Report of the

HEALTH AND DISABILITY COMMISSIONER

Te Toihau Hauora Hauātanga

For the year ended 30 June 1997

Presented to the House of Representatives Pursuant to Section 16 of the Health and Disability Commissioner Act 1994.

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

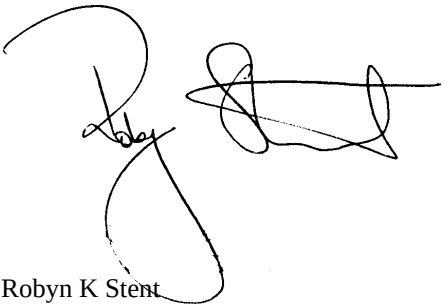
22 October 1997

The Minister of Health
Parliament Building
WELLINGTON

Minister

In accordance with the requirements of Section 16 of the Health and Disability Commissioner Act 1994, I enclose the Annual Report of the Health and Disability Commissioner for the period ended 30 June 1997.

Yours faithfully



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The Kaupapa of the Health and Disability Commissioner is to facilitate improved consumer service and to enhance wellness in New Zealand.

He tautoko, he whiriwhiri kia whaia ko nga taumata e piki ake ai te oranga ki roto i a Aotearoa.

COMMISSIONER'S INTRODUCTION

The first year of operation has been an exciting but demanding time for the Commissioner and staff. The policies and systems established for the introduction of the legislation on 1 July 1996 served the office well. Staff numbers grew from approximately six staff at the beginning of June 1996 to 29 at year end. Staff numbers are necessarily increasing due to the growing demands on the office as the Act becomes fully operational.

There were many highlights during the course of the year and most of these are flagged in the reports from relevant divisions of the office in this annual report.

Demand

The year commenced slowly as the public and the sector took time to become aware of the availability of the Commissioner as an avenue of complaints. During the first part of the year many complaints to the office could not be investigated because they were about events which took place prior to 1 July 1996, or were about entitlement to services rather than quality of services (the Code of Rights does not cover issues relating to entitlement to services). A number of early complaints originated from people or groups who had a particular interest in issues and who saw our arrival as another avenue to apply pressure. Over the course of the year this aspect of our workload diminished and was offset by a steady increase in enquiries and complaints from the health and disability sector and the general public.

Political influences

We anticipated that the election, with its focus on issues including health and disability services, would cause high demands on our resources. In fact this did not eventuate. Enquiries and complaints were particularly low during the coalition negotiations. It appeared, in the absence of a government and an opposition trading blows in the media, that the usual flow of health stories diminished to a trickle. It was perhaps not a coincidence that complaints to the office dipped at this time. In part this indicates the huge impact political parleying has on the sector.

While the political stakes in health are high, lobby groups and politicians must understand that the Commissioner's role is apolitical, consisting of the impartial application of legislation. Some politicians have criticised the Commissioner when the office processes have failed to deliver outcomes they desire.

They should address themselves to the Act and the Code and seek legislative and political change as they see fit. The unfortunate consequence of political criticism can be a mistaken belief by the public that the Commissioner will be unable or unwilling to assist consumers who have difficulties with health and disability services.

Offsetting this (and with no publicity), I am aware that many politicians and lobby groups complained directly or referred consumers to the Commissioner, enabling speedy and effective resolution of complaints.

Health and Disability Sector Accord

A conclusive solution to the politicisation of health and disability issues would be the forging of a health and disability accord, along the lines of the former superannuation accord.

A multi-party agreement on health and disability could be established in the interests of consumers of these services and, in a cooperative manner, the nation could address future demands and plan and allocate services accordingly. The establishment of an objective accord might reduce the endless source of emotionally charged, and often frightening, media stories. Surely, nothing can be more important than the well-being of the nation and politicians should act in partnership now to achieve the best possible long-term public services.

Volume

One difficulty in anticipating volumes arose from a time lag following changes in legislation which came into effect at the same time as the Code of Rights. From 1 July 1996 all complaints to health registration bodies relating to matters after that date were required to be referred first to the Health and Disability Commissioner. I did not start receiving these complaints in significant numbers until November, evidence of a five month delay from the time of an incident to a complaint about it reaching an independent body for investigation.

Referral to advocacy

As the number of complaints began to increase in November, I started to refer some complaints to advocacy for resolution between the parties, rather than commencing an investigation. By this time advocacy services had had time to settle, come to understand the requirements of the Act and were in a good position to assist in this low level resolution. Complaints are forwarded to advocacy at this stage only where there are clearly no public safety issues involved or professional practice concerns.

The Commissioner and advocacy services

Advocacy is proving to be an effective front-line service to assist consumers. I thank the individuals who have provided advocacy over the year.

Advocacy is currently structured under the Act through an independent Director of Advocacy, who contracts with advocacy service providers which employ advocates. The resultant layers of independence create administrative costs and structural inefficiencies. I am required to review the Act in the 1997-98 year and will consult on this method of providing advocacy services along with other issues.

As the year drew to a close, the understanding of the Commissioner's staff and advocates regarding their respective roles had improved considerably and we were seeing an increase in referrals and effective resolution of complaints at local level.

The understanding in the community regarding the respective roles of advocates and the Commissioner is still confused and will continue to be a focus of our education in the future.

Performance and expectations

The statistics and outcomes for the year reached targets set, although total complaints were fewer than original estimates, possibly due in part to the five-month time lag referred to earlier. The awareness and promotional targets of the office were achieved. While our failure to prosecute health professionals has caused some negative comment, one of the key objectives of the Act is to achieve low-level, efficient resolution of complaints. This means that, where there are no competence or public safety issues, matters which may have previously been dealt with by disciplinary proceedings may now be resolved in a less conspicuous and more productive way. In opinions where there was a breach of the Code, I made recommendations with which all parties duly complied.

In comparison with the past, individuals and the public at large were saved months of waiting for the results of disciplinary procedures which would penalise an individual health professional without necessarily ensuring ongoing practice or behavioural change. Issues were therefore resolved in accordance with the purpose of the Act in 'a fair, simple, speedy and efficient' manner. Changing interest group expectations in line with this new approach will take time.

To complete the legal structures which deliver fair, speedy and satisfactory outcomes to both consumers and providers, all health professional body legislation needs to be brought up to par with the Medical Practitioners Act as soon as possible and I will continue to ask Government to put this higher on the legislative timetable.

The first year of the full operation of the office was not necessarily typical for a variety of reasons.

1. There was a gradual development of the understanding of the role of the office.
2. It takes less time to find no breach than a breach of the Code of Rights, which meant for the early months there were an untypically high number of opinions that no breach had occurred.
3. By year end, two breaches had been referred to the Director of Proceedings. An estimated two or three of these per month will occur in future.

The building up of awareness and understanding of the role of new legislation initially takes time.

Scope of the Commissioner's Powers

A major recognition of the Commissioner's role arose when I decided to investigate public safety at Christchurch Hospital and parties who were unsure of the Commissioner's powers requested a review of my decision to do so by the High Court. The Court confirmed that the Commissioner has independence from all bodies, can investigate on her own initiative rather than simply act on receipt of complaints and has wide powers to look at policies and practices. Throughout the course of this financial year, I undertook seven investigations on my own initiative. Many of these were as a result of anonymous complaints but others were commenced as a result of findings during an investigation which gave rise to concerns about public safety. The role of the Commissioner is now better understood, although awareness will need to improve.

At the end of the financial year the investigation into patient safety at Christchurch Hospital was continuing. Although this major investigation was not envisaged for the first year, either financially or in terms of strategic priorities, it was clearly within the scope of the legislation, a view supported by the Court. The judgements also clarified the application of the Code of Rights to the delivery of health and disability services in institutional settings.

Review

I am pleased with the achievements in the first year of operation. We are constantly reviewing our practices as a result of feedback from the community, consumers and providers. We received many letters and calls of appreciation and it was encouraging to hear of consumer groups actively resolving issues for their members by using the Code.

I would like to take this opportunity to thank all those who worked for the Commissioner over the course of the year. In demanding times they lived by our code of practice which is the Code of Rights and put great effort in to attempting to achieve our vision to facilitate improved consumer service and enhance wellness in New Zealand.

PUBLIC AWARENESS AND ACCEPTANCE

Media trends

The full implementation of the legislation on 1 July 1996 brought about a change in the public perception of the role and activity of the Health and Disability Commissioner. Up till that point the Commissioner had been seen primarily as a promoter of the rights of consumers of health and disability services and as an architect of the Code of Health and Disability Services Consumers' Rights.

On 1 July it became possible for providers to breach the Code and for the Commissioner to accept complaints and investigate alleged breaches. Inevitably many early enquiries and complaints were outside jurisdiction as they were about events which had occurred prior to 1 July, or were about access to services. The Commissioner consistently addressed these issues in media interviews.

Another early trend was the assumption by media that the Commissioner would publicly discuss individual complaints. In the final two or three months of the year the media were showing signs of understanding that the office would not function in this way as a regular source of topical stories but works more in an impartial manner along the model of the Ombudsmen.

This is partly out of a need to effect fair, simple, speedy and efficient resolution of complaints, which is often best achieved out of the media limelight. Additionally, section 67 of the Act prevents the Commissioner from making any comment that is adverse to any person, unless that person has had a chance to provide a written response to the criticism.

The Commissioner's decision in February to commence an investigation into Christchurch Hospital and the Minister of Health's subsequent decision to defer his proposed inquiry into the same matters gave rise to media discussion about the Commissioner's role.

