complaint. It is not counselling as at the end of an investigation we refer formally under section 39.

The Hon. Dr B. P. V. PEZZUTTI: In an instance when a person has been the subject of a sexual assault process about which the police have been informed, the police have conducted an investigation, the matter has proceeded to court and the court has found the person not guilty, I cannot understand why you would then separately investigate the matter.

Ms WALTON: Because they are two totally different jurisdictions. Different standards of proof are required and the nature is different. For example, you might have a doctor before the Coroner's Court who is seeking to establish the cause of death. The coroner may or may not refer it. It could also be a complaint to the commission and we are investigating the doctor and a complaint to the police who are investigating. Our Act says that notwithstanding any criminal or civil proceedings we are to proceed to investigate and prosecute because it is in the public interest to do so. It is a protective jurisdiction.

We have Supreme Court rulings about the necessity to continue notwithstanding criminal proceedings. Many doctors have taken the commission to the Supreme Court to stop our proceedings until after the criminal court and they do not even agree with that. It is a protective jurisdiction and it has a different standard of proof.

The Hon. Dr B. P. V. PEZZUTTI: What is the standard of proof?

Ms WALTON: It is Briggenshaw in our jurisdiction. The criminal standard is on the balance of probabilities, not beyond reasonable doubt.

The Hon. Dr B. P. V. PEZZUTTI: I read the Commissioner's judgment and it says "comfortably satisfied" which is different from a reasonable probability—

Ms WALTON: On the balance of probabilities—that is because the more serious the consequences that flow, the higher onus on the standard of proof. Most of our complaints in the tribunal are really serious so it is probably a higher standard.

The Hon. Dr B. P. V. PEZZUTTI: In relation to complaints received by category—on page 13—there were 70 nil or incorrect clinical practice diagnoses. Further down you have "Diagnoses incorrect 103". What is the difference between those two?

Ms WALTON: None as far as I can see from looking at it. I think we should probably have one category and add them altogether. It should be 177 and we should just have "Diagnoses nil incorrect". I think it is an error.

The Hon. Dr B. P. V. PEZZUTTI: In relation to treatment incorrect and treatment inadequate I can understand the separation. On that same table patient rights, second opinion not provided?

Ms WALTON: It is where they have asked for it.

The Hon. Dr B. P. V. PEZZUTTI: Do you think everybody should get a second opinion if they ask for it?

Ms WALTON: The Department of Health has circulars on patients' rights. They are entitled to a second opinion.

The Hon. Dr B. P. V. PEZZUTTI: It is interesting that there has only been one complaint about that. Does that indicate that just about everybody who asks for a second opinion gets one?

Ms WALTON: I think people probably do not ask for them.

The Hon. Dr B. P. V. PEZZUTTI: On the quality of care it says, "Inappropriate discharge and premature discharge"?

Ms WALTON: A premature discharge is when they are sick and should not be discharged. An inappropriate discharge is at 2.00 o'clock in the morning they put an older person in a taxi and send them home.

The Hon. Dr B. P. V. PEZZUTTI: There is a lot of semantics about what is called "early discharge" which has crept into hospital management or care management. Early discharge is not necessarily unplanned, is it? Would these be complaints about what is basically an unplanned process where the patient is not satisfied with the plan or where no plan was made?

Ms WALTON: We do not use the phrase "early discharge". No, it is when the patient or the family were too sick and should not have been discharged in a manner or method or whatever.

The Hon. Dr B. P. V. PEZZUTTI: I was surprised to see the very small number of only 89 complaints about standard of care facilities.

Ms WALTON: It is a small number but that category might take in the standard of the building, the shower and all that. I do not think patients complain to us about those matters.

The Hon. Dr B. P. V. PEZZUTTI: I was also surprised by the very small number of 15 complaints about delay in admission.

Ms WALTON: We do not get complaints about waiting lists because the Department of Health has a person to deal with those. We do not get them when there has been a delay for elective surgery or whatever.

Mr WEBB: That is an administrative problem rather than health care matter?

The Hon. Dr B. P. V. PEZZUTTI: The 35 complaints about fees is also a small number?

Ms WALTON: That is true and do not forget they are written complaints. People might ring us up and we tell them not to complain to us about fees because there is nothing we can do about it, go to Fair Trading.

The Hon. Dr B. P. V. PEZZUTTI: The 53 complaints about medico-legal reports is a tiny number. I hear lots of complaints about medico-legal reports and how long they take to get done and I am surprised you only received 53 complaints.

Ms WALTON: It is one a week.

The Hon. Dr B. P. V. PEZZUTTI: It is not very many. I am surprised by the areas in which you get complaints but in areas where there are a lot of complaints to

members of Parliament and others that you are not getting them. Maybe people make the judgment that you can not do much about them and they see you just as a clinical health care agency. They do impact on their lives dramatically.

Ms WALTON: I know they do and I do not think we deal with them very efficiently either. Generally we have a policy on medico-legal that we usually do not deal with them unless there is a reason if there is another avenue. We have a number of serious medico-legal reports which raise issues of conduct and competence but they are an exception. Mostly we think that if they are represented by a solicitor or lawyers they have an avenue to test the validity of the report. We need to rethink that because there is a growing trend of lack of independence about some of the reports.

The Hon. Dr B. P. V. PEZZUTTI: Earlier this year a judgment about reports caused me some concern and I have referred it to the Committee to discuss regarding the ability of the court to discover information which they were not able to discover before. What is your concern about that matter?

Ms WALTON: It is where the plaintiff in a medical negligence claim subpoenas all the complaints against a respondent, not just their matter. The court has said we are to produce it. It actually is not the open door that a lot of people think it is because the lawyers still have to argue whether it is relevant. It is not as bad as the wild west as everyone thinks and you can get access to everything. The court has just said that we have to produce it. The next step though is for the lawyers for the plaintiff to argue the relevance, and I am not sure they would be successful.

The Hon. Dr B. P. V. PEZZUTTI: In relation to waiting lists, there were three complaints in 1996-97, none in 1997-98 and two in 1998-99. From that one would think that nobody is worried about waiting lists. Is that because the waiting lists complaint hotline has taken those figures or because usually people complain about waiting lists to their local area health service?

Ms WALTON: Both of those or, thirdly, they might ring the commission and we tell them to go to the hotline or the area health service.

