Report of the

HEALTH AND DISABILITY COMMISSIONER

Te Toihau Hauora Hauātanga

For the year ended 30 June 1998

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

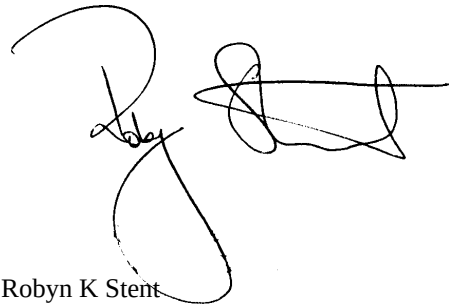
22 October 1998

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 1998.

Yours faithfully



Robyn K Stent
Health and Disability Commissioner

P O Box 1791, Auckland
Level 5, Quay Towers
Cnr Lower Albert and Customs Sts
Auckland, New Zealand
Ph/TTY: 09 373 3556 Fax: 09 373 3557
Toll Free Ph: 0800 11 22 33

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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 SUMMARY

The year was complex and challenging for the Commissioner and staff. With the Act having been fully operational for one year and the Canterbury Health investigation underway, the year began with high expectations of the office and queries regarding the skills and resources available to undertake its tasks. During the twelve months, in line with good management practice of reviewing processes and procedures and learning from experience, a number of changes were made to the way the office operated. As a result of this fine tuning, structural changes were made including:

- the creation of teams, improvement in paperflows for the processing of investigations and appointment of additional staff
- certain education activities were transferred to the legal department
- appointment of a full time Director of Proceedings
- identifying information was removed from many opinions which were published on the internet
- opinions were actively used for education purposes at conferences and in speeches
- a project to improve our computer system commenced to ensure more efficient monitoring and reporting in future.

Advocacy also found that its focus altered from answering consumer enquiries to assisting with complaints. As complaints were received, I referred a greater number of these to advocacy for resolution. Advocacy services have also been reviewing their operations. The current contracts, which are funded in terms of number of advocates rather than outputs, will be reviewed by the Director who needs to be able to focus the services on the relevant areas of concern and ensure outputs are achieved. During 98/99 the Director will review these contracts and request proposals for the provision of advocacy services from July 99 onwards. I have advised the Director that the resources allocated to the Health and Disability Commissioner from Parliament will be reduced with respect to advocacy in my attempt to allocate funding equitably between the various functions. In July next year this allocation will be adjusted to reflect increased consumer awareness and the empowering tools inherent in the Act and Code of Rights, such as the availability of support persons.

Throughout the year focus has been on the purpose of the Health and Disability Commissioner Act to *"promote and protect the rights of health consumers and disability services consumers, and, to that end, facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights"*. There was a 10% increase in complaints received and a 28% increase in closures. The complexity of complaints,

legal challenges by providers and investigations by the Ombudsman and Privacy Commissioner have increased workload and have resulted in a greater understanding of the Health and Disability Commissioner Act and its interaction with other bodies and legislation.

To ensure promotion and protection remains a key purpose, recommendations and suggestions are made wherever possible or whenever concerns are brought to my attention. Sometimes such recommendations are general ones only, as the office cannot have in depth operational knowledge of the entire health and disability sector. A good example of this is the recommendations made in the Canterbury Health Limited Report, which have subsequently been analysed by other hospitals in the country in a review of their quality processes. Unless I continue to focus on providing feedback to the sector, minimal lessons will be learnt. As we complete the year, I continue to assess how to best use the enormous amount of knowledge and experience built up from enquiries and investigations to educate the sector.

Canterbury Health Report

The successful completion of the Canterbury Health investigation in March 1998 was an important milestone for the Commissioner. The investigation and preparation of the report demanded a high amount of personal input. As is the case with all investigations, only the Commissioner can form an opinion as to whether there has been a breach of the Code. In the case of Canterbury Health, the resultant report broadened the public's understanding of the Commissioner's ability to make public comment on any matter affecting the rights of health and disability service consumers and is now being used to examine the overall quality processes and risk management systems in hospitals throughout the country. It has also been used as a resource by working parties developing new strategies for the sector.

Sector change and the Code

Over the past eight years there has been a shift in New Zealand from health as a vocation to health as a business. With this shift has come an increased emphasis on quality service and risk management. In some ways this provides a perfect opportunity to sell the Code to providers as a quality improvement tool, a blueprint for customer service, and encourages them to incorporate its principles into training programmes and codes of practice. Despite the fact that providers are legally required to inform consumers of their rights and enable them to exercise them, partnership is essential to the ongoing effectiveness of the Code.

Historically, the sector (particularly registered health professionals) was somewhat numbed by the 'big stick' disciplinary approach. Now providers, whether individual health professionals or managers, must be aware of a

range of issues when dealing with consumers, not just the ones which led to disciplinary action in the past. In the pre-Code of Rights era, if a professional came under scrutiny from a regulatory body the focus would be on whether or not the service met appropriate standards. This is only one of ten equally important aspects of service delivery demanded by the Code. Complaints such as "the doctor was rude to me" are valid within the Code environment and must be taken seriously both by the professions and by me. Rudeness and arrogance are detrimental to outcomes as consumers stop listening and participating in the service.