The matter was addressed by the High Court which made a valuable contribution to provider, consumer and media understanding of the role and powers of the Health and Disability Commissioner.

Promotion and Education

During the year 275 public addresses were made to consumer and provider groups and the Health and Disability Commissioner featured in 892 media stories. Some of the other activities undertaken during the year included:

- 'Risks, Issues and Interfaces' one-day conferences held in Auckland in November and Wellington in February. These inexpensive seminars on Code and Act issues were well attended and received positive evaluations from participants.
- In-house training on the Act, the Code and office processes to organisations with which the office has a working relationship, such as the Human Rights Commission, Ombudsman and Ministry of Health.
- A monthly column to GP Weekly, a newspaper for general practitioners.
- In circumstances where it is considered useful, the Commissioner has removed identifying information from written opinions and circulated them among relevant organisations. For example, an opinion relating to breaches of the rights of two people with intellectual disability was issued to RHAs with the request that they circulate the information to all organisations contracted by them for the provision of care for people with intellectual disability.
- The Commissioner's speech in Christchurch to an annual conference of rest home providers, supported by the release of specific case notes, highlighted concerns about standards in the rest home industry and generated media discussion of the issue.
- An address to the National Methadone Symposium also provoked media interest. The Commissioner commented on the protocol for managing opioid-dependent prison inmates. The Department of Corrections indicated that it will consider the Commissioner's concerns when it reviews this protocol.
- The Commissioner maintains a website, which contains the Code of Rights, the Health and Disability Commissioner Act and various items of information, including contact details for advocacy services. In the 1997-1998 year, this will be upgraded to carry case notes, articles and speeches.
- Advocates devoted considerable time and resources, particularly in the first months of the year, to familiarising providers and consumers in their areas with the Code of Rights and advocacy services. Advocacy Services made a total of 2,751 presentations.

Provider education

An early decision was made to focus education on providers. A major reason was the belief that information about rights in relation to health and disability services was most likely to be noted at the time and point of service. There was also a degree of reluctance to advertise the Code nationally to consumers, due to expense and the concern at being seen to be promoting complaints. Also, the Commissioner's vision was and is for providers to take ownership of the Code as a quality of service standard and involve their consumers on that basis. Clause 1 of the Code accordingly obliges providers to inform consumers of their rights, which led to two key operating assumptions:

- Early promotion should focus on educating and equipping providers to meet their obligation to inform.
- Providers should meet the modest and reasonable cost of meeting this new legal requirement.

Educational Resources

As a consequence of the above assumptions, the Commissioner produced a range of resources to enable providers to easily and cheaply inform consumers of their rights under the Code and the available avenues of support and complaint. These resources include:

- Posters in English and Maori
- Leaflets containing the Code of Rights in various forms, from the complete regulation to a short list of the ten rights
- Leaflets providing information about advocacy services
- A video for consumers, available in English, subtitled English, Maori, Samoan, Tongan and Niuean
- A video for providers
- An audio tape of the Code of Rights and advocacy information
- Bilingual pocket cards with the brief ten rights in English and another language - these presently include Maori, Samoan, Tongan, Cook Island Maori and Niuean
- The advocacy services leaflet, which contains the rights information as set out in the poster, has been translated into the main Pacific Island languages. These are available in photocopied form while demand is being assessed.
- The website

The Commissioner is now considering the need for resources in other languages.

Acceptance

Early indications that providers would find this approach acceptable appear to have been borne out, with some significant, sector-specific exceptions. Approximately 1,000 orders for resources to a value of $36,000 were received during the year.

Total quantities of the various resources sold or given away are as follows:

Publication type	Number
Videos	972
Your Rights leaflets	152,700
Full Code leaflets	85,000
Advocacy service leaflets	125,000
Pocket cards	89,875
Posters	21,683
Audio tapes	25

A small number of correspondents expressed concern that providers with minimal funding might find the costs onerous. As the Commissioner charges only ten cents for a copy of the Code of Rights and twenty-five cents for a poster, this argument is difficult to sustain. Resources are provided free of charge to consumers.

Crown Health Enterprises, private hospitals and rest homes, other residential institutions and teaching institutions constitute the bulk of the Commissioner's 'customers' for information and resources. General practitioners and medical specialists are conspicuously scarce and this absence is reflected in the poor scores for these sectors in the awareness survey.

Awareness Survey

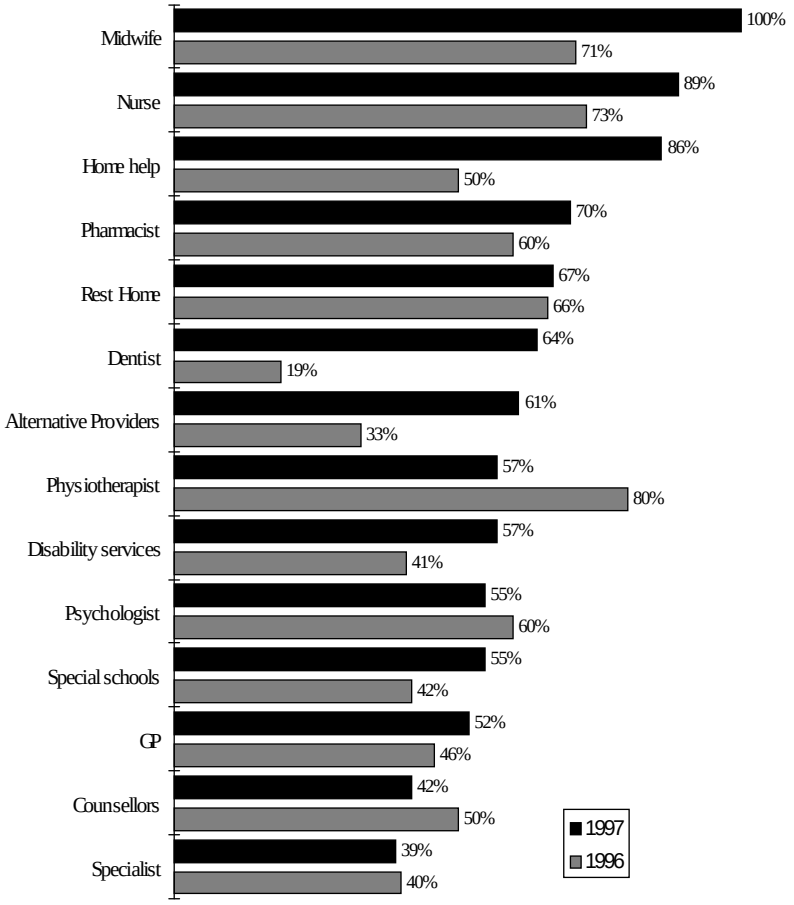
As part of its Statement of Service to Parliament and in order to measure the development of awareness the Commissioner commissioned a survey, carried out in June 1997 by Colmar Brunton Research. Providers were asked the same questions about their awareness of the Code of Rights, the Commissioner and advocacy services as in a similar survey the previous June. For the first time since the introduction of the Code consumers were also interviewed.

Provider awareness

Provider awareness of the Code of Rights, as measured by the answer to the question 'Have you heard of the Code of Health and Disability Services Consumers' Rights?' in both surveys is shown below.

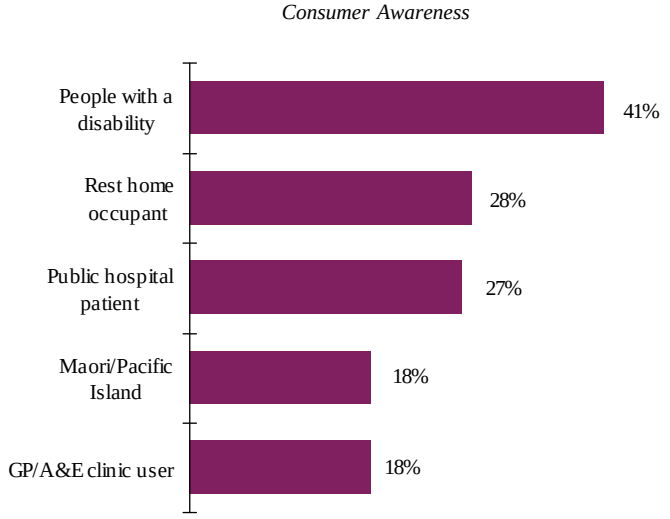
The over-all awareness across all types of provider increased from 52% to 64%.

Provider Awareness



Consumer awareness

1,257 consumers were interviewed using telephone, mail and personal interview. Their general awareness scores are shown below.



Knowledge of rights

Both providers and consumers were asked to name rights covered in the Code. 'Don't know' scores were high, averaging 75% for consumers. Providers' 'don't know' scores however have improved from 76% to 47% in the year that the Code has been in force. Where people were able to name rights, they most frequently identified the rights to respect, information and 'fair treatment.' Nurses, who also scored highly on general Code awareness, were most knowledgeable about specific rights.