The Hon. Dr B. P. V. PEZZUTTI: These people have usually gone past the telephone inquiry to make a formal complaint to you, and you have then accepted it as a complaint?

Ms WALTON: Yes. For example, the patient support officer may well have quite an active involvement in helping people sort out their waiting list problem which we would not even know about.

The Hon. Dr B. P. V. PEZZUTTI: You received two complaints about resources. About 4,000 signatures came to this Parliament about the resources of the Northern Rivers Area Health Service but such complaints do not necessarily come to you as an official complaint? I am not saying it is misleading but I am saying that you have to be careful what the report is or is not saying.

Ms WALTON: This is just a complaint category and that would be a letter of complaint that we want an MRI machine in a hospital.

The Hon. Dr B. P. V. PEZZUTTI: Surely that would not be an official complaint?

Ms WALTON: It is a complaint.

The Hon. Dr B. P. V. PEZZUTTI: To increase the figures we should get everyone to write to you to complain about the resources of the area health services?

Ms WALTON: It would be a waste of time because the Act prohibits us from doing anything.

The Hon. Dr B. P. V. PEZZUTTI: You would still put it in as a complaint?

Ms WALTON: Yes.

(Luncheon adjournment)

CHAIR: I have some questions following upon what was discussed before lunch. I have some concerns about issues raised with us when this Committee undertook an inquiry into management and reporting of malpractice. Dr Tjiong, who is the chief executive officer of United Medical Protection, gave some information which was quite interesting. I note in the report under "Goals" on page 6 that it states "to undertake impartial and fair prosecutions in disciplinary matters". That is one of the goals of the Health Care Complaints Commission.

I turn to page 41 under "Prosecutions" which states that the commission prosecuted 28 health care providers before Professional Standard Committees. On page 46 the report details the number of cases that went before the Professional Standard Committees rather than before the full tribunal. I just want to clarify whether it is correct that before the full tribunal, both the Health Care Complaints Commission and the doctor have legal representatives.

Ms WALTON: Yes.

CHAIR: Before the Professional Standard Committee, there are no legal representatives. Is that correct?

Ms WALTON: That is correct. They are legal advisers to the respondent.

The Hon. B. P. V. PEZZUTTI: They are allowed to have advisers but they are not represented.

Ms WALTON: No. The advisers are in the room. They advise them and sometimes they speak, with permission.

CHAIR: I will quote quite a large slab from Dr Tjiong's submission to our inquiry. That will take a little while, but it gives the background and then I will move to the case in point. Dr Tjiong stated:

The structure of the Health Care Complaints Commission is such that the investigating arm of the Health Care Complaints Commission and the de facto prosecuting arm of the Health Care Complaints Commission, or the de facto prosecuting division, are both part of one Health Care Complaints Commission presided over by one single

commissioner and that, Chairman and members of this Committee, is akin to the police department in New South Wales and the Director of Public Prosecutions being put under one head, combining the Minister for Police and Attorney General under one portfolio.

We could disagree and argue about that.

We feel that there is an inherent unfairness in due process by combining the two. The division of the two is essential for fair play, due process and democracy, and the division of these two functions of such a process is observed in Great Britain; it is observed, to the best of my knowledge, in Victoria and in Queensland, and I would like to think, and I cannot speak of this as strongly with knowledge as a formed impression, that this division is observed in the majority of the jurisdictions in the United States Of America and I would like to think that the Americans are even more gung-ho, if that is the word that could be said, about the protection of citizens' rights.

At the end of the day it is not so much to do with citizens' rights as it is to do with the Health Care Complaints Commission being able to produce the outcomes expected of it, and I do not believe that the Health Care Complaints Commission is able to produce the outcomes when the structure combines investigations and prosecution.

The unfairness of this process, or the weakness of this process, is evident conspicuously in the proceedings of the Professional Standards Committee [PSC]. I do not know whether this Committee is aware that in the proceedings of the PSC the respondent doctors are required to represent themselves.

We know from the due process of court law processes that if I were the respondent and there were criticisms made of me of a serious nature— otherwise I would not be there at the PSC—my emotion is such that I could not possibly think clearly, let alone cross-examine or examine other witnesses and then provide my own defence.

Contrast this against "the opposition", and I say "opposition" in the sense that there should not be an opposition but the processes within the PSC are very much conducted along the lines of "them and us". On the HCCC side, they have a person whose responsibility it is to provide evidence for the Professional Standards Committee but he invariably conducts himself, or herself, as a prosecutor, adversarial in his or her approach.

These officers are not supposed to be lawyers because the doctors are not supposed to be represented by anybody else, let alone by a lawyer, and I accept that is a good process, that is, that neither side should have a lawyer, because then we introduce more adversarialness into the process.

Now, given that our undertaking, out joint undertaking and, thirdly, the undertaking of the Medical Board, is that this shall be non-adversarial so that we will not have lawyers representing the HCCC or representing the respondent doctor, invariably, however, we find that the HCCC officer is either a professional in his or her job in prosecuting or is a learned lawyer —a qualified lawyer—without a licence to practice law.

I give as an example the lady to my left, Helen Turnbull, who worked for the HCCC for a time. She was a qualified solicitor of many years standing in jurisdictions outside New South Wales. You may have detected her New Zealand accent. She worked in Britain as a qualified solicitor. She was recruited by the HCCC at a time when she had not acquired a licence to practice in New South Wales but, for all intents and purposes, you must accept that she had the skill of a lawyer and was prosecuting as a lawyer on behalf of her master, the HCCC.

I was quite surprised to hear that because, I agree, that I would have thought that if the matter goes before the committee, neither side should be represented by someone with the legal qualifications. I wonder whether you could comment on that and explain how that situation occurred. Is it an ongoing situation where the HCCC is employing lawyers who are qualified but not registered in New South Wales?

Ms WALTON: You have asked me three questions so I will take the first one of Dr Tjiong's observations about every other country in the world and in every other State having a separation of those functions. He is wrong. In Victoria, the medical board receives the complaint, assesses the complaint, investigates the complaint and prosecutes the complaint. In prosecuting, it is in no way different to what we do, that is, it briefs counsel and in fact adjudicates on the complaint. In this State, we have separated the investigation and prosecution from adjudication.