I am also concerned that many health professionals see an investigation by the Health and Disability Commissioner as simply a dress rehearsal for a hearing by the professional body. However, the Code establishes standards in its own right and the Commissioner's opinion, the result of a thorough and impartial fact gathering process, stands regardless of the outcome of any subsequent disciplinary action. To reinforce this, I have announced that I will be publishing investigation outcomes more extensively in the future - including names where necessary.

I have also been advocating the need for similar openness in professional disciplinary proceedings. The Medical Practitioners Act has been amended so that hearings are held in public unless otherwise ordered and name suppression is the exception rather than the rule. However, other legislation needs to be changed, or interpreted in a manner that accords with the new environment of accountability.

For both registered practitioners and the raft of individual providers and organisations not subject to regulation, the Commissioner's ability to report on the outcome of investigations is an important route to public accountability and education. Any decision to publish the name of a health or disability professional will obviously be carefully weighed up bearing in mind the public's right to know, public safety, the individual circumstances of the consumer and provider, the seriousness of the matter and the educative value of publishing details. But the purposes of the Act must be the Commissioner's focus. The Act and the Code exist to protect health and disability consumers, not professionals and I must do everything in my power to fulfil the Act's purpose.

Stretching the shrinking contents of the public purse to meet the increasing needs of New Zealand's ageing population will be a constant challenge for governments of the future. The exact direction our health system takes will depend upon how much of an inherited system successive governments decide (or can afford) to change. The current track is leading towards increased privatisation. Integrated care is being promoted as a softer model of the American managed care system. In the USA the rise of managed care has been accompanied by a growth in consumer rights movements and a push for associated legislation. In this respect, New Zealand is ahead of the play.

Advantages of the Act and Code

Critics of the Health and Disability Commissioner have stated that the legislation's effectiveness presumes the existence of a state funded system where access to care is not an issue. It is correct that the Code only applies to services given but it provides an important "buffer" against some of the harsher aspects of a commercialised health environment. It demands that consumers are provided with information about all the options available to them, not just those provided by a particular plan which an insurer or practice management organisation believes is good value, or is supplied by a preferred contractor, or subsidised by a particular drug company. Its broad scope means consumers can access the Code's protection regardless of the system within which the service is delivered. Its ability to hold a vast array of health and disability professionals to account - not just those subject to registration - will be increasingly important if current trends towards de-regulation continue. And its clauses concerning co-operation and continuity of care will guard against gaps in the network of public and private providers, and the barriers between competitors, however complex these interrelationships and tensions become. However, much of its protection lies in the public's knowledge and use of the Act and Code as tools to demand quality service. This is no easy task and will be partially offset by provider concerns about the Commissioner's investigation and publicity of breaches.

Even more importantly, the Commissioner is not intended as an auditor for the sector but a watchdog. Issues such as the decision to privatise ACC, policy moves to descriptive rather than prescriptive legislation and major restructuring within the sector, the Ministry of Health, the HFA and providers, tend to increase complaints to the Commissioner. The sector must be aware of the impact of process change on consumers and how this drives complaints. Certainly the Commissioner's funding is not sufficient to meet current demand let alone any increase. One way to destroy the effectiveness of this legislation would be to inundate the Commissioner with individual complaints. This would limit the Commissioner's ability to undertake large systemic reviews and influence the sector overall. The issue is to ensure the Act and processes have sufficient flexibility to deal with individual complaints.

Changes in the sector impact consumer satisfaction and in my last annual report I suggested the forging of a health and disability accord by political parties. I reiterate this suggestion, noting that structural changes to the sector (including policy changes in the areas of ACC, social welfare and education) often have a detrimental effect on the health of the public. Restructuring reduces the focus on delivering quality health and disability services. Participants in the sector at all levels of the spectrum (be they individual consumers, health professionals, managers, businesses the media and politicians) often promote concerns for their own gain and not for the overall public good.

In New Zealand we are extremely fortunate to have a regulation protecting consumer rights within the health and disability sector. At a recent international medico-legal conference in Europe, I discovered that only three other countries in the world have such rights in law. However, they were much more limited than ours and did not cover the disability sector. New Zealand's legislation is extremely comprehensive. It is significant that our legislation and expertise is being drawn upon to develop the US Federal Bill of Consumer Rights and Responsibilities.

I commenced the role of Commissioner with a strong belief in the power this legislation gives consumers to have their say in ensuring they receive quality health and disability services. However, I have never underestimated how hard this would be. When announcing the release of the draft Code I said *"One of the most difficult things for me over the next 12 months will be keeping consumers aware that all their expectations can't be met. People need to understand that the world can't change overnight. This is a method of doing it slowly through the system, rather than banging heads together to get quick responses which doesn't really create long term change."* This statement is still relevant today. Attitudinal, long term change takes time. The Commissioner has been the focus of enormous public expectation from individuals, interest groups and the media, both in terms of the issues I am able to address and the time and resources it should take me to do so. Despite this pressure, the legislation is successfully fulfilling the legacy of the Cervical Inquiry Report - transforming individual tragedy into systemic change to ensure mistakes are not repeated and the lessons learnt benefit all.