Recall of Commissioner's educational resources

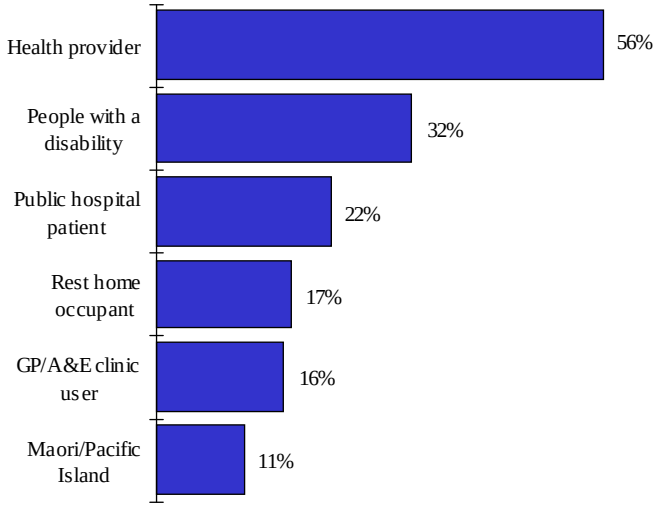
People were asked if they had seen any of the Commissioner's posters, leaflets or videos. Recall was highest amongst health providers at an average of 47%, with home help workers (at 86%), nurses (at 76%) and rest home staff (at 62%) topping the poll.

On the consumer side public hospital patients showed the highest recall at 28%, followed by people with a disability (25%), rest home occupants (20%) and Maori and Pacific Island people (18%). Consistent with the results in other sections of the questionnaire, GP and after-hours clinic patients were at the bottom of the list, with only 12% having seen anything that they could identify as coming from the Commissioner.

Awareness of advocacy service

The chart below shows awareness of an advocacy service associated with the Health and Disability Commissioner. The pattern is consistent with other awareness figures.

Awareness of Advocacy Service



Summary

In summary, the year brought a large measure of success with an increased awareness of a new piece of legislation on a limited budget. The volumes of papers and initiatives in the sector has meant that the Commissioner has had high competing demands.

In 1997/98 the focus remains on increasing providers awareness through education, particularly with the increased use of opinions on the outcomes of complaints.

TE TIRITI O WAITANGI, WORKING WITH MAORI, PACIFIC ISLAND PEOPLE AND OTHER ETHNIC GROUPS

The Kaiwhakahaere - Manager Maori Issues was appointed to the senior management team to achieve two principal objectives:

- to assist the Health and Disability Commissioner to promote and protect the rights of Maori consumers of health and disability services; and
- to advise the Commissioner on the role and structure of all services in order to fulfil the aim of effective management consistent with the principles of Te Tiriti o Waitangi.

The Kaiwhakahaere focuses on ensuring the Commissioner's processes are accessible and maintains a consumer perspective.

Communication - Education

During 1996, the Kaiwhakahaere worked to increase knowledge in both Maori provider and consumer groups. The method of communication "te kanohi kitea" (being seen) is effective for both education about the Code and promotion of the Commissioner's processes.

Promotional activities included:

- Distribution of educational resources through national and regional hui, Maori networks and Pacific Island community groups.
- Ten four-minute interviews, one on each Code right, with Ruia Mai radio.
- Ad hoc appearances on Kahungungu Radio, Ngati Porou Radio, Cape Kidnappers Radio Pacific Island programme and the Framework Trust Radio.

The Kaiwhakahaere is the Commissioner's principal authority on Te Reo. The Code of Rights poster and video are available in Maori and advice is given as to the appropriate and necessary use of Te Reo through all publications and communications. The availability of resources in Te Reo Maori and the 'easy-to-use' pocket cards have done a lot to gain the confidence of Maori consumers and providers alike.

Human Resource services

The Commissioner aims "to incorporate the principles of Te Tiriti o Waitangi into the operations of the office and the Code". All staff attend at least one in-house training in Te Tiriti o Waitangi. New staff are accorded powhiri, induction in Te Tiriti and working with Maori. The principles of Te Tiriti

are applied throughout the employment process. Staff attend a presentation on pronouncing kupu Maori used within the office.

Advocacy Services

Treaty of Waitangi advice and training was provided to advocacy services and the Director of Advocacy. Services were assisted to establish links with iwi Maori, other Maori organisations and Maori consumer groups. The Kaiwhakahaere also provides advice to the Director regarding effectiveness of advocacy services to Maori consumers.

Investigation and Mediation

The Kaiwhakahaere provides expert advice on the complaints process and specific issues regarding Maori consumers and providers. There are regular meetings between the investigations team and the Kaiwhakahaere to ensure that culturally appropriate methods are used when dealing with Maori complainants. The Kaiwhakahaere took part in recruitment and interviews for staff.

Executive Services

A section on Te Tiriti o Waitangi is included in the human resources manual. Processes for advertising vacancies, interviewing and writing job descriptions have input from the Kaiwhakahaere. Regular meetings occur between the Kaiwhakahaere and Executive Services Manager.

Legal

The Kaiwhakahaere has contributed to several submissions and opinions written by the Commissioner, bringing a Maori and consumer perspective to legal discussion. Ensuring that Health and Disability Commissioner processes do not alienate those least able to advocate on their own behalf and yet are consistent with the requirements of the Act is often difficult.

Working with Maori

The Kaiwhakahaere facilitates co-operation between the Commissioner and Te Puni Kokiri. She has also established links with major iwi groups in both North and South Island.

Maori generally have been enthusiastic in their response to information about the Code of Rights. Maori providers view the Code as a positive way of

looking at the quality of services they provide. It is interesting to note that rather than seeing the need to empower consumers as a legal obligation, Maori providers regard this as a responsibility to their consumers.

Maori consumer groups have expressed a sense of relief and excitement that the Code now exists. The fact that Te Tiriti o Waitangi is visible throughout the activities of the Health and Disability Commissioner encourages a sense of ownership in Maori consumers. Right 1 in particular, with its inclusion of Maori needs, values and beliefs, has ensured that Maori believe their cultural safety is protected by the Code.

People with a disability

The Kaiwhakahaere has worked with Maori with a disability. As this is one of the most disempowered groups within our society it has been good to see confidence in the Health and Disability Commissioner grow. In the Hawkes Bay two Maori men with a disability support the Kaiwhakahaere as Kaumatua when she visits the area. The Health and Disability Commissioner, in partnership with Te Puni Kokiri, supported Maori with a disability to attend and present at the International Conference on Rehabilitation in Auckland.

The Kaiwhakahaere has become a recognised contact for people with a disability. As a result, they are beginning to feel included in a meaningful way in Health and Disability Commissioner services.

Pacific Island Peoples

Establishing links with Pacific Island peoples is ongoing. The Kaiwhakahaere has met with Pacific Island groups in the major city centres and established a relationship with the Ministry of Pacific Island Affairs. Face to face meetings are the most effective method of building and developing these relationships.

Pacific Island people have some difficulty with the 'complaints' process as this conflicts with their cultural value of courtesy. However, whilst there are still challenges for the Health and Disability Commissioner in reassuring Pacific Island people of their cultural safety when accessing the Code, they are positive in their acceptance of how the Code can assist when they access Health and Disability services.

Key people in different communities and towns have undertaken to disseminate information to their particular groups and generally, Pacific Island providers are happy that Code of Rights material is available in the Pacific Island languages.

Other Ethnic Groups

Some contacts have been made with other ethnic groups, predominantly through interpreters and with refugee and migrant services. Effective dissemination of information needs development. The specific needs for information for new immigrants have not yet been ascertained. These groups will be given a higher focus in the coming year.

ENQUIRIES AND INVESTIGATIONS

Enquiries

The Health and Disability Commissioner operates a free 0800 enquiry line. This service is run by three enquiry staff based in Auckland and one enquiry officer in Wellington.

The Enquiry and Complaint Database System (ECDS) was operational on 1 July 1996 and logs all enquiries and complaints as they are received whether by phone or in writing. The system is proving effective as a means of recording data, although reporting capabilities are still under development.

Callers are given the option of volunteering statistical information such as geographical location, ethnicity, referral method (i.e. how the caller came to hear about the Health and Disability Commissioner) and age. This will enable future analysis such as the identification of demographic sectors which are under-utilising the Commissioner's service.

Definitions

An 'enquiry' is any contact relating to the services the office provides. A 'complaint' is a contact alleging a possible breach of the Code and requesting an action by the Commissioner in relation to that possible breach.

The total of 7278 enquiries received in the first year of operation exceeded original expectations of 6000.

Action taken on enquiry	**Number**
Enquiries that progressed to complaints	210
Open	9
Provided a formal response	164
Provided verbal and written information	1355
Provided verbal information	3699
Referred to advocacy	487
Referred to communication/education	177
Referred to other staff	13
Requested information from enquirer	11
Sent written information	1153
TOTAL	**7278**

Explanatory comments

Enquiry staff assist callers by explaining the options available to them, including the availability of advocacy services, sending out promotional material and referring the caller to other agencies when appropriate.

Only callers who are transferred directly to an advocacy service are recorded as 'advocacy referrals'. While other callers may be given information about advocacy services, they are included in statistics as having been provided verbal or written information.

Formal responses to enquiries include requests for information about the Health and Disability Commissioner and clarification or interpretation of various sections of the Health and Disability Commissioner Act 1994. Formal responses by Legal Services are included in this total. 'Sent written information' refers to the sending of pamphlets and educational material.

Similar data is collected for complaints and may be useful during the investigation process.

Investigations

The Investigation team has increased over the year from six staff (four based in Auckland and two in Wellington) to a staffing establishment of eight. The Commissioner now has five Investigation Officers in Auckland and three in Wellington. Two Senior Investigation Officer positions were created and existing staff were promoted to these positions.

Most training was conducted in-house, with opportunities for staff to meet as one team occurring four times during the year.

- 29 October 1996: Code training day. Advocacy services were also invited to this session and it was well attended
- 24 September 1996: Auckland and Wellington staff met to discuss operational changes
- 18 and 19 November 1996: Investigation and Enquiry staff attended the Health and Disability Commissioner conference at the Ellerslie Convention Centre and a day of in-house training in Auckland.
- 28 February 1997: New staff attended Health and Disability Commissioner conference and advocacy conference in Wellington as part of their induction training.