I think it is mischievous at the highest level to actually say that this State is doing an undemocratic thing whereas in every other place they are doing a very democratic thing. I can tell you that every country such as America and the UK are offended beyond belief that their general medical councils and medical boards receive, assess, investigate, prosecute and adjudicate.

I cannot believe this. This indicates the frustration about the level of intellectual rigour that goes into understanding our jurisdiction. It is political point-scoring to use other examples when people themselves do not take the effort to understand and know the processes that are in place. I cannot say that highly enough, and that answers that question.

Further to that, I have been to see Mr Cowdery, the Director of Public Prosecutions [DPP], about those problematic perceptions about our functions. His view and the view of many other people is that we are not prosecutors in the criminal sense and are more like counsel assisting. We have two pieces of legislation, namely, The Medical Practice Act and the Health Care Complaints Act, and we have a statutory responsibility to bring a charge and to provide the evidence for that charge. It is adjudicated and determined by a totally separate body. We are not like the police. In fact, if we had board doing all these things, it would be like the police investigating the police. It is not like the police investigating the police. That is the answer to the first question.

Second, how Professional Standards Committee matters are heard is under the Medical Practice Act and it has absolutely nothing to do with the Health Care Complaints Commission. That is pretty easy. If there is no legal representation allowed, that is because the Act says that.

Third, we have employed hearings' officers with legal qualifications because the medical board specifically requested us to have knowledgeable and experienced people with expertise in administrative law and natural justice because it is not a legal process. They do not want a kangaroo court, so they have relied on the commission to have people with specific training. They wanted them to be dedicated positions so that they could run these hearings in a fair and just way. I have not known of any case where it has been put us that there has been an adverse effect or breach of natural justice to a respondent in those forums. They are not adversarial. They are inquisitorial.

Often our officers get to ask questions after everybody else. Often we are left feeling bruised and hurt from the pro-respondent attitude of the committee. I just think: What do they want? Do they want us to put inexperienced people up there who have a poor understanding of the law, who have a lack of information and a lack of skills in advocacy so that the complainant wins every case? That serves the public interest, does it?

The Hon. Dr B. P. V. PEZZUTTI: In relation to the issue that was raised it is not that you investigate and prosecute, because the police do that in the criminal courts. Somebody has to make a decision about whether the matter should proceed. That is where the DPP comes in. Is there enough evidence, is there a sufficient case and is it reasonable to prosecute somebody under those circumstances with the

evidence that you have? That is the difference between the criminal court and the administrative process. The function of the DPP is to make a judgment about whether or not you will put everybody through the court procedure. Whereas you, having done the investigation, make a decision about whether or not to proceed with a prosecution. That is what is missing. You act as your own DPP, which is what Richard Tjiong was saying.

Ms WALTON: He was using the other place as an example. Those other places do exactly the same thing. The commission is a regulatory authority.

The Hon. Dr B. P. V. PEZZUTTI: Just because everybody else does it too does not make it reasonable. That is the question that was asked.

Ms WALTON: Dr Tjiong wants you to believe that the other places are doing it right and that we are doing it wrong. I will correct you on one thing. The Act requires us to consult with the medical board, so there is no single body. If the medical board wants us to prosecute and we do not want to prosecute, we are obliged to prosecute. We do not make that determination; the decision is made by the body that takes the more serious view of what should happen.

CHAIR: If the board says that you have to prosecute you must prosecute?

Ms WALTON: We must under the Act. Further to that, where is the evidence that we are failing and that we are doing prosecutions that we should not be doing. We are successful in 90 per cent of our prosecutions. If we lose one or two prosecutions, people use that as an example. People say that we, as a prosecutor, should be winning only 75 per cent of our cases. If we have too high a success rate it means that we are too conservative and that we are taking on only those matters that we are sure we will win. What about all those cases that should go? And if we make a decision to pre-empt that, we do not want the bad press.

CHAIR: When you appear before the committee does the representative from the Health Care Complaints Commission outline the case, or is that committee fully aware of all the facts?

Ms WALTON: The committee has everything prior to the hearing. The other side has everything before we even make the complaint. Under section 40 of our Act we have to lay out our case and tell the other side what we intend to do. Sometimes they reply and give us more information and we decide not to proceed or we decide to do something else. But we consult with the medical board. We either agree or do not agree on a decision and the more serious view prevails. In professional standards committees, the committee and the other side get all the documents. So when we meet everyone has everything, sometimes with the exception of the commission. The other side often does not provide documents when it is supposed to or when it has been ordered by the committee to do so. They play games. A legal adviser for the respondent and our hearing officer will appear. The committee takes charge of the proceedings and there is a list of witnesses to be questioned, cross-examined and re-examined by the respondent and the commission. But often the commission will be the last body to ask questions.

CHAIR: Are you saying that respondents can take along a representative?

Ms WALTON: Yes, and they do. So you have the lawyer beside them writing out questions and the doctors then mouth the questions.

CHAIR: So they can have someone with them but not representing them, in a sense?

Ms WALTON: But the respondent is required to appear.

CHAIR: The impression that has been given to us is that the doctor goes in there by himself, and he is up against a qualified lawyer or barrister.

Ms WALTON: No, that is not the case.

The Hon. Dr B. P. V. PEZZUTTI: Mr Chairman, you may have Catherine advising you as Chair of the Committee. But a medical practitioner might not necessarily be experienced at doing the sort of work that the commission's lawyer is experienced at doing. The reality is that an experienced lawyer is prosecuting a matter before the committee.

Ms WALTON: Let me go back to what we are doing. We are not talking about two equal parties before a judge; we are talking about a government body bringing evidence before a committee to determine a matter. Are you going to cut it off at the knees and say, "Let us do shoddy work so that all the doctors can get off?" This argument is unbelievable.

The Hon. Dr B. P. V. PEZZUTTI: The committee is more interested in the safe practice of medicine. It will not determine whether or not to strike somebody off. So this really goes to the protective part of the Act under which you operate rather than to the prosecutions and disadvantages. The sort of penalty that somebody will get will probably be a reprimand or a loss of prescribing rights. He or she will not lose his or her practice.