Future Direction

There are a number of challenges for the future including:

- Managing demand within the limited resources available to ensure speedy, effective low level resolution while at the same time not compromising public safety.
- Ensuring a balance between small complaints (which individuals have the right to bring before the Commissioner for resolution) and large systemic investigations. I note this has been a particular disappointment in terms of the investigation into prosthetic services where the volume of individual complaints has hindered my ability to manage that enquiry in a timely way.
- Sharing the Commissioner's knowledge amongst providers and consumers.
- Balancing activities between promoting rights and resolving complaints.
- Establishing jurisprudence.

- Ensuring investigation processes remain simple and do not become legalistic and cumbersome in reaction to a small number of time consuming legal challenges.

A major task in 1998/99 is to undertake a combined review of the Act and Code. When submissions were being accepted on the draft Code a number were received in relation to the Act. I do not want legal technicalities to prevent submissions from being taken into account, hence the decision for a joint review. It will be interesting to see what slant submissions take. During the original Code consultation process I was amazed at the homogenous nature of the comments received. Going through the anonymous quotes in the proposed draft Code document, it is almost impossible to attribute them to a provider or consumer. I hope the experience of the Code in action has not polarised opinion and that the same goodwill for continuing improvement is still present on both sides.

Conclusion

In conclusion, I wish to thank all those who assisted the Commissioner during the course of the year ended 30 June 1998. A particular thanks to all my staff. The pressures on them throughout the year were enormous and my significant involvement in the Canterbury Health investigation meant I did not provide the leadership that might have otherwise been available to them. I thank them for their dedication and ongoing commitment to promoting and protecting rights.

The detailed reports that follow reflect that commitment by providing detail of the work undertaken and outputs achieved during the 1997/98 financial year.

PUBLIC AWARENESS AND ACCEPTANCE

Promotion and Education

During the past year a total of 1,898 public addresses were delivered by Health and Disability Commissioner staff and advocates to a wide range of both consumer and provider groups, highlighting both the Code of Rights and the role of the Health and Disability Commissioner

Notable activities throughout the year included:

- 'HDC Issues 98' one-day conferences were held in Auckland and Wellington in March. These seminars on Code and Act issues were very well attended and positive evaluations were received from participants.
- The Commissioner contributed a monthly column to GP Weekly, a newspaper for general practitioners.
- In circumstances where it was considered useful, the Commissioner removed identifying information from written opinions and circulated them among relevant organisations.
- The Commissioner addressed several major conferences throughout the year, including: Ophthalmic Nurses, New Zealand Ophthalmological Society, New Zealand Pharmaceutical Society, Marie Burgess Seminar for health professionals, Independent Nurse Practitioners, Health Complaints Commissioner's Meeting (Australia), Licensed Care Providers, Medico Legal, Royal Australian College of Surgeons, National Commissioners/Health Ombudsmen (Australia) and the Multi Ethnic Council.
- Two seminars were held on the Ministry of Health's "Taking Care II" proposal for the revision of legislation concerning elderly care. The seminars were designed to encourage interested parties to make informed submissions to the Ministry.
- The advocacy service continued to fulfil a vital role in informing providers and consumers about the Code of Rights and the role of advocacy services.

Educational Resources

The Commissioner has continued to produce and review a range of educational resources for both consumers and providers. These are designed firstly to educate consumers about their rights under the Code and available avenues of support and complaint, and secondly to provide information for providers regarding their obligations under the Code of Rights.

Current 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 in English, Maori, Samoan, Tongan and Niuean.
- A video for providers.
- An audio tape containing information about the Code of Rights and advocacy services.
- Bilingual pocket cards with the brief ten rights in English with translations into Maori, Samoan, Tongan, Cook Island Maori and Niuean.
- An advocacy services leaflet, which contains the rights information as set out in the poster. This has been translated into the main Pacific Island languages.
- An Internet website (www.hdc.org.nz) containing the Code of Rights, the Health and Disability Commissioner Act and contact details for advocacy services. In the 1997-1998 year, this was upgraded to include opinions, articles and speeches and the site was accessed an average of 2000 times per month.
- Specific educational resource packages are also now being developed for key target provider and consumer groups in response to identified demands.
- A large number of opinions, edited to remove identifying features, have been made available through the website, at conferences or workshops and in response to requests.
- Formal responses to enquiries, prepared by the Legal Section to clarify queried aspects of the Act and Code are also an important educational resource.

Public Acceptance

In the year ended June 1998 public demand for information and educational materials remained consistently high. Orders for resources to a total value of $25,563.00 were received throughout the year, including a significant demand for copies of the Canterbury Health Ltd Report. Resources continued to be provided free of charge to consumers.

Specifically, resources either sold or provided free of charge were:

Publication Type	Number
Videos	158
'Your Rights' leaflets and poster	49,596
Code Regulation leaflets	47,393
Advocacy service leaflets	2,763
Pocket cards	39,310
Posters	2,111
Audio Tapes	53
Canterbury Health Ltd Report	834
Total	**142,218**

Media trends

This year has seen a further increase in levels of media interest related to a range of activities involving the Commissioner. The Commissioner's decision in February 1997 to conduct an investigation into Canterbury Health Ltd had a significant impact. Coverage of the announcement of the Commissioner's investigation and the Minister of Health's subsequent decision to discontinue his inquiry, the opposition of interested parties to this move and the outcome of the judicial review, and the findings of the report itself all helped to clarify media and public perceptions of the Commissioner's role. The report itself generated over 200 items during the month of release (April 1998) and ongoing interest through the remainder of the year.