In addition to their investigative or enquiry roles, all staff contributed to the education and promotion of the Code by giving presentations to various provider and consumer groups.

Complaints

During 1996/97, 1,000 complaints were received at year end and 419 remained open. A single complaint may involve multiple consumers or providers but is still recorded as one complaint. Complaints were received both verbally and in writing.

The following table indicates a breakdown of the 1,451 providers subject to investigation in the 1,000 complaints.

Provider	Open	Closed	Total
Acupuncturist	0	1	1
Ambulance Service	2	1	3
Anaesthetic Technician	1	0	1
Anaesthetist	8	4	12
Cardiologist	0	1	1
Caregiver	0	4	4
Crown Health Enterprise	31	56	87
Chiropractor	3	8	11
Counsellor	4	6	10
Dental Technician	3	3	6
Dentist	20	38	58
Dermatologist	3	3	6
Ear/Nose/Throat	2	3	5
General Medical Practitioner	118	174	292
Geriatrician	0	2	2
Gynaecologist	5	3	8
Home Service Provider	15	22	37
House Surgeon	9	3	12
Laboratory Technologist	1	0	1
Medical Administrator	10	23	33
Midwife	17	23	40
Mental Health Worker	14	0	14
Naturopath	2	1	3
Needs Assessor	2	4	6
Neurologist	2	7	9
Nurse	24	72	96
Obstetrician	5	4	9
Occupational Therapist	2	3	5

Ophthalmologist	1	1	2
Optometrist	2	5	7
Orthopaedic Surgeon	7	14	21
Osteopath	1	1	2
Other Disability	24	21	45
Other Health	38	68	106
Other Non-health	4	43	47
Paediatrician	5	7	12
Pharmacist	14	24	38
Physician	12	10	22
Physiotherapist	3	7	10
Plastic Surgeon	1	0	1
Podiatrist	5	1	6
Prison Service	2	4	6
Private Hospital	2	2	4
Psychiatrist	12	22	34
Psychologist	10	34	44
Radiologist	6	9	15
Radiology Technician	0	2	2
Registrar	8	3	11
Rest Home Licensee	41	64	105
Rest Home Manager	31	55	86
Rheumatologist	1	0	1
Surgeon	20	22	42
Urologist	4	6	10
TOTAL	**557**	**894**	**1451**

Source of complaints and interface with Professional Boards

Since I July 1996, health registration boards have been required to send all complaints to the Health and Disability Commissioner. The boards may not take any action until the Commissioner has determined what action (if any) is to be taken under the Act. Of the 1,000 complaints received, 234 or 23.4% were referred by registration boards.

Of the total number of complaints received, 69.7 % were returned to the referring health registration board as the events being complained about happened prior to 1 July 1996. If a complaint about a registered health professional did not involve the provision of a health or disability service then this would also be returned to the professional board.

Received from	**Open**	**Closed**	**Total**
Chiropractic Board	3	8	11
Dental Council	6	16	22
Dietitians Board	-	-	-
Medical Council	33	74	107
Medical Radiation Technologists Board	-	2	2
Nursing Council	4	42	46
Occupational Therapy Board	-	-	-
Opticians Board	2	2	4
Pharmaceutical Society	3	10	13
Physiotherapy Board	-	4	4
Podiatrists Board	1	-	1
Psychologists Board	7	17	24
Subtotal (professional boards)	**59**	**175**	**234**
Advocacy	37	51	88
Commissioner initiative	3	4	7
Disability consumer	13	13	26
Employee	7	11	18
Friend	6	11	17
Health consumer	140	140	280
Lawyer	2	3	5
Member of public	7	26	33
Relative	82	69	151
Visitor	2	1	3
Other	12	11	23
Member of Parliament	5	-	5
Minister of Health	1	8	9
ACC	1	-	1
Ombudsman	2	2	4
Privacy Commissioner	-	2	2
Professional association	9	15	24
Regional Licensing Office	5	15	20
Health provider	22	23	45
RHA	4	1	5
Subtotal (other sources)	**360**	**406**	**766**
TOTAL	**419**	**581**	**1000**

Outcomes achieved

Complaints concerning events prior to 1 July 1996, or which did not relate to the provision of a health or disability service (e.g. access to service or health funding), are recorded as being outside jurisdiction (103), or referred to a professional body where appropriate (153) or referred to another agency (36). Where a complaint falls outside jurisdiction, every endeavour is made to provide the consumer or complainant with information about alternative sources of assistance. In total 51% of closed complaints fell into this category.

On receipt of a complaint the Commissioner can refer the matter to an advocate, investigate the complaint, or take no further action. 14% of complaints closed resulted in no further action. This may be because there are other remedies available to the complainant, or investigation into the matter is not appropriate due to any of a number of reasons listed in s37 of the Act, such as time elapsed since the incident, triviality or the unwillingness of the aggrieved party.

Consumers and providers resolved 42 complaints between themselves during the course of the investigation. Consumers reported that receiving information about their rights was empowering and gave them the confidence to deal with the matter directly with the provider.

The Commissioner may refer a complaint to an advocate either prior to or during an investigation. The parties are informed that the Commissioner has either received or has been investigating a complaint and has decided that the matter could be resolved with the assistance of an advocate. Advocates report to the Commissioner on outcomes, agreements and/or unresolved issues and 27 complaints closed were resolved with advocacy assistance.

Mediation, using either Health and Disability Commissioner staff or external consultants, is another mechanism used to resolve complaints. All 5 of the Health and Disability Commissioner's mediation sessions were successful.

Following investigation of a complaint, the evidence is referred to the Commissioner who assesses whether or not there has been a breach of the Code. In 50 cases there was no breach of the Code. Either the provider was able to provide evidence refuting the complaint or there was insufficient evidence to support the complaint. In 16 cases a detailed report was written to assist the parties' understanding.

Of the 419 open complaints, in 2 cases an opinion was formed that the Code was breached and the matter referred to the Director of Proceedings. One is in respect to a dentist and the other a podiatrist.

Outcome	Number
Breach and report	25
Complaint resolved by parties	42
Complaint to health professional body	153
Complaint withdrawn	25
Consumer not proceeding	28
Mediation	5
No breach found	34
No breach found - detailed report written	16
No further action	87
Outside jurisdiction	103
Referred to Privacy Commissioner	9
Referred to Ombudsman	2
Referred to other agency	25
Resolved with advocacy	27
TOTAL	**581**

Complaints where a breach found

Of the 581 complaints closed, 25 resulted in a report of a breach of the Code. The breakdown of the service types involved in these cases is as follows:

Service Type	Number
Accident and Emergency	1
General medical	2
General practice	5
General practice/radiology	1
Medical administration	1
Nursing	1
Orthopaedic	1
Paediatric medicine	1
Pharmaceutical	4
Psychiatry	1
Rest Home	6
Surgical	1
TOTAL	**25**

Open Complaints as at 30 June 1997.

A total of 419 complaints were carried forward into the 1997/98 financial year. The following table shows the dates that these open complaints were received.

Month	Received	Closed	Carried forward
July	62	61	1
August	78	73	5
September	68	64	4
October	63	45	18
November	79	61	18
December	57	42	15
January	67	41	26
February	106	60	46
March	81	41	40
April	107	48	59
May	119	34	85
June	113	11	102
TOTAL	**1000**	**581**	**419**

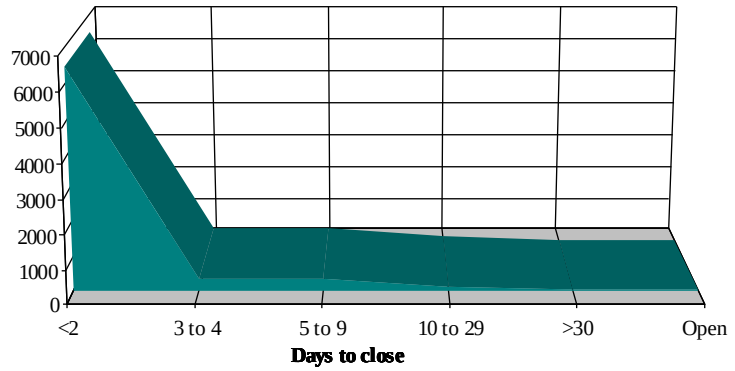
Reporting

The reporting aspect of the complaints is undergoing further development. The complication of multiple providers, multiple outcomes and in some cases multiple consumers, to any one complaint is proving difficult for statistical analysis but it is sensible from a consumer perspective. The consumer received a service. Where this involved many parties, it is not consumer-friendly to send the consumer multiple reports. By way of example, one current investigation is in respect of 10 service providers. This is necessary in order to fully investigate the events. Another investigation involves over 30 individual consumers.

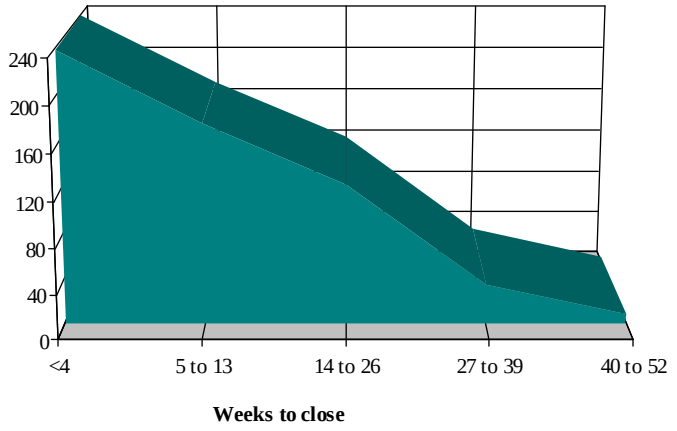
This focus on the consumer does result in a lack of comparative analysis with other agencies who record complaints differently.