Ms WALTON: That is right. United Medical Protection and a lot of people in the Australian Medical Association will fight in the political arena and have you believe that they are an equal party to the commission. We are a government agency. The Environment Protection Authority and other government bodies, such as the Legal Services Commissioner, the Law Society, and probably every other statutory body, have these same processes. We are not just a body in the community waving a flag; we are a body to which the Parliament has given these powers. We are not an equal party.

The Hon. Dr B. P. V. PEZZUTTI: I can understand the complaint. As a doctor, if I appeared before a disciplinary committee—in spite of the fact that I might have advice from a lawyer—I would have to argue my case as a doctor. My opposition, which would be putting up a case against me, would put forward all the facts. However, we are not really referring to a case. The commission is not pleading for an outcome, is it? It just wants to establish the facts before it proceeds to obtaining a judgment.

Ms WALTON: And once the judgment has been made we make submissions on protective orders.

The Hon. Dr B. P. V. PEZZUTTI: But this sort of hearing is misunderstood by a lot of people. As I understand it—and I would like you to correct me if I am wrong—the commission must establish the facts and the doctor has to explain those facts.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: The findings are then the findings of the committee. But it is still intimidating for a doctor in general practice, or in specialist practice, or for an anaesthetist to appear before the committee and to put his or her best foot forward when the opposition is represented by an experienced lawyer, although his charge is not adversarial. It is a really complex issue.

Ms WALTON: Forget the lawyer. Look at the cost effectiveness of how we run our organisations. Our expertise will reside in one or two people. Is it being suggested that it would be fairer for us to have inexperienced people—to have a new one pop up every time—because that somehow equals their inexperience? That is ludicrous.

CHAIR: It is incumbent on members of this Committee, when allegations or statements such as these are made to us, to ask questions about them.

Ms WALTON: I am pleased to be able to put forward a view.

CHAIR: Earlier we had a lady sitting in the Committee room nodding her head in agreement. She later made some comments about this matter. She obviously agreed completely with Dr Tjiong's statements. She did work for the Health Care Complaints Commission. So it is incumbent on us to ask these questions. As I said, we are currently conducting an inquiry into mandatory reporting negligence. We have spoken to Supreme Court representatives and we need to speak to representatives from the District Court as some cases go there. I am suggesting that members of this Committee should be allowed to sit in on one of those cases to establish what happens in court. We should be able to sit in on a tribunal case. However, I do not know whether we would be able to sit in on a standards committee hearing.

Ms WALTON: You could ask the commission and it would ask for the consent of the parties. If the parties agreed, one Committee member—or two at the most—would be entitled to sit in at a hearing.

CHAIR: If we are able to do that we would be able to determine matters first-hand and we would be able to put certain statements to bed.

Ms WALTON: You really have to focus on the Medical Practices Act and not on the Health Care Complaints Act. The Medical Practices Act actually determines the nature of proceedings. It actually refers to legally qualified practitioners. We

employ a law student who is experienced in appearing before tribunals. I think I would rather face this allegation than an allegation that I employ inexperienced people with no expertise in positions which carry significant responsibility. The other person that the commission employs is a person with legal qualifications who worked at the medical board in Queensland.

The Hon. Dr B. P. V. PEZZUTTI: At many of the hearings before the Professional Standards Committee would a doctor admit to a problem but have extenuating circumstances?

Ms WALTON: No. Often, if they admit to the problem and there are extenuating circumstances, we would not even get into disciplinary hearings; it would just involve counselling.

CHAIR: How would that be dealt with?

Ms WALTON: It would be dealt with by way of counselling because they have said in evidence that they accept that they have done something wrong, they have taken remedial action and we are pretty confident that it will not happen again.

CHAIR: So the commission would organise that in conjunction with the board?

Ms WALTON: The medical board or, as we still call it, the committee, would proceed. That is what would happen.

The Hon. Dr B. P. V. PEZZUTTI: Take the example of Dr Pham on page 43 of the annual report. What would you do if he said, "I admit that I have been—

Ms WALTON: That is a tribunal case. I remember Dr Pham as being a prescribing case.

The Hon. Dr B. P. V. PEZZUTTI: This again is separate from the impaired practitioners.

Ms WALTON: Totally.

The Hon. Dr B. P. V. PEZZUTTI: That is not even mentioned in this document. That would be a matter for the board to report in its annual report.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: Impaired practitioners may or may not lose their practising rights. We do not get to see that. Should we be looking at the report of the medical board as that would give us a fuller picture?

CHAIR: In the next few weeks the medical board will be coming to see us. We might be able to ask a few questions.

The Hon. Dr B. P. V. PEZZUTTI: Impaired practitioners can take their legal advisers with them, can they not?

Ms WALTON: It is probably no different from professional standards committees or counselling. They do, in fact.

The Hon. Dr B. P. V. PEZZUTTI: We have to stop people from saying, "I did it. I want to hang myself", and his or her lawyer saying, "Do not say that. Just go this far." People get carried away with guilt.

Ms WALTON: You must remember that United Medical Protection is concerned not only about the disciplinary process; it wants to look after medical negligence claims that might follow. So any diminishing of admissions is important for what defences are offered in medical negligence cases.

CHAIR: Are you aware whether any of the employees of the Health Care Complaints Commission have approached patients, either during hours, outside hours or at weekends, soliciting them to sign affidavits of complaint against doctors? This issue has been raised with me and I just need to ask you that question.

Ms WALTON: If we knew from a patient that another patient or another person had a complaint we would certainly contact that person. We would be pretty poor investigators if we did not. But we do not roam around the streets just asking people. I would have to have more detail. It is not our policy to go out looking for complaints. If someone tells us about someone else we will want to interview him or her.

CHAIR: I have asked for documentary evidence—statements and so forth. I will then proceed further.

The Hon. Dr B. P. V. PEZZUTTI: I refer to page 16 of the annual report. How many complaints does the Minister receive each year? Do you have any idea? Other people receive complaints; it is not just the board. Area health services receive complaints and the Minister receives separate complaints. How many of those sorts of complaints are there? The Minister does not refer them all to you, of course.

Ms WALTON: No. I can only tell you how many the Minister referred to us. That was obviously 81 in 1998-99.

The Hon. Dr B. P. V. PEZZUTTI: Members of Parliament referred some 30 complaints.

Ms WALTON: Page 17 refers to the source of complaints. We combined Parliament and Minister. The figure increased from 39 last reporting year to 81.