The investigation also made the Commissioner a popular candidate for reporters seeking comment from an independent, consumer-focused perspective in relation to a variety of health and disability sector policies and issues.

With recognition came an increase in media requests seeking confirmation that the Commissioner had either received or was intending to investigate specific complaints. The Commissioner has given this on a very limited number of occasions, notably decisions to investigate the provision of prosthetic services in the Northern Region, mental health services at Western Bay Health and Waikato ambulance and emergency services. In generally adhering to a 'no comment' policy when asked to confirm complaints or investigations, the Commissioner has both the principles of natural justice and often the interests or wishes of the consumer in mind. Any party to a

complaint is entitled to disclose and discuss their issues with whomever they choose. However, it remains the current practice of the Commissioner to continue to treat matters as confidential until finalised, even where they have become the subject of public and media debate.

While decisions to withold information have occasionally caused comment, decisions to release it have been even more controversial. In October 1997, the Commissioner made an announcement, in the interests of public safety, naming a midwife found in breach of the Code. The midwife was due to appear before the Nursing Council and the Commissioner's decision to name her prior to this resulted in wide and often heated debate about professional accountability and protectionism. Over 40 media items appeared over the month of the announcement (October 1997) and the story continued to attract interest as the Nursing Council hearings progressed and findings were announced.

Awareness Survey

Key Result Area One of the Commissioner's Statement of Service Performance requires the Commissioner to *"Educate health and disability services consumers and provider groups as to the provisions of the Code of Health and Disability Services Consumers' Rights."*

In the 1997-98 year, targets for this key result area focused on activities conducted by the Commissioner - the number of presentations and educational resources put into the public arena. This differs from the previous year when measurement focused on levels of public awareness, with percentage targets for key groups. While an awareness survey was not strictly necessary to report achievement against this year's targets, it was felt that this would still provide valuable information about the Commissioner's progress in this area. The 1998 Awareness Survey was conducted in June by Colmar Brunton Research and the resultant data, in combination with Statement of Service Performance figures, provides a rounded picture of the Commissioner's promotional work and its effect.

Summary of awareness

The current year has again resulted in an increased public awareness of the Code and the role of the Health and Disability Commissioner. Compared with 1997, more people have seen resource/educational materials and more have a knowledge of the advocacy service and its role.

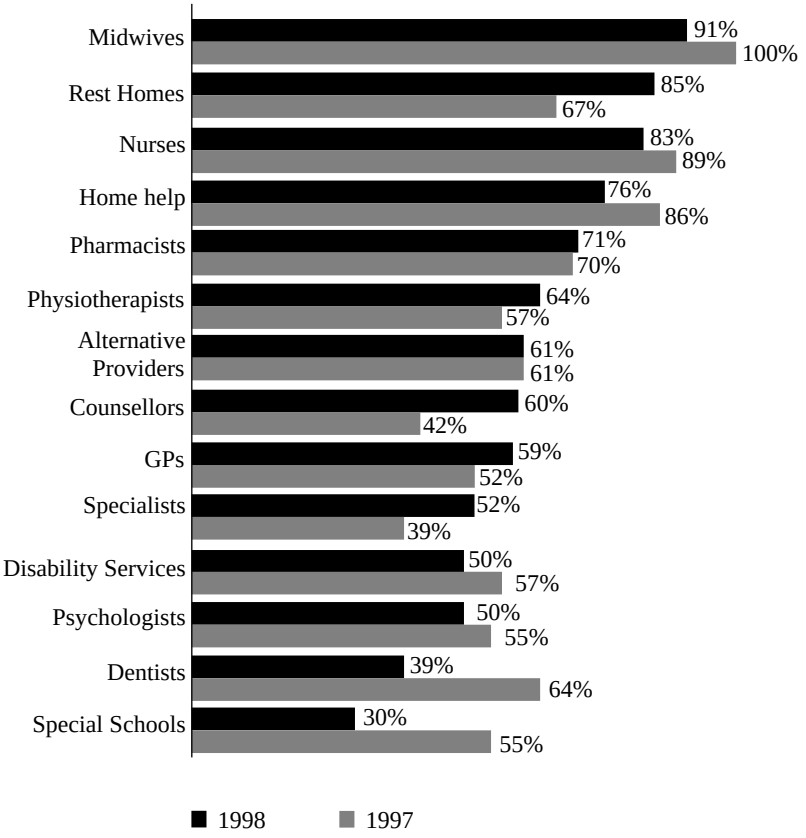
Of particular note is the pleasing increase in understanding of both the Code and the specific rights, amongst people with disabilities.

Provider awareness

Providers were asked about their awareness of the Code of Rights, the Commissioner and application of the Code. Consumers were asked about their awareness of the Code, the Commissioner, and the advocacy service.