The statistics show that in processing the 1,000 complaints received, we commenced 1,451 individual investigations, some of which were to a party who had a potential vicarious liability as an employing authority.

Days taken to close Enquiries



Weeks taken to close Complaints



REPORT OF THE DIRECTOR OF ADVOCACY

Introduction

The year was a challenging time for advocacy service providers as they established their services and began working with consumers and providers of health and disability services. Advocates were recruited in early 1996 and received training in April 1996. Following the implementation of the Code of Rights in July 1996, work began in earnest for advocates as they promoted the Code and assisted consumers to resolve concerns over health and disability services. During this first year services concentrated on establishing themselves and training staff as they became more familiar with their role and the Code.

Background

Under section 25 of the Health and Disability Commissioner Act 1994, the Director of Advocacy has the following functions:

a) To administer advocacy service agreements

b) To promote advocacy services by education and publicity

c) To oversee the training of advocates

d) To monitor the operation of advocacy services and to report to the Minister from time to time on the results of the monitoring.

Statement of Service Performance

The New Zealand Health and Disability Advocacy service is committed to the delivery of the services which contribute to objectives in the Health and Disability Commissioner's Statement of Service Performance. For 1996/97 the specific objective relating to advocacy was:

Operation of a New Zealand wide advocacy service from 1 July 1996, designed to assist health and disability service consumers resolve complaints about breaches of the Code at the lowest appropriate level.

Advocacy Agreements

There are ten service agreements in place which extend through to June 1999. These agreements ensure that advocacy services are available to health and disability service consumers throughout New Zealand. The regional offices of all ten advocacy services are now located in the community. The services vary in size between 1.5 and 8 full-time equivalent advocates. Three of the providers awarded contracts with the Director of Advocacy were providing advocacy services under the Ministry of Health prior to the

appointment of the Health and Disability Commissioner. These providers are now responsible for four advocacy services regions around the country. Working under the Health and Disability Commissioner Act was a challenge for these services as they came to understand and implement advocacy under the Director and the Code. The remaining six services were established in early 1996 and were also challenged as they set up their services and appointed new staff who needed to become familiar with their role.

All ten services were guided in their activities by the Advocacy Guidelines and standards outlined in the Performance and Monitoring Manual. They also received support from the Director as they learned about the practice of advocacy under the Code of Rights.

In July 1996 it became apparent that the Waikato Health and Disability Advocacy Trust was not providing services in accordance with its Agreement with the Director of Advocacy. An investigation and financial audit took place, resulting in the Trust returning to the Commissioner an amount equivalent to two month's funding. The trustees resigned and new trustees and advocates were appointed.

Staffing

The agreements provide for 33 full-time equivalent advocates which comprise 59 advocates, the majority of whom work part-time. The employment of part-time advocates has enabled all services to provide a geographical spread of service in their area. There was some turnover of staff in the first year, mostly for various personal reasons unconnected with the work although some staff left when their experience of advocacy did not match their expectations. The services are fortunate to have a high calibre of staff committed to the Code of Rights and assisting consumers.

Training

In October 1996 staff from the Commissioner's Legal Section provided training on interpretations of the Code for both advocacy and Commissioner staff. A two day Best Practice Conference was held for all advocates in Wellington in March 1997, which was the first time advocates had met together in one place to undertake training and share ideas. Advocacy service providers have continued to provide training within their own region and to orientate new staff.

Promotion

Services began the year concentrating on promoting the Code, the Commissioner and advocacy to both consumers and providers. This led to increased awareness in the community as advocates visited rest homes,

hospitals, GPs and marae, giving a total of 2,751 presentations during the year. The Commissioner produced a new advocacy brochure which all services are now using.

Enquiries and Complaints

The service handled 3,953 complaints and 6,377 enquiries during 1996/97. Services focus on low level resolution and empowerment as they work with consumers to resolve their concerns. Empowerment means that wherever possible, consumers are supported to express their concerns and resolve their complaints directly with service providers. This has proved beneficial for both consumers and providers.

Referrals by the Commissioner

Under sections 36 and 42 of the Act the Commissioner may, before or during an investigation, refer a matter to an advocate for resolution between the parties. During the latter part of the year there was a significant focus on these referrals, totalling 83 by the year's end.

Advocacy Activity by Region

Service	**FTE**	**Complaints**	**Enquiries**	**Presentations**
Northland	2	187	603	238
Auckland	8	1061	923	392
Waikato	2	77	253	122
Bay of Plenty/ Gisborne	3.5	283	440	216
Hawkes Bay	1.5	94	490	94
Taranaki, Wanganui Manawatu	3	744	614	773
Wellington	3	333	318	398
Nelson/Marlborough	1.5	176	174(est.)	40
Canterbury/West Coast	5	536	1,997	331
Otago Southland	3.5	462	565	147
Total	**33**	**3,953**	**6,377**	**2,751**

FTE = staff levels expressed as Full-Time Equivalents

The activity statistics for the 1996/97 year vary significantly between the services. Work is currently being carried out on definitions to ensure higher levels of reporting consistency for the 1997/98 year.

Monitoring and Operation of Advocacy Services

All advocacy services provided regular activity and financial reports to the Director during the year. These assisted the Director to monitor compliance with the Advocacy Service Agreement and the performance standards in the Performance and Monitoring Manual. The Director has also visited all advocacy services during the year to discuss performance and meet with staff.

In May 1997 work began on developing an audit tool which will be used to carry out the Social Audit of services later in the year, following the completion of annual reports. The Audit will be conducted by an independent auditor who will assess compliance with Advocacy Guidelines and Standards, consumer satisfaction and service management practices.

LEGAL SERVICES

1996/1997 was a busy year for the Legal section, with an increasing demand for legal advice following implementation of the Code of Rights and growth in the Commissioner's office. Advice included formal advice to the Commissioner on interpretation of the Health and Disability Commissioner Act 1994, written responses to enquiries from the public on all aspects of the Act and Code of Rights and overview of complaint files and educational materials. In addition, preparatory work was undertaken on a significant number of submissions for the Commissioner.

The large number of general enquiries to the Commissioner was reflected in the number of formal responses to enquiries (75) about the Act and Code of Rights prepared by the Legal section, which trebled the annual target. These covered a wide range of topics, with information often being sought on jurisdictional matters, informed consent and complaints processes in particular.

Submissions addressed a wide range of proposed policy and legislative changes in the health and disability sector. The number of submissions (27) also exceeded targets and more than doubled the projected number of submissions for the year. Priority was given to those matters which most directly impacted on consumers' rights to quality health or disability services, or which related to the operation of the Health and Disability Commissioner Act. Submissions included:

- Complaints Review Tribunal Regulations
- Ministry of Health paper "The Public Health Role of Local Government"
- The Health (Retention of Health Information) Regulations 1996
- Draft Guidelines on the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Law Commission's paper "Women's Access to Legal Information"
- Law Commission's paper "The Privilege Against Self-Incrimination"
- Ministry of Health paper "Delivery of Treatment for People with Opioid Dependence in New Zealand: Options and Recommendations"
- Ministry of Health paper on the proposed inclusion of benzodiazepines as controlled drugs under the Misuse of Drugs Act 1975
- Osteopaths Bill
- Ministry of Health Draft Service Charter
- SRHA review of Carer Support Services

- ARCIC (Independence Allowance Assessment) Regulations 1997
- Prime Ministerial Task Force on Positive Aging "Facing the Future: A Possible Way Forward"
- Ministry of Health "The Safety and Quality Issues Associated with Extending Limited Prescribing Rights to Nurses"
- Ministry of Health "The National Mental Health Standards: Draft 2"
- Ministry of Health "The Health and Wellbeing of Older People and Kaumatua: Public Health Issues"
- Ministry of Health "Whaia te Whanau*kata*ka: Ora*k*a Whanau"
- Penal Institutions Amendment Bill
- Review of vocational services for people with disabilities
- Crimes Amendment Bill (No 5)

The High Court decision in *Nicholls and Brown v Health and Disability Commissioner*, High Court, Christchurch, 12 March 1997, M No.74/97, arising from a judicial review action, was a significant event for the Commissioner and for the Legal section in particular. Justice Tipping confirmed the breadth of the Health and Disability Commissioner's jurisdiction to investigate systems issues (including management policies and practices) relevant to a possible breach of the Code of Rights, in what was the first judicial interpretation of the Health and Disability Commissioner Act 1994. It is hoped that this decision will help clarify the scope of the Commissioner's functions and powers for those operating in the health and disability sector.

The Legal section expanded during the year to accommodate the increasing workload of the Office. At the end of the year, staff consisted of a manager and two legal officers, with plans for the appointment of an additional legal officer to assist in the preparation of case notes and conference papers for the Commissioner.

EXECUTIVE SERVICES

The year ending 30 June 1997 was a period of bedding in and improving office systems and procedures. It was the first full operational year with most staff on board and afforded the opportunity to test systems and procedures in the light of live experience.

The office of the Health and Disability Commissioner commenced the year with an establishment of 23 staff. As demand for the services of the office grew additional staff were taken on, mainly in the investigation area. The office finished the year with an establishment of 29 staff, 18 of whom were with the office throughout the year. A Director of Proceedings was appointed in May 1997, completing the management structure.