The Hon. Dr B. P. V. PEZZUTTI: Not very many come to you.

Ms WALTON: No.

The Hon. Dr B. P. V. PEZZUTTI: Has the Minister ever told you how many he has received?

Ms WALTON: No. The Department of Health would deal with all ministerials on behalf of the Minister.

The Hon. Dr B. P. V. PEZZUTTI: Do you have any idea how many the department receives, over and above the area health services?

Ms WALTON: Unless they do it in their reports. I do not know. We are certainly not told.

The Hon. Dr B. P. V. PEZZUTTI: I refer to "Category of complaints" which is to be found on page 17 of the report. What sort of complaints are involved in the 103 business practices for medical practitioners?

Ms WALTON: For example, offering jewellery to patients who solicit patients. There are other commercial activities, financial inducements.

The Hon. Dr B. P. V. PEZZUTTI: This is about laser eye surgery when the referring practitioner is offered substantial sums. Mr Chairman, I declare an interest: I am a member of an ethical committee for the Macquarie Street Laser Practice. I was made aware of a complaint made to Ms Walton by that practice concerning other practices which offer up to $600 as a finder's fee. That serious matter should be looked at by the board and by the Health Care Complaints Commission.

Ms WALTON: We referred it to the board and it received legal advice that share-care arrangements in which a percentage of the fee is given to the referring agents was not illegal.

The Hon. Dr B. P. V. PEZZUTTI: It is almost like fee sharing, and I thought that was illegal.

Ms WALTON: When we prosecuted Dr Edelsten, it was about fee-sharing arrangements he had with radiologists. We referred it to the board, and the board sought a legal opinion.

CHAIR: Is there a similar situation in the cosmetic surgery record?

Ms WALTON: I am not sure of that.

The Hon. Dr B. P. V. PEZZUTTI: They do not give kickbacks, they might give gifts.

CHAIR: There was one particular lady involved.

Ms WALTON: Yes, Pam.

The Hon. Dr B. P. V. PEZZUTTI: For surgery to both eyes, $600 goes to the finder.

Ms WALTON: That is for the optometrists.

The Hon. Dr B. P. V. PEZZUTTI: Optometrists and doctors. General practitioners can get it as well as ophthalmologists.

Ms WALTON: The board made inquiries, you will have to talk to it. We did not do that.

The Hon. Dr B. P. V. PEZZUTTI: I would like to know the number of complaints you received about the Minister.

Ms WALTON: I can honestly say we never received complaints about the Minister.

The Hon. Dr B. P. V. PEZZUTTI: What complaints did you receive about the department?

Ms WALTON: The complaints about the department we would record in the category "Complaints received against Facilities", page 15. There were 11 complaints about the Department of Health in 1996-97, eight complaints in 1997-98, and zero in 1998-99, the last reporting year.

The Hon. Dr B. P. V. PEZZUTTI: In your report entitled *Health Investigator*, dated 1 January—and I notice that you are a Y2K compliant—you state that 49 per cent are investigations about facilities. In other words, 29 per cent are about public hospital in-patients. Quite a lot of complaints are made against patients who received care in public hospitals. Page 15 states that 323 complaints were received about public hospitals in 1997-98 and 336 in 1998-99. It is a bit like the pot calling the kettle black for the Minister to start referring complaints to you, considering that most people complain to the area health service. As I mentioned earlier, the area health service annual report states that 264 complaints were made about Lismore Base Hospital. It is interesting that a number were dealt with by the department, not referred to you. Do you know how many there were?

Ms WALTON: I cannot comment on that.

The Hon. Dr B. P. V. PEZZUTTI: Mr Chairman, could the Committee ask the department how many complaints it deals with separately from the area health services? I am sure that is not stated in its annual report. Page 18 of the commission's report states that one case was referred to the director-general. Do you know what that was about?

Ms WALTON: No.

The Hon. Dr B. P. V. PEZZUTTI: Of all the public hospital matters, of which there were 336, you state on page 18 that one was referred to the director-general.

Ms WALTON: That refers to files opened.

The Hon. Dr B. P. V. PEZZUTTI: Yes, including files received in past financial years and still open. You referred one to the director-general.

Ms WALTON: It means we are going to refer it, it is still in the commission.

The Hon. Dr B. P. V. PEZZUTTI: How many have you referred to the director-general?

Ms WALTON: That is shown on page 19, "Outcome of Assessment of all complaints". On page 21 it states that we referred 63 to the director-general.

The Hon. Dr B. P. V. PEZZUTTI: Of the 336 that you received, does the department become the respondent?

Ms WALTON: No. They become the responsible body to report back, or resolve it.

The Hon. Dr B. P. V. PEZZUTTI: That is a procedural matter. As at 30 June 1999, the commission had some 916 files still open. Is there a table of how long they have been running?

Ms WALTON: Yes, on page 37, "Time taken to investigate complaints closed in 1998-99". The average has gone from 701 to 631 days.

The Hon. Dr B. P. V. PEZZUTTI: It has improved. What is the median?

Ms WALTON: It is 604 days, it has improved from 686.

The Hon. Dr B. P. V. PEZZUTTI: Page 21 shows "Complaints referred for action to another body or person by category". What were the 311 clinical standards which went to other bodies?

Ms WALTON: Incorrect or nil diagnosis, incorrect or inadequate treatment. It would be about the actual clinical decision making, clinical care and treatment of a patient.

The Hon. Dr B. P. V. PEZZUTTI: In other words, for action by another body. Would that include the medical board?

Ms WALTON: Yes, it could, and the area health service. You were reading out the counselling of doctors under section 26, that could be the medical board or a hospital, but mainly an area health service.

The Hon. Dr B. P. V. PEZZUTTI: If I complained that I was misdiagnosed by a Dr Smith at Orange hospital, what would happen?

Ms WALTON: We would write to you, as the complainant, and say that we had assessed the claim to be investigated by the area health service and if the complainant did not like that decision he could ask for a review.

The Hon. Dr B. P. V. PEZZUTTI: Action means investigation or other things, not determination?

Ms WALTON: That is correct.

The Hon. Dr B. P. V. PEZZUTTI: The complaint may come back to you?

Ms WALTON: Yes, and sometimes they come back after the investigation and say they are not happy.