Provider awareness of the Code of Rights, was measured by responses to the question 'Have you heard of the Code of Health and Disability Services Consumers' Rights?'. The results (compared with 1997) are shown below. The overall awareness across all types of provider increased from 52% to 64%.

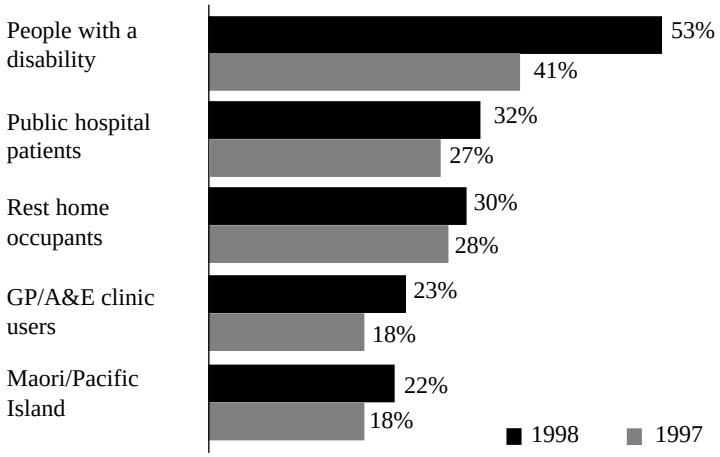
Provider Awareness



Consumer awareness

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

Consumer Awareness



Knowledge of rights

Both providers and consumers were asked to identify rights covered in the Code. Amongst most groups, awareness was similar to the 1997 survey results. Increases in consumer knowledge of rights were recorded for people with disabilities, public hospital patients, and Maori/Pacific Island consumers groups. Nurses, midwives and rest home staff were the provider groups with the highest recall of the rights.

Recall of Commissioner's educational resources

Sample groups were asked if they had seen any of the Commissioner's posters, leaflets or videos. Over 50% of health providers were able to recall specific resources (1997=47%). Recall among consumer groups was generally higher, the highest increase being represented by people with disabilities (1997=25%, 1998=44%).

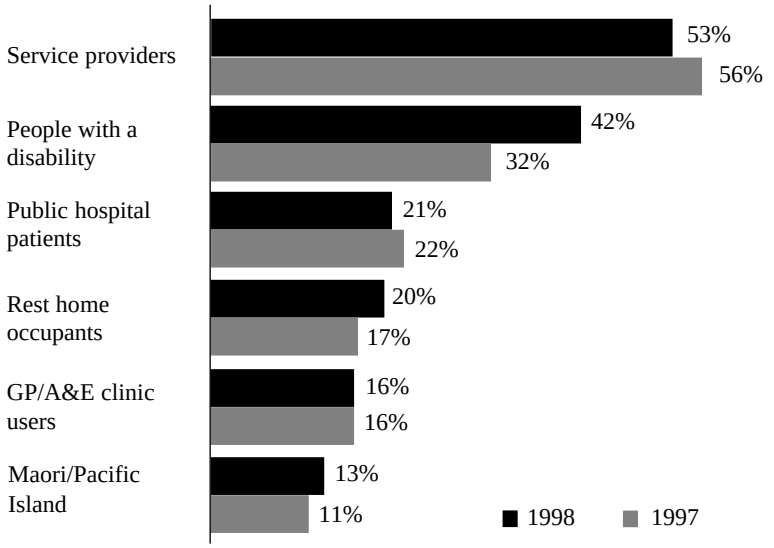
Commissioner's involvement in Canterbury Health investigation

Participants were asked if they were aware of the Commissioners role in the Canterbury Health Ltd inquiry. 31% of all respondents were aware. Of the health provider groups, awareness was highest for midwives (82%), and nurses (75%).

Awareness of advocacy service

The chart below illustrates awareness of the advocacy service associated with the Health and Disability Commissioner. Health providers have the highest awareness of this service. Among consumer groups 1997/1998 results were generally consistent, with a marked increase for people with disabilities.

Awareness of Advocacy Service



Increasing Awareness

In 1998/99 the plan is for us to focus more specifically on educating key identified provider and consumer groups. Additionally, the awareness of the general public needs to increase as a large number of complaints are being recieved from members of the public who are not in a consumer group and have an isolated encounter in the sector.

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.

The Kaiwhakahaere continues to work to increase knowledge within Maori provider and consumer groups. 1997 has seen a more consumer focused education programme with promotion programmes delivered to collective provider groups and Maori health policy writers.

Te kauohi kitea ("being seen", or face to face interaction) amongst Maori consumer and provider groups, is the most effective method of communication about the Code and Commissioner's processes.

Active networking and attendance at national hui has been a major promotional activity this year, as has promotion with whanau groups and other roopu Maori. The Kaiwhakahaere has carried out education programmes with Taura Hehe and urban Maori authorities.

The Kaiwhakahaere continues to work with the education/communication division in the publication of resources, media and education and training programmes for HDC staff.