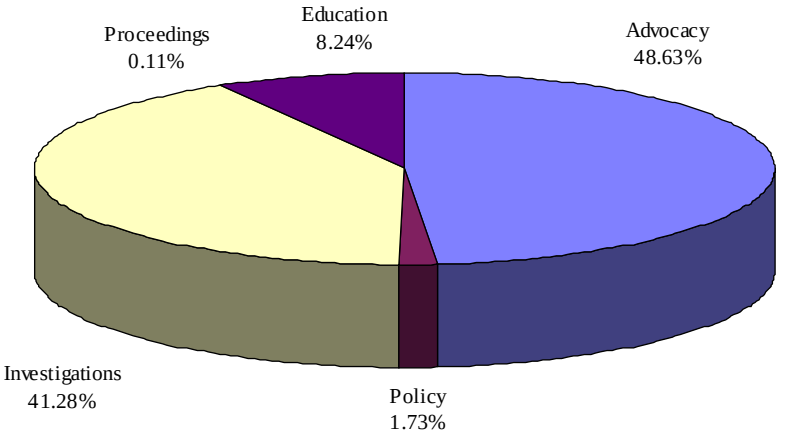
A temporary office was opened in Christchurch between 26 March and 26 July 1997 as a base for the major investigation into Christchurch Hospital commenced by the Commissioner in February 1997.

A purpose-built computerised information system for recording enquiries and complaints (the ECDS) became operational from 1 July 1996. Experience identified a number of shortcomings with both the design and some operational aspects of the database, in particular causing difficulties with obtaining some of the reports specified in the design tender. A structured programme for identifying and addressing the inadequacies has been put in place by the office and its technology partner.

The lease on the Wellington office in the State Services Commission building expired on 31 March 1997. New premises were located at Level 13, Vogel Building, Aitken St. After minor renovations were effected relocation took place on 24 March 1997. The office's Legal, Executive Services and Advocacy functions are based in Wellington, with Investigation and Mediation, Proceedings, Maori, and Communications and Education functions based in Auckland.

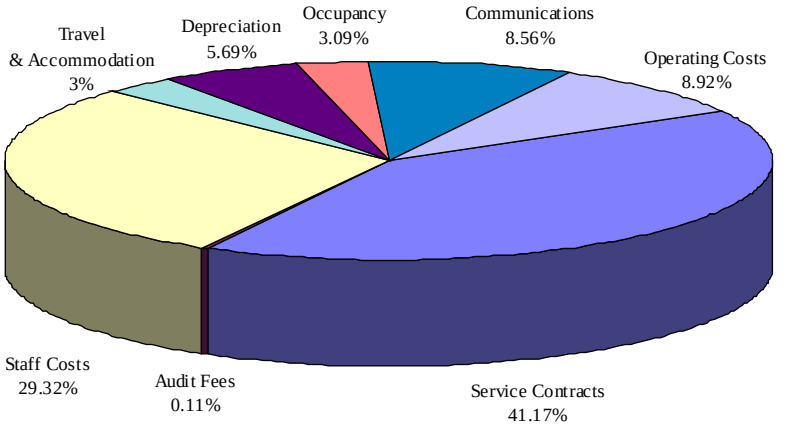
EXPENDITURE BY OUTPUT

The Health and Disability Commissioner has only one output class. However, the office delivers five interrelated sub-outputs. A breakdown of expediture by these sub-outputs is given in the following chart. As this is the first year of operational activity for the office a prior year comparison is not possible.



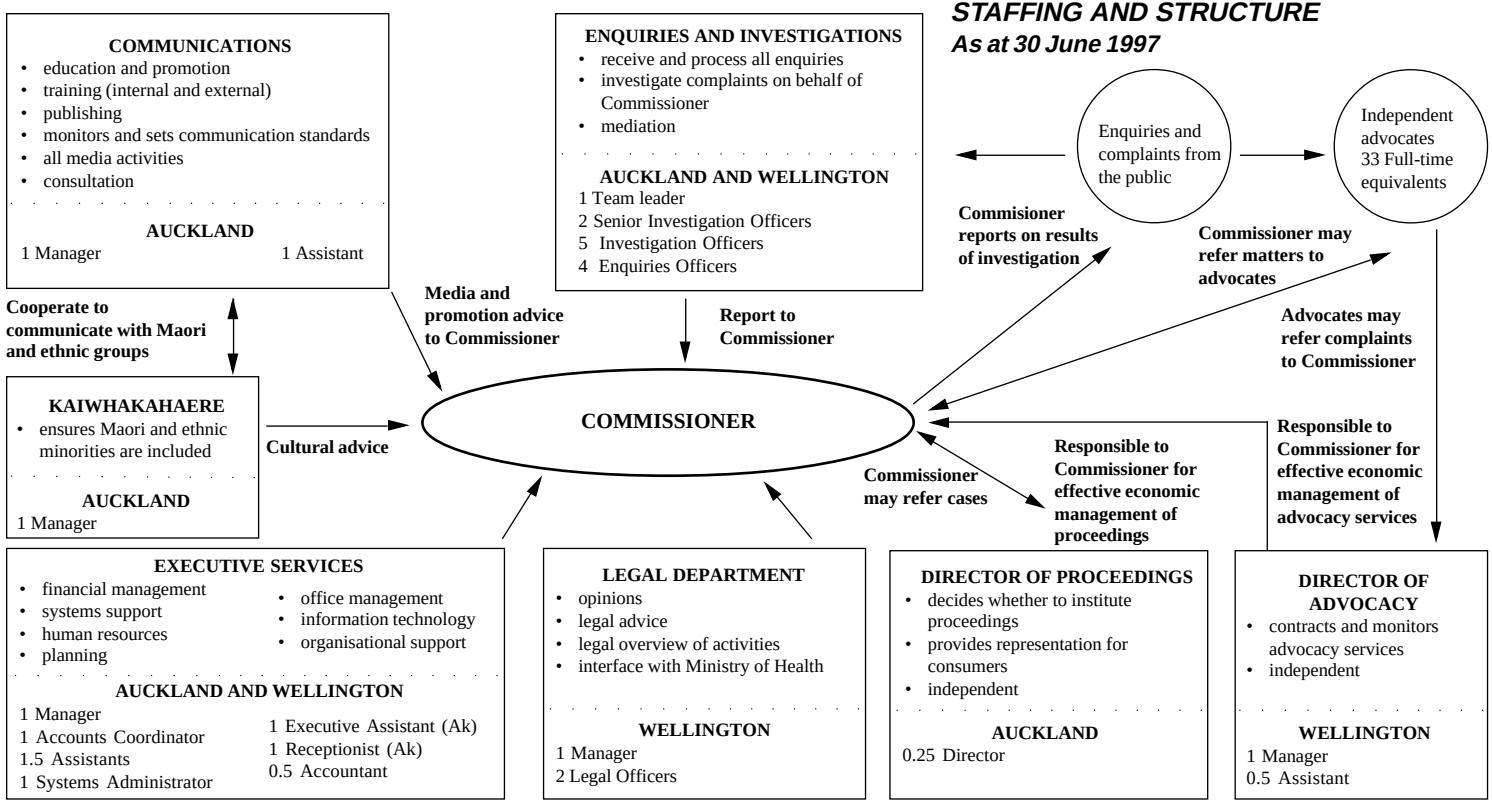
EXPENDITURE BY TYPE

The office started the year with a balanced budget but managed to achieve a net operating surplus of $738,036 which is 11.6% of total revenue. Expenditure on advocacy service contracts represented 41% of total expenditure and staff costs a further 29%. A full breakdown of expenditure by major expenditure groups is given in the following chart



STAFFING AND STRUCTURE

As at 30 June 1997



STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 1997

Actual 95/96 $		Actual 96/97 $	Budget 96/97 $
	Revenue		
4,649,778	Operating Grant Received	6,116,444	6,116,444
194,281	Interest Received	228,983	142,468
0	Publications Revenue	30,608	25,000
4,844,059	**TOTAL REVENUE**	**6,376,035**	**6,283,912**
	Less Expenses		
1,490,782	Advocacy Service Contracts	2,320,892	2,458,672
6,000	Audit Fees	6,000	6,000
998,939	Staff Costs	1,653,062	1,529,033
164,087	Travel & Accommodation	178,016	298,693
111,829	Depreciation	320,625	297,477
97,949	Occupancy	173,944	162,996
662,659	Communications	482,338	732,707
339,787	Operating Costs	503,122	798,334
3,872,032	**TOTAL EXPENSES**	**5,637,999**	**6,283,912**
972,027	**Net Operating Surplus**	**738,036**	**0**

The accompanying accounting policies and notes form an integral part of these financial statements.

STATEMENT OF FINANCIAL POSITION

As at 30 June 1997

Actual 95/96 $			Actual 96/97 $	Budget 96/97 $
	Crown Equity			
1,297,488	Accumulated Funds	**(Note 1)**	2,035,524	1,297,488
732,000	Capital Contributed		788,000	788,000
2,029,488			2,823,524	2,085,488
	Current Liabilities			
949,046	Sundry Creditors	**(Note 2)**	436,743	489,003
2,978,534			**3,260,267**	**2,574,491**
	Current Assets			
760,745	Bank Account		55,989	78,909
1,124,238	Call Deposits		2,295,508	1,524,718
10,000	Prepayments		20,064	10,000
48,968	Sundry Debtors		19,336	25,000
172,121	GST Receivable		123,288	113,409
2,116,072			2,514,185	1,752,036
862,462	**Fixed Assets**	**(Note 3)**	746,082	822,455
2,978,534			**3,260,267**	**2,574,491**

The accompanying accounting policies and notes form an integral part of these financial statements.