The Hon. Dr B. P. V. PEZZUTTI: On the top of page 21, under "Assessed for referral to another body", you have an area health service which may investigate itself.

Ms WALTON: That is true. An area administrative centre will be responsible for investigating a hospital, and that is a continuing concern. That is the reason why we got this funding, to train the staff about what is a proper investigation and how to make it transparent.

The Hon. Dr B. P. V. PEZZUTTI: These are matters which you have closed and got the area health service to deal with?

Ms WALTON: Yes, and have told the complainants they can come back to us if they are unhappy.

The Hon. Dr B. P. V. PEZZUTTI: Although it has been finalised by you, if the complainant is not happy he can come back to you.

Ms WALTON: Yes, and the patient support office will be involved with the patient and may also refer it back.

The Hon. Dr B. P. V. PEZZUTTI: I notice the commission's action on receipt of investigation reports by another body resulted in no further action in almost all cases. When a matter is referred to another body for action, almost all are closed; 138 out of 149. Not a large percentage The number of complaints that end up as substantial matters are not a large percentage of all complaints received, are they?

Ms WALTON: No, 20 per cent or less. Those we investigate run at about 10 to 15 per cent at the moment.

The Hon. Dr B. P. V. PEZZUTTI: Have you looked at the percentage of the possible interactions that could cause a complaint?

Ms WALTON: I do not think I can, because I need to know the motivation for people complaining. It could be irrelevant.

The Hon. Dr B. P. V. PEZZUTTI: I understand. If there were 2,000 complaints for 50 million consultations, that would be meaningless.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: On page 23 under "Outcome of complaints received and referred to HCR", those terminated on agreement being reached are a small number of the total. Is that why you are concerned?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: On page 26, under "Category of Complaints assessed for investigation" shows about one-fifth of every category you investigate. About 20 per cent of reports require investigation; that does not mean that they are not serious matters, does it?

Ms WALTON: No, but within the body of complaints we investigate, we substantiate probably 30 or 40 per cent, which means we are getting the assessment pretty right. Most investigations end up in a 5 per cent substantiation; we have a higher substantiation because we are better at selecting the ones for investigation.

The Hon. Dr B. P. V. PEZZUTTI: On page 27 under "Complainant Profile" you state a very high response rate; 1,400 responses from 1,600 sent out. Yet, it was a waste of time, frankly. The information you got from the responses was hopeless.

Ms WALTON: That was the whole point. We did it to get the socio-demographics of our complainants. And that is what we got.

The Hon. Dr B. P. V. PEZZUTTI: You could have asked more questions, that would have made it more valuable.

Ms WALTON: But we may not have got a response.

The Hon. Dr B. P. V. PEZZUTTI: On page 28 "Patient Support Office" [PSO], how many do you have in the country and how accessible are they?

Ms WALTON: We have a statewide service which operates from Sydney. With the additional officers we will divide the State and have a nominated person for each; a bit like the proposal for universities incorporating the rural sector. We will have a person responsible for metropolitan plus the rural sector. It will be an area responsibility. We would love to have someone in every rural area but resources do not enable that.

The Hon. Dr B. P. V. PEZZUTTI: On page 30,"PSO service provision" and "Outcomes", how many PSOs tell you that they are dealing with impossible clients?

Ms WALTON: We probably would not use the word "impossible"; we would say that sufficient resources have been expended and we do not seek they will be a better outcome. Probably 1 per cent or less. Bruce tells me it is on page 30, 4 per cent.

The Hon. Dr B. P. V. PEZZUTTI: Yes, I was looking at that. It states "4% unable to be resolved". As a result of those statistics how many would be seen to be impossible people?

Ms WALTON: It might also be that the hospital is just going to dig its heels in.

The Hon. Dr B. P. V. PEZZUTTI: I was asking a separate question: How many are found to be difficult people?

Ms WALTON: We do not know within that 4 per cent.

The Hon. Dr B. P. V. PEZZUTTI: The officers of the patient support office do not report to you that a client was just impossible?

Ms WALTON: From time to time.

The Hon. Dr B. P. V. PEZZUTTI: A large number provide information—1,123 out of 2,800. That must be an important source of information for the community at large.

Ms WALTON: Yes, just getting information about where to go or about their rights.

The Hon. Dr B. P. V. PEZZUTTI: If I was a good politician, could I go to the PSO to find out more about what is happening in the department?

Ms WALTON: I doubt it.

The Hon. Dr B. P. V. PEZZUTTI: Northern Rivers had a very small number of complaints against it. In your experience, are some areas better at dealing with complaints than others?

Ms WALTON: I think so. The data shows there is a significant difference between metropolitan and rural. I do not think it is just size. It relates to knowledge and interpersonal communications and relationships. The Western area probably gets far more. I am not sure of the population bases; we would have to look at that. For example, with 15 per cent of complaints Western Sydney received the highest category, followed by South Eastern, and Central Sydney was 8 per cent.

The Hon. Dr B. P. V. PEZZUTTI: There is no explanation for the difference. Is it because Western Sydney provides a dreadful service, it has awful doctors and awful people or because there are more people in Western Sydney? The population is not bigger than South Eastern. The population in Eastern Sydney is just as educated. Is it because people in Eastern Sydney feel powerful enough to deal with the matters themselves, they do not bother complaining to you, or they go elsewhere?

Ms WALTON: I cannot answer. This table is raw data about where the complaints come from.

The Hon. Dr B. P. V. PEZZUTTI: You do not do any proactive sampling?

Ms WALTON: No. Some of the chairpeople of the boards have written to us wanting a breakdown of complaints and we are going to provide that. A lot more

relationship data and information can be provided to separate areas. If Northern Rivers wanted a breakdown of complaints we could provide that.

The Hon. Dr B. P. V. PEZZUTTI: On page 38 a large number of the finalised investigations are against medical practitioners. There are more nurses than doctors in New South Wales and fewer psychologists. Why is there a preponderance of complaints against medical practitioners.

Ms WALTON: There are about 80,000 registered nurses and about 20,000 doctors on the register with about 12,000 practising. There is an increase in complaints against nurses, but the reason people complain about doctors is because they identify the doctor as being responsible for their health care. That is the way it is. There are not many nurse practitioners.