Human Resources Services

Staff training is ongoing. The Kaiwhakahare attended the Advocacy Best Practice Conference and the regular 3 monthly training with investigations staff. All staff receive at least one training session on the Treaty of Waitangi and cultural safety. The Kaiwhakahaere participates in all staff induction programmes and organises powhiri for senior staff as well as ensuring that all staff are accorded a welcome.

Advocacy

Treaty of Waitangi advice and training was provided to the Director of Advocacy through regular monthly meetings, and at other times as necessary. Working with Maori and presentation training was carried out at the Best Practice Conference and in other forums.

Investigations and Mediation

The Kaiwhakahaere provides expert advice for complaints processes regarding Maori consumers and providers. With the improved recording of ethnicity data, more effective processes are now in place. The Kaiwhakahaere has also carried out interviews and provided support and information to Maori consumers. Regular training is provided about cultural safety. The Kaiwhakahaere reports public safety concerns to the Investigations Manager, in regular meetings.

Policy Advice

The Kaiwhakahaere has contributed to submissions, policy advice and opinions written by the Commissioner. She provides input to legal advice bringing a Maori and consumer perspective to legal discussion.

Working with Maori

The Kaiwhakahaere has provided information/education to Maori groups who are not necessarily aligned with iwi. All divisions of the office have received advice on the most appropriate methods of working with Maori. More Maori consumers and providers are now accessing the Commissioner's services, and feeling supported through the process. Staff are proactive in seeking advice and support in their relationships with Maori consumers. The Health and Disability Commissioner is now being seen as a safe organisation by many Maori. It is encouraging to note that the empowerment process used by the Commissioner has an impact for Maori consumers with many people using the resources as an empowering tool before contact with providers, advocacy or the Commissioner's office.

The Kaiwhakahaere has provided support and advice to ensure that Maori and consumers are comfortable within the legalistic environment when proceedings occur.

People with a Disability

This is an area in which the Kaiwhakahaere has worked diligently to raise the awareness of the Code and to inspire confidence in the Health and Disability Commissioner. There was a particular focus within Mental Health

services and presentations on the Code to members of disability consumer groups.

Pacific Island Peoples

Establishing links and providing information to Pacific Island peoples is progressing steadily. The "reputation" of the Health and Disability Commissioner is gaining acceptance within this group and confidence in the process is building. It is important to maintain a process that protects the cultural integrity of Pacific Island people.

ENQUIRIES AND INVESTIGATIONS

Enquiries

The Health and Disability Commissioner operates an enquiry line through its Wellington and Auckland offices. Through a toll-free call line (0800 11 22 33) enquirers can contact the 4 enquiries staff in Auckland or Wellington.

The Enquiries and Complaints Database System (ECDS) is used to record details of both enquiries and complaints. The system is in the process of being upgraded to allow for better quality of information.

An "enquiry" is defined as any contact relating to the services which the Commissioner provides. A "complaint" is a contact where a breach of the Code is alleged, and where action by the Commissioner is required in relation to the Code under Part IV of the Act.

8,502 enquiries were received during the year, exceeding the estimate of 8,400.

Actions taken as enquiry	**Number**	
	1998	**1997**
Enquiries later becoming a complaint	209	210
Open	0	9
Provide a formal response	262	164
Provided verbal and written information	1,345	1,355
Provided verbal information	5,280	3,699
Referred to advocacy	374	487
Referred to communication/education	98	177
Referred to other staff	3	13
Requested information from enquirer	4	11
Sent written information	927	1,153
TOTAL	**8,502**	**7,278**

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. "Provide verbal information" covers the provision of general information to callers. This is an area where significantly more work was done this year.

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. This includes formal responses by Legal Services. These formal responses are time consuming and are a significant part of the educational role of the Commissioner, ensuring the Rights are understood, providing interpretation of the Act and the Code, in an attempt to pro-actively ensure quality services are delivered to New Zealanders.

"Sent written information" refers to sending of pamphlets and educational material.

Investigations

During the course of the year, an Investigations Manager was appointed and the investigation staff numbers increased from 8 to 10. The Investigations staff have been structured into 3 teams (2 in Auckland and 1 in Wellington) to improve throughput and consistency. Each of the teams is led by a Senior Investigation Officer and is made up of about 4 investigation officers and an enquiry officer.

Most training has been conducted in-house with staff meeting as a team on two occasions:

5-8 September 1997	Investigations and Legal staff training
20 and 23 March 1998	HDC Conferences

Further team and individual training occurs regularly. Case conferencing allows the dissemination of expertise within the Auckland and Wellington teams.

In addition to the investigation and enquiries roles, all staff contributed to further knowledge of the Code by giving presentations to both provider and consumer groups.

Complaints

Complaints may be given both in writing and verbally. During 1997/98, the Commissioner received 1,102 complaints, having commenced the year with 419 open complaints. At the end of the year 778 complaints remained open following the completion and closure of 743 complaints.

Each complaint may involve multiple consumers or multiple providers, but for the purpose of consumer legislation, one record is kept for each individual's complaint. Of the 1,102 complaints received, investigations were commenced into 1,446 providers as indicated in the following chart. Many of these were undertaken as the employing authority has vicarious liability for the actions of an employee or agent under section 72 of the Act.