STATEMENT OF MOVEMENTS IN EQUITY

For the year ended 30 June 1997

Actual 95/96 $		Actual 96/97 $	Budget 96/97 $
719,461	Opening Balance 1 July 1996	2,029,488	2,029,488
972,027	Plus Net Operating Surplus (Total Recognised Revenue and Expenses)	738,036	0
338,000	Equity funding received from Government as a contribution towards the purchase of fixed assets.	56,000	56,000
2,029,488	Closing Balance 30 June 1997	**2,823,524**	**2,085,488**

The accompanying accounting policies and notes form an integral part of these financial statements.

STATEMENT OF CASH FLOWS

For the year ended 30 June 1997

Actual 95/96 $		Actual 96/97 $	Budget 96/97 $
	Cashflows from Operating Activities		
	Cash was provided from:		
4,649,778	Operating Grant	6,116,444	6,116,444
194,281	Interest on Short Term Deposits	228,983	142,468
(39,427)	Income Received	29,632	23,968
0	Publications revenue	30,608	25,000
4,804,632		6,405,667	6,307,880
	Cash was applied to:		
(769,568)	Payments to Employees	(1,194,396)	(778,030)
(3,098,031)	Payments to Suppliers	(4,595,012)	(5,609,736)
(3,867,599)		(5,789,408)	(6,387,766)
937,033	**Net Cashflows from Operating Activities (Note 4)**	**616,259**	**(79,886)**
	Cashflows from Financing Activities		
	Cash was provided from:		
338,000	Capital Contribution	56,000	56,000
338,000	**Net Cashflows from Financing Activities**	**56,000**	**56,000**
	Cashflows from Investing Activities		
	Cash was provided from:		
1,314	Sale of Fixed Assets	5,520	0
	Cash was applied to:		
(162,923)	Purchase of Fixed Assets	(211,265)	(257,470)
(161,609)	**Net Cashflows from Investing Activities**	**(205,745)**	**(257,470)**
1,113,424	**NET INCREASE IN CASH**	**466,514**	**(281,356)**

STATEMENT OF CASH FLOWS - continued

For the year ended 30 June 1997

Actual 95/96 $		Actual 96/97 $	Budget 96/97 $
1,113,424	**NET INCREASE IN CASH**	**466,514**	**(281,356)**
771,559	Cash brought Forward	1,884,983	1,884,983
1,884,983	Closing Cash carried forward	**2,351,497**	**1,603,627**
	Cash Balances in the Statement of Financial Position		
760,745	Bank Account	55,989	78,909
1,124,238	Call Deposits	2,295,508	1,524,718
1,884,983		**2,351,497**	**1,603,627**

The accompanying accounting policies and notes form an integral part of these financial statements.

HEALTH AND DISABILITY COMMISSIONER STATEMENT OF ACCOUNTING POLICIES FOR THE YEAR ENDED 30 JUNE 1997

Statutory Base

The financial statements have been prepared in terms of Section 41 and Section 42 of the Public Finance Act 1989.

Reporting Entity

The Health and Disability Commissioner is a Crown Entity established under the Health and Disability Commissioner Act 1994. The role of the Commissioner is to promote and protect the rights of health consumers and disability services consumers.

Measurement Base

The financial statements have been prepared on the basis of historical cost.

Particular Accounting Policies

(a) Recognition of Revenue and Expenditure:

The Commissioner derives revenue through the provision of outputs to the Crown and interest on short term deposits. Revenue is recognised when earned.

Expenditure is recognised when it is incurred.

(b) Fixed Assets

Fixed Assets are stated at their cost less accumulated depreciation.

(c) Depreciation:

Fixed assets are depreciated on a straight line basis over the useful life of the asset. The estimated useful life of each class of asset is as follows:

Furniture & Fittings	5 years
Office Equipment	5 years
Communications Equipment	4 years
Motor Vehicles	5 years
Computer Hardware	4 years
Computer Software	2 years

The cost of leasehold improvements is capitalised and depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is shorter.

(d) GST

The financial statements are shown exclusive of GST and the net GST at the end of the period is included as a receivable.

(e) Debtors

Debtors are stated at their estimated net realisable value after providing for doubtful and uncollectable debts.

(f) Leases

The Health & Disability Commissioner leases office premises. These costs are expensed in the period in which they are incurred.

(g) Provision for Employee Entitlements

Annual leave is recognised as it accrues to employees.

(h) Financial Instruments

All financial instruments are recognised in the Statement of Financial Position at their fair value.

All revenue and expenditure in relation to financial instruments is recognised in the Statement of Financial Performance.

(i) Taxation

The Health and Disability Commissioner is exempt from income tax pursuant to the Second Schedule of the Health and Disability Commissioner Act 1994.

Statement of Changes in Accounting Policies

There has been no change in Accounting Policies. All policies have been applied on basis consistent with the prior period.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 1997

Actual 95/96 $	Note		Actual 96/97 $
	1	***Accumulated funds***	
325,461		Opening balance	1,297,488
972,027		Net Operating Surplus	738,036
1,297,488		**Closing balance**	**2,035,524**
	2	***Sundry Creditors***	
888,108		Trade Creditors and Accruals	367,991
29,538		PAYE	31,591
31,400		Annual Leave	37,161
949,046			**436,743**

3 ***Fixed Assets***

1997	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	604,062	209,744	394,318
Computer Software	159,255	88,028	71,227
Communications Equipt.	29,432	11,996	17,436
Furniture & Fittings	127,821	32,260	95,561
Leasehold Improvements	140,904	37,156	103,748
Motor Vehicles	42,280	18,624	23,656
Office Equipment	60,440	20,304	40,136
Total Fixed Assets	**1,164,194**	**418,112**	**746,082**

Actual 95/96 $	Note		Actual 96/97 $
	3	***Fixed Assets - cont.***	

1996	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	567,362	63,463	503,899
Computer Software	105,297	8,636	96,661
Communications Equipt.	28,438	4,653	23,785
Furniture & Fittings	80,175	10,485	69,690
Leasehold Improvements	107,159	18,711	88,448
Motor Vehicles	42,280	10,169	32,111
Office Equipment	56,829	8,961	47,868
Total Fixed Assets	**987,540**	**125,078**	**862,462**

	4	***Reconciliation between Net Cashflows From Operating Activities and Net Operating Surplus***	
972,027		Net Operating Surplus	738,036
		Add Non-cash items:	
111,829		Depreciation	320,625
		Movements in Working Capital Items	
531,285		Increase/(Decrease) in Sundry Creditors (512,303)	
(542,003)		Increase/(Decrease) in Fixed Asset Creditors 1,500	
(39,427)		(Increase)/Decrease in Sundry Debtors 29,632	
75,443		(Increase)/Decrease in Prepayments (10,064)	
(172,121)		(Increase)/Decrease in GST Receivable 48,833	
(146,823)			(442,402)
937,033		Net Cashflows From Operating Activities	**616,259**

Actual 95/96 $	Note		Actual 96/97 $
	5	***Commitments***	
		(a) Ten contracts exist for the provision of consumer advocacy services. They are all effective from 1 March 1996 for a period of 40 months. The total commitment of $7,036,405 (excluding GST) is payable in monthly instalments. The remaining commitment from 1 July 1997 is $4,690,944.	
		Operating Leases including leasehold improvements	
		Wellington $76,000 per annum until March 2006	
		Auckland $70,736 per annum until March 2002	
		Classification of Commitments	
124,845		Less than one year	2,492,208
81,334		One to two years	2,492,208
65,758		Two to five years	422,524
0		Over five years	285,000
271,937			**5,691,940**

6 ***Contingent Liabilities***

As at 30 June 1997 there were no contingent liabilities (1996 Nil).

7 ***Financial Instruments***

As the Health and Disability Commissioner is subject to the Public Finance Act, all bank accounts and investments are required to be held with banking institutions authorised by the Minister of Finance.

Actual 95/96 $	Note		Actual 96/97 $
	7	***Financial Instruments - cont.***	

The Health and Disability Commissioner has no currency risk as all financial instruments are in NZ dollars.

Credit Risk

Financial Instruments that potentially subject the Health and Disability Commissioner to credit risk principally consist of bank balances with Westpac Trust and sundry debtors.

Maximum exposures to Credit risk at balance date are:

1,884,983	Bank Balances	2,351,497
48,968	Sundry Debtors	19,336
1,933,951		**2,370,833**

The Health and Disability Commissioner does not require any collateral or security to support financial instruments with financial institutions that the Commissioner deals with as these entities have high credit ratings. For its other financial instruments, the Commissioner does not have significant concentrations of credit risk.

Fair Value

The fair value of the financial instruments is equivalent to the carrying amount disclosed in the Statement of Financial Position.

STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 1997

KEY RESULT AREA 1: EDUCATION

Educate health and disability services consumers and provider groups and individuals as to the provisions of the Code of Health and Disability Services Consumers Rights.