The Hon. Dr B. P. V. PEZZUTTI: About one in 10 complaints that you receive and investigate ends up before the board. Of the matters you receive you investigate about 20 per cent, and of that about one in 10 end up in front of the board. Of 277 investigations, 27 went to the board for counselling, 29 to the Professional Standards Committee and 36 to the tribunal. Of that 277 about 80 went to the board.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: Many of your investigations which are finalised do not go to board, they do not go any further.

Ms WALTON: Because we make adverse comment under our Act or we substantiate it with the practitioner or the hospital has taken a sufficient stance and we close the matter.

The Hon. Dr B. P. V. PEZZUTTI: Even though you investigate them fully, about two-thirds would simply be closed?

Ms WALTON: Yes, with remedial action being taken.

The Hon. Dr B. P. V. PEZZUTTI: On what basis can someone appeal to the Court of Appeal from a decision by the tribunal.

Ms WALTON: And they can appeal to the Professional Standards Committee.

The Hon. Dr B. P. V. PEZZUTTI: Yes.

Ms WALTON: On the severity of the penalty and the error in law.

The Hon. Dr B. P. V. PEZZUTTI: They are the only two?

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: I would like to wish you the best of luck in your new job. I hope the new commissioner has the opportunity to have access to your breadth of knowledge in this area. We always need someone who is going to try

to ensure continuing high quality practice, not only professional bodies but someone independent of them and government. It is a shame that you do not have access to the area health services. The new commissioner might have access to a more open system. Good luck, and thank you for your information.

Ms WALTON: Thank you.

CHAIR: In relation to retrieving data from area health services, when you talk to the chief executive officers of the area health services has the Health Care Complaints Commission requested to address the boards of those services?

Ms WALTON: No, we have not.

CHAIR: Their role is one of governance. Perhaps your staff and the next commissioner could take that on board.

Ms WALTON: Maybe that is the next step.

CHAIR: You should be going to the boards. There are many lay people on the boards who may see the benefits in what you are putting forward and give instructions down the line.

Ms WALTON: Thank you, Mr Chairman, we will take that on board.

CHAIR: I know that if I have problems locally I often speak to board members and I can resolve the problems without going to the chief executive officer or managers of different sectors within the area health services. On page 6 under Goals at point 2 you say, "provide a timely, thorough and independent investigation of complaints which arise from the delivery of health services in New South Wales". Last year we talked about the waiting time. You said it was three years, you got it down to two years, and you were trying to get it down further. I asked you what you thought was a fair period of time to resolve a complaint and you thought the average time should be about one year.

At page 37 it is expressed in days for facilities and professions. For facilities it has dropped from 1,479 days down to 1,380 for the maximum time taken. For professions it is dropped from 1,597 days down to 1,435 days. Earlier I mentioned Action for Victims of Medical Accidents of Australia, and I hope your people can talk with that group. A representative said that many of the complaints the group receives are from people who do not want to go to the Health Care Complaints Commission because it takes too long. They want their matters resolved early. The median time you have for facilities has increased from 690 days to 701 but for professions has dropped from 686 to 604.

Ms WALTON: It is still not there. I said 12 to 18 months was probably our goal. If we keep going the way we are, I do not think we will ever achieve it. To try to help the new commissioner, as my last effort before I leave I held a half-day seminar with representatives of the Medical Board, our Consumer Advisory Committee and staff. We devised priority listings of categories of complaints within

section 23. The categories were high risk to the public, medium risk and low risk. Then we subdivided the high risk category.

Within that category there are six or seven types of complaints, such as an impaired doctor who is still practising, a surgeon facing multiple complaints, or a practitioner not qualified. There are a number of categories. Within that category there is again high risk, medium risk and low risk. High risk matters should be completed within three months, medium risk within three to six months and low risk within six to 12 months. If all our resources go into looking after those complaints, we still have two other categories of complaints that we are never going to get to.

I have developed a proposal to treat them differently. For those two categories, we will get a report from the doctor or hospital, if it looks okay then we will try to get the parties together. I have written up the final paper and circulated it to the Medical Board and our staff. I have suggested to the new commissioner a number of things to progress this. One, do an audit of every file under investigation to put it into a category so we know what we are looking at. Two, pilot one case load in each team—the legal team and two investigation teams—using the new priority framework with resourcing and management support. Let us see how it goes and evaluate it after 12 months. If that works, then undertake consultation with the stakeholders about the new priority of managing complaints.

It needs that level of detail to do it. We can continually chase our tail. You will see that we had more complaints referred for investigation this year than last year. It is difficult. I know the expectations, all of you know them, the community knows them, and they are very reasonable expectations. But, with every will in the world, we do not seem to be able to change it. There are just too many cases.

The Hon. Dr B. P. V. PEZZUTTI: Also, if the Commission does not investigate the matters, complainants will write to us and say the Commissioner is not doing a proper job.

Ms WALTON: We are trying to be strict gatekeepers to control that flow.

CHAIR: The resources of the Conciliation Registry might be better spent elsewhere.

Ms WALTON: That is only a pittance too.

CHAIR: As to mandatory reporting, in your submission you said something along the lines that if mandatory reporting did not come directly to the Health Care Complaints Commission it could go to the board.

Ms WALTON: Yes.

CHAIR: We have found that the Australian Medical Association would be happy with de-identified information going to the board and on to the Health Care Complaints Commission, and less happy about identified information going to the board, as long as it was de-identified to go to the Commission. Dr Tjiong said that his indemnity fund is now the only indemnity fund in New South Wales with 95 per cent

of doctors. It is in a position to release the number of cases that it is defending. He is happy at any time to provide us with the number of cases. He said the fund is in a position to send de-identified information to the board or to the Commission if necessary.

How do you feel about the Medical Board receiving identified information, filtering that and giving you the statistics which allows you to fulfil that section of the Act which does not talk about identification, just the trends and so forth? If the Medical Board finds a number of complaints against a doctor, what powers does it have to refer the matters to you for investigation?

Ms WALTON: It must have that power. I am perfectly comfortable with identified information going to the board. When the board receives it, then the board must implement its Act, which is to consult with the Commission about whether a matter should be referred. That can be done within the board's action. De-identified information should be passed on or it can be given to us direct. To provide de-identified information with no power to act on it is a nonsense. There would be an outcry.

CHAIR: You are happy with the board receiving the information?

Ms WALTON: Yes. We have enough work to do, it can do the paperwork.