Provider	**1998**	**1997**
Acupuncturist	2	1
Ambulance Service	4	3
Anaesthetic Technician	0	1
Anaesthetist	10	12
Cardiologist	5	1
Caregiver	13	4
Chiropractor	8	11
Counsellor	3	10
Dental Technician	2	6
Dentist	59	58
Dermatologist	3	6
Dietician	1	0
Ear/Nose/Throat Specialist	4	5
General Medical Practitioner	279	292
Geriatrician	1	2
Gynaecologist	22	8
Home Service Provider	8	37
House Surgeon	15	12
Laboratory Technologist	0	1
Medical Administrator	16	33
Mental Health Worker	-	14
Midwife	41	40
Naturopath	2	3
Needs Assessor	3	6
Neurologist	13	9
Nurse	98	96
Obstetrician	24	9
Occupational Therapist	3	5
Opthamologist	4	2
Optometrist	4	7
Orthopaedic Surgeon	18	21

Osteopath	0	2
Other Disability	47	45
Other Health	110	106
Other Non Health	43	47
Paediatrician	6	12
Pharmacist	52	38
Physician	46	22
Physiotherapist	11	10
Plastic Surgeon	7	1
Podiatrist	6	6
Prison Service	10	6
Private Hospital	9	4
Psychiatrist	33	34
Psychologist	25	44
Public Hospital	207	7
Radiologist	9	15
Radiology Technician	1	2
Registrar	16	11
Rest Home Licensee	61	105
Rest Home Manager	42	86
Rheumatologist	0	1
Social Worker	3	0
Surgeon	35	42
Urologist	2	10
TOTAL	**1,446**	**1,451**

Source of complaints

Since 1 July 1996, health registrations 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 1,102 complaints received, 189 (17.1%) were referred by the Boards.

Received From	**Open**	**Closed**	**Total**	**Last Year**
Chiropractic Board	1	3	4	11
Dental Council	4	17	21	22
Dietitians Board	-	-	-	-

Medical Council	48	34	82	107
Medical Radiation Technologists Board	-	1	1	2
Nursing Council	17	22	39	46
Occupational Therapy Board	-	1	1	-
Opticians Board	-	1	1	4
Pharmaceutical Society	12	4	16	13
Physiotherapy Board	3	3	6	4
Podiatrists Board	-	2	2	1
Psychologists Board	3	13	16	24
Subtotal (professional boards)	**88**	**101**	**189**	**234**
Advocacy	60	36	96	88
Commissioner's initiative	5	4	9	7
Disability consumer	1	5	6	26
Employee	5	3	8	18
Friend	10	7	17	17
Health consumer	233	187	420	280
Lawyer	11	7	18	5
Member of public	9	14	23	33
Relative	123	68	191	151
Visitor	-	-	-	3
Other	-	-	-	23
Member of Parliament	11	4	15	5
Minister of Health	2	2	4	9
Accident Compensation	23	7	30	1
Ombudsman	2	4	6	4
Privacy Commissioner	-	-	-	2
Human Rights Commissioner	-	1	-	2
Professional association	5	4	9	24
Regional Licensing Office	4	6	10	20
Health provider	25	17	42	45
Health Funding Authority	8	-	8	5
Subtotal (other sources)	**537**	**376**	**913**	**766**
TOTAL	**625**	**477**	**1,102**	**1,000**

Outcomes achieved

Complaints concerning events prior to 1 July 1996, or which did not relate to the provision of a health of a disability service (eg complaints about access to service or about health funding) are recorded as outside jurisdiction (92), referred to a professional body wherever appropriate (68) or referred to another agency (28). Where a complaint falls outside jurisdiction, the complainant is given information about other sources of assistance whenever possible. In all, 25% of closed complaints during the year fell into this category. This is significantly below the figure for the previous year (51% of 581 closures) because consumers are less likely to complain about events prior to 1 July 1996 as time has passed. As a corollary, more complaints need investigation and this has driven the number of open complaints upwards at the end of the year.

On receipt of a complaint, the Commissioner can refer the matter to advocacy, investigate the complaint or take no further action. 131 (18%) complaints closed resulted in no further action. This may be because there are other remedies available to the consumer, or investigation into the matter is not appropriate in terms of the reasons listed in the Act. In many cases significant investigation has been undertaken prior to this decision. During 1998/99 further analysis of these outcomes is being recorded.

Consumers and providers resolved 67 (9%) complaints between themselves during the course of an investigation. This figure is comparable to this result last year (7%).

During the course of investigation, 39 (5%) consumers chose not to proceed or to withdraw their complaint. This compares with 53 (9%) of consumers who chose this same course last year.

The Commissioner may refer a complaint to an advocate either prior to or during an investigation. The parties are advised that the Commissioner has either received or has been investigating a complaint and the matter could be assisted by reference to an advocate. Advocates report to the Commissioner on outcomes, agreements and unresolved issues. This year 107 (15%) of complaints were resolved in this manner, compared to 5% last year. This change reflects the increasing use of advocates in the process to empower consumers to resolve complaints at the lowest appropriate level, with the provider. This only occurs when there is no perceived public safety issue.

Mediation, using both internal staff and external mediators, was used during the last year on 7 occasions. While all mediations but one were successful, this method of settlement is used infrequently and for carefully chosen matters.

Following the investigation of a complaint, the evidence is reviewed and a decision made by the Commissioner as to whether there has been a breach of the Code. In 156 (21%) complaints, there was no breach of the Code. In such cases, the provider is able to provide evidence to show that the complaint is unwarranted or that the provider acted reasonably in the circumstances, or there was insufficient evidence to find that the complaint was warranted. In 20 cases, a detailed report was written to assist the parties' understanding and to provide an educational resource.

In 48 (6%) complaints, the Commissioner decided that there had been a breach of the Code. The result of the breach was a report to the parties about that breach, detailing where the breaches had occurred. In most reports, there was action to be taken by the provider, and reported upon to the Commissioner. In addition, the report was forwarded to other interested parties such as the Health Funding Authority or organisations to which the provider belonged.

In addition to the breaches referred to above, the Commissioner reached an opinion that there was a breach of the Code and the file was referred to the Director of Proceedings in 12 complaints (2 last year) in order to consider further action under the Act and another 4 complaints were awaiting recommendations.

Outcome	**Total for year**	**Last year**
No investigation		
Referred to health professional body	68	153
Outside jurisdiction	92	103
Referred to Privacy Commissioner	8	9
Referred to Human Rights Commissioner	1	-
Referred to Ombudsman	1	2
Referred to other agency	18	25
Subtotal	**188**	**292**
Resolved or withdrawn		
Complaint resolved by parties	67	42
Complaint withdrawn	39	53
Mediation	7	5
Resolved with advocacy	107	27
Subtotal	**220**	**127**

Investigation		
Breach and report	48	25
No breach found	136	34
No breach found - detailed written report	20	16
No further action	131	87
Subtotal	**335**	**162**
TOTAL CLOSED	**743**	**581**

These outcomes reflect the increased throughput of the office during the year with an overall increase from 581 to 743 (27.88%) and completed investigations from 162 to 335 (106.79%).

Complaints where a breach is found

Of the 743 complaints closed, 48 resulted in a report of a breach of the Code. Additionally, 12 complaints where a breach was found have been referred to the Director of Proceedings and will be recorded as closed only when all action on the file is complete. A further 4 complaints which resulted in a breach are awaiting completion of recommendations. The breakdown of the service types involved in these cases was as follows:

Service type	**Closed**	**Last year**
Accident and Emergency	1	1
Chiropractic	1	-
Counselling	2	-
Dental	1	-
General medical	3	2
General Practice	12	6
Intellectual disability services	4	-
Medical administration	-	1
Mental Health Services	2	-
Naturopathic	1	-
Needs assessment services	1	-
Nursing	-	1
Obstetrics and Gynaecology	1	-
Orthopaedic	1	1
Other Health	1	-
Paediatric medicine	-	1
Pharmaceutical	7	4

Psychiatry	1	1
Rest Homes	9	6
Surgical	-	1
TOTAL	**48**	**25**

Open Complaints as at 30 June 1998

A total of 419 complaints were brought forward into the 1997/98 financial year. Of these, 266 complaints were closed and 153 complaints from this year carried forward into the 1998/99 financial year. Additional effort isbeing made to clear these files though several are open pending action by the Director of Proceedings and some awaiting the outcome of Coroner's hearings.

The following table shows the date that these open complaints were received.

Month Received	**Brought forward and new**	**Closed**	**Carried forward**
July 96 - Dec 96	61	39	22
Jan 97 - June 97	358	227	131
Total 1996/97	**419**	**266**	**153**
July 97- Sept 97	261	165	96
Oct 97 - Dec 97	285	143	142
Jan 98 - Mar 98	231	90	141
Apr 98 - Jun 98	325	79	246
Total 1997/98	**1,102**	**477**	**625**
Open at 30/06/98			**778**

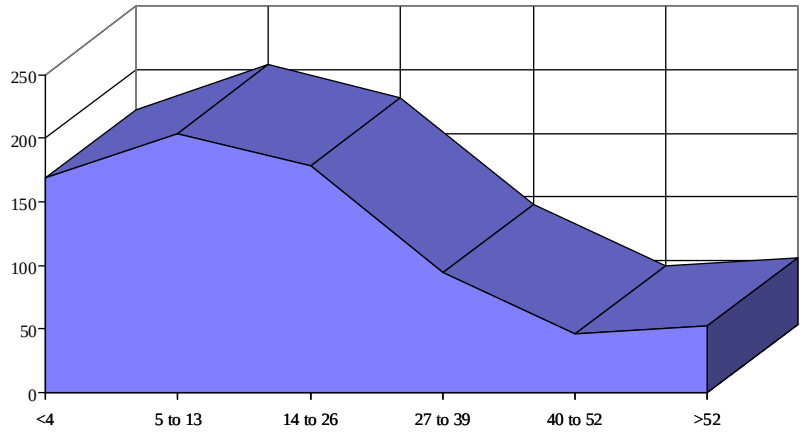
Of the 778 open complaints, 14 complaints were with the Director of Proceedings for consideration of further action under the Act and 4 awaiting recommendations including the Canterbury Health investigation.

Reporting