Objective: *Provider promotion - raise awareness to agreed target levels by June 1997.*

	Target	Actual
CHE staff	60%	80%
GPs and A&E Clinic staff	60%	72%
Other health providers	50%	58%
Rest home patient contact staff	50%	67%
Professional disability service providers	50%	59%

Objective: *General awareness.*

	Target	Actual
Stories in print media	72	695
Electronic media articles	24	197
Total	96	892

Objective: *Continue public addresses to providers and consumers.*

	Target	Actual
General provider groups	55	96
Maori or Pacific Island provider groups	45	68
General consumer groups	45	39
Maori or Pacific Island consumer groups	25	26
Other bodies	15	46
Total	185	275

Objective: *Consumer promotion raise awareness to agreed target levels by June 1997.*

	Target	Actual
Users of public hospitals	25%	27%
Users of GPs and A&E clinics	20%	18%
Occupants of rest homes	20%	28%
People with disabilities accessing disability media and services	30%	41%
Maori and Pacific Islanders aged 18-50 using services.	15%	18%

KEY RESULT AREA 2: ADVOCACY SERVICES

Operation of a New Zealand wide advocacy service from 1 July 1996, designed to assist health and disability services consumers resolve complaints about breaches of the Code at the lowest appropriate level.

Objective: *Consumers using advocacy services are satisfied with the level of service.*

Target: 80% of consumers satisfied.

Actual: High levels of satisfaction have been reported by all services. This is to be confirmed by the Social Audit.

Objective: *Create an awareness of advocacy services.*

Target: 90% of Health and Disability providers contacted are displaying HDC materials.

Actual: Advocacy services have carried out promotional work and have distributed leaflets and order forms to providers who are not displaying HDC material.

Target: Nationwide service contracts are in force.

Actual: 10 agreements in place with 9 organisations to provide nationwide cover for advocacy services.

Objective: *All advocacy services provide high quality and independent service.*

Target: No more than 10 significant complaints against individual advocates or advocacy service providers verified by social audit.

Actual: An evaluation of complaints is included in the social audit of advocacy services for the 1996/97 year. The Report is due by 31 October.

Objective: *Advocacy services are delivered in an efficient manner during 1996/97.*

Target: All complaints about Health and Disability service providers acknowledged within 5 work days.

Actual: Standard practice is to acknowledge all complaints within 2 days of receipt but this is currently not reported on.

Target: 65% of complaints finalised within two months.

Actual: Preliminary reports indicate 60% of complaints closed are finalised within 60 days of receipt. As this is a consumer driven process this target is not entirely within the control of the advocacy services.

Objective: *Ensure effective management of contracts.*

Target: Reports completed by due dates as per performance and monitoring manual.

Actual: Quarterly and annual reporting is occurring within agreed timeframes.

Objective: *Resolution of complaints through advocacy.*

Target: 75% of complaints resolved with Advocacy.

Actual: Due to technical difficulties reporting from the database is not able to be verified. Performance against this target is not yet available.

Objective: *Advocacy services delivered.*

	Target	Actual
Presentations to providers	300	1,563
Presentations to consumers	200	1,188
Report on the number of enquiries and complaints actioned in order to create a baseline.		
Enquiries processed	6,000	6,377
Complaints processed	4,000	3,593

KEY RESULT AREA 3: INVESTIGATIONS

Assess and investigate complaints concerning breaches of the Code of rights and provide mediation services as required.

Objective: *To meet agreed throughput and quantity targets for the year.*

	Target	Actual
Report on the number of complaints investigated in order to create a baseline		
Complaints received	1600	1000
Complaints closed	1000	581
Enquiries received	6000	7278
Closed within 48 hours	90%	88.44%
Closed within 0 to 5 days	95%	93.16%
Average number of investigated complaints referred to Director of Proceedings for decisions regarding the Complaints Review Tribunal.	<1%	0%
Average number of investigated complaints referred to Director of Proceedings for decisions regarding disciplinary hearings based on public good	<1%	0.32% (2 cases)

Target: 200 complaints (50%) finalised per quarter within 16 weeks of receipt.

Actual: Of the 581 complaints finalised 414 (71.2%) were finalised within 13 weeks of receipt.

Target: All complaints finalised within 26 weeks.

Actual: Of the 581 complaints finalised 538 (92.6%) were finalised within 26 weeks of receipt.

Objective: *To meet agreed quality targets for the year.*

	Target	Actual
Client satisfaction with the process.	90%	99%

Of the 1,000 complaints received up to 30 June 1997, 10 written complaints were received about the process. Other complaints received concerned the outcome of an investigation, not the process involved.

There were no complaints made to the Office of the Ombudsmen requiring investigation by an Ombudsman into the complaints process.

A client satisfaction survey was not conducted.

Target: Culturally appropriate enquiry and investigations service developed.

Actual: All Investigation and Enquiry staff participated in Treaty of Waitangi training as part of their induction and ongoing training. This is coordinated by our Kaiwhakahaere.

Interpreter and translation services required during an investigation are provided by the Health and Disability Commissioner. Somali and Samoan translation and interpreting services were used this year as part of investigations.

Complaints or enquiries involving consumers who identified as Maori were discussed with the Kaiwhakahaere to ensure that service delivery was culturally appropriate.

All consumers who withdrew from the complaints process were followed up to determine the reason. Consumers who identified as Maori were followed up by the Kaiwhakahaere to determine whether the process was a contributing factor.

KEY RESULT AREA 4: POLICY ADVICE

Advise the Public, the Minister of Health and Government Agencies on matters relating to the Code of Rights and the administration of the Act.

Objective: *Commissioner supplies sound advice on the HDC Act and Code of Rights.*

	Target	Actual
Formal responses to enquiries regarding the Act and the Code of Rights	24	75
Submissions on policy and other legislation.	12	27
Total	36	102

KEY RESULT AREA 5: MANAGEMENT

The organisational structure and management systems support the efficient and effective delivery of the Commissioner's services and position the office well to deliver high quality services in the future.

Objective: *To ensure HDC meets all its legislative and employer responsibilities.*

Target: Audit report clear of major issues.

Actual: Audit New Zealand expressed an unqualified opinion as at 10 October 1996.

Target: Policy manuals finalised.

Actual: Manuals are developing documents which are frequently updated and therefore not absolutely finalised.

As of 30 June 1997 the following manuals were current and in use:

Advocacy manual
Enquiries and Complaints manual
Human Resources manual
Purchase and Payments manual

Target: Annual report completed on time.

Actual: The Annual report for the year ending 30 June 1996 was completed in accordance with the provisions of the Public Finance Act 1989 and the Health and Disability Commissioner Act 1994.

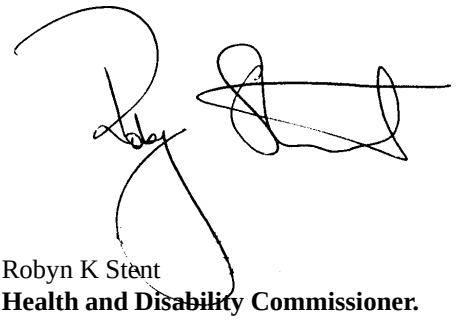
STATEMENT OF RESPONSIBILITY

In terms of Section 42 of the Public Finance Act 1989:

1. I accept responsibility for the preparation of these financial statements and the judgements used therein and

2. I have been responsible for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting, and

3. I am of the opinion that these financial statements fairly reflect the financial position and operations of the Office of the Health and Disability Commissioner for the period ended 30 June 1997.



Robyn K Stent
Health and Disability Commissioner.

Audit New Zealand

REPORT OF THE AUDIT OFFICE

TO THE READERS OF THE FINANCIAL STATEMENTS OF THE HEALTH AND DISABILITY COMMISSIONER

FOR THE YEAR ENDED 30 JUNE 1997

We have audited the financial statement on pages 38 to 56. The financial statements provide information about the past financial and service performance of the Health and Disability Commissioner and its financial position as at 30 June 1997. This information is stated in accordance with the accounting policies set out on pages 43 to 44.

Responsibilities of the Commissioner

The Public Finance Act 1989 and the Health and Disability Commissioner Act 1994 require the Commissioner to prepare financial statements in accordance with generally accepted accounting practice which fairly reflect the financial position of the Health and Disability Commissioner as at 30 June 1997, the results of its operations and cash flows and the service performance achievements for the year ended 30 June 1997.

Auditors Responsibilities

Section 43(1) of the Public Finance Act 1989 requires the Audit Office to audit the financial statements presented by the Commissioner. It is the responsibility of the Audit Office to express an independent opinion on the financial statements and report its opinion to you.

The Controller and Auditor-General has appointed Mr C R Fabling, of Audit New Zealand, to undertake the audit.

Basis of Opinion

An audit includes examining, on a test basis, evidence relevant to the amounts and disclosures in the financial statements. It also includes assessing:

- the significant estimates and judgements made by the Commissioner in the preparation of the financial statements *and*

- whether the accounting policies are appropriate to the Health and Disability Commissioner's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with generally accepted auditing standards in New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error. In forming our opinion, we also evaluated the overall adequacy of the presentation of information in the financial statements, and the Health and Disability Commissioner's compliance with significant legislative requirements.

Other than in our capacity as auditor acting on behalf of the Controller and Auditor-General, we have no relationship with or interests in the Health and Disability Commissioner.

Unqualified Opinion

We have obtained all the information and explanations we have required.

In our opinion, the financial statements of the Health and Disability Commissioner on pages 38 to 56:

- comply with generally accepted accounting practice *and*
- fairly reflect:
  - the financial position as at 30 June 1997 *and*
  - the results of its operations and cash flows for the year ended on that date *and*
  - the service performance achievements in relation to the performance targets and other measures adopted for the year ended on that date.

Our audit was completed on 22 October 1997 and our unqualified opinion is expressed as at that date.

C R Fabling
Audit New Zealand
On behalf of the Controller and Auditor-General

Wellington, New Zealand