CHAIR: If it sees a case—

Ms WALTON: In consultation with the Commission, yes, that is fine. In retrospect, I would probably prefer that, because we have enough work to do and we would like someone-else to filter some of it.

The Hon. Dr B. P. V. PEZZUTTI: If you deal with four complaints against an individual doctor, do you deal with each complaint as a separate matter?

Ms WALTON: We are required to by law.

The Hon. Dr B. P. V. PEZZUTTI: When the tribunal meets and makes a decision it is entitled to deal with all four together.

Ms WALTON: Yes, that is a recent decision of the Supreme Court.

The Hon. Dr B. P. V. PEZZUTTI: You are not entitled to do that. You have to deal with each matter individually.

Ms WALTON: Yes, but we will have them heard at the same time.

The Hon. Dr B. P. V. PEZZUTTI: Of course, if you want to. You may want to only hear two of them. Is the board entitled to hear about the other two while it is hearing the first two?

Ms WALTON: In a recent case we have referred one matter to the Professional Standards Committee and the other matters to the tribunal. We used to refer them all to the tribunal thinking that was the most expedient way, but the tribunal has often

said that a matter could have been heard by the Professional Standards Committee. We are now separating them. I think it is worse for a doctor to have to go to two forums when the doctor could have just dealt with one, but that is what the tribunal wants.

CHAIR: We are talking about looking at a future inquiry into conciliation and at some local complaints handling. Do you see any other areas the Committee could inquire into or you believe should be inquired into?

Ms WALTON: The one which probably has a public interest component in relation to our Act is the monitoring of other people's investigations. We have no power. If we read about a matter in the paper and the system wants to close down, we can be prevented from looking at something.

The Hon. Dr B. P. V. PEZZUTTI: If you read something in the paper, you can call it in if you want, can you not?

Ms WALTON: No.

The Hon. Dr B. P. V. PEZZUTTI: Say, for example, Dr Smith of Orange was accused of sexual assault?

Ms WALTON: No, I cannot. Sometimes an anonymous complaint will come to us and it is serious. We cannot act on anonymous complaints. We consult the Medical Board and it will become the complaint.

The Hon. Dr B. P. V. PEZZUTTI: So the board can pick it up from the newspaper and take to you?

Ms WALTON: If it is of a mind to, but it is hard to do that. We have to cajole someone else into making a complaint.

The Hon. Dr B. P. V. PEZZUTTI: So you do actually cajole people into making complaints?

Ms WALTON: No, the Medical Board.

The Hon. Dr B. P. V. PEZZUTTI: You were asked the question whether you were out there touting for business.

Ms WALTON: Every day.

The Hon. Dr B. P. V. PEZZUTTI: It is the serious matters you might read about in the newspapers. Say, for example, a matter of sexual assault of a patient is going before the Supreme Court?

Ms WALTON: I would cut it out, take it to my meeting with the registration board and say: "Have you seen this? What are you doing about it? Why do you not make some inquiries and make a complaint?"

CHAIR: How regularly do you meet with the board?

Ms WALTON: Every month.

The Hon. Dr B. P. V. PEZZUTTI: Can you call a patient in and ask the patient to talk about it?

Ms WALTON: Well, we can do that.

The Hon. Dr B. P. V. PEZZUTTI: The complainant who is appearing before the Supreme Court?

Ms WALTON: No, we would never ring a complainant who is appearing before the Supreme Court. Nor would the board.

The Hon. Dr B. P. V. PEZZUTTI: Who will pick up the doctor who does the sexual assault? Instead of going to you, the patient may go to the police and say, "This doctor assaulted me in his surgery."

Ms WALTON: The police refer it to us, with consent from the complainant.

The Hon. Dr B. P. V. PEZZUTTI: Are the police required to refer it to you?

Ms WALTON: No. But they do.

CHAIR: This is the same case we were talking about—the identified information of court cases going to the Medical Board. If the board gets a number of complaints against one particular doctor, it is in a position to raise it with the Commission and hand over the information. We need to clarify that process with the board. Maybe it is something the Committee could look at and raise with the board, rather than you initiating it.

Ms WALTON: Yes.

The Hon. Dr B. P. V. PEZZUTTI: If I am picked up for drink-driving on three occasions, I go to court and I lose my licence, do the police report back to you?

Ms WALTON: No, the courts inform the Medical Board and the Medical Board reports it to us.

The Hon. Dr B. P. V. PEZZUTTI: Is there a requirement for the court to notify you?

Ms WALTON: No.

The Hon. Dr B. P. V. PEZZUTTI: That was an issue we had before.

CHAIR: I would like to thank you for your assistance in the time that I have been Chairman, which is not very long. It has been a pleasure to work with you. I wish you all the best for the future. Would you mind outlining the position you are

going to take up, what you will be doing and how that position may assist the Committee?

Ms WALTON: I have taken up an appointment with the medical faculty of the University of Sydney. One does not get credentialed to a position until you are on site. So I cannot tell you where I am until next week. I will be attached to the Clinical School of the Royal North Shore Hospital and I will also be at the University of Sydney. My appointment will cover a number of departments in curriculum development committees through to a number of other areas, but I am a bit unsure. I will be teaching and doing research and I will be doing a PhD on junior doctors.

I would like to say a few words about the Committee. A number of people have said that it must be difficult being a Commissioner working with a joint parliamentary committee. Certainly I have read in the papers some notorious relationships between statutory officers and joint parliamentary committees. But I have a firm belief in the democratic process of accountability. While I can remember some pretty difficult sessions that Dr Pezzutti was involved in some years ago, and notwithstanding the gruelling cross-examination by Dr Pezzutti today and at other times, I think that this Committee is absolutely essential. With such a volatile community and the involvement of stakeholders, the Commission needs a overseeing body that is independent and truly bipartisan, that is not only questioning and holding us accountable, but is also supporting our existence and warding off a lot of criticism. In some ways it is a lightning rod for people who have axes to grind.

I would like to thank the Committee. I have always felt tested in these forums. I have felt that the preparation for them, which I take very seriously—from sleepless nights to wondering in the shower about every question you will pop at me—is important for me to be able to function. So I thank you all very much. I hope the next commissioner sees the benefit of such a body.

(The Committee adjourned at 2.18 p.m.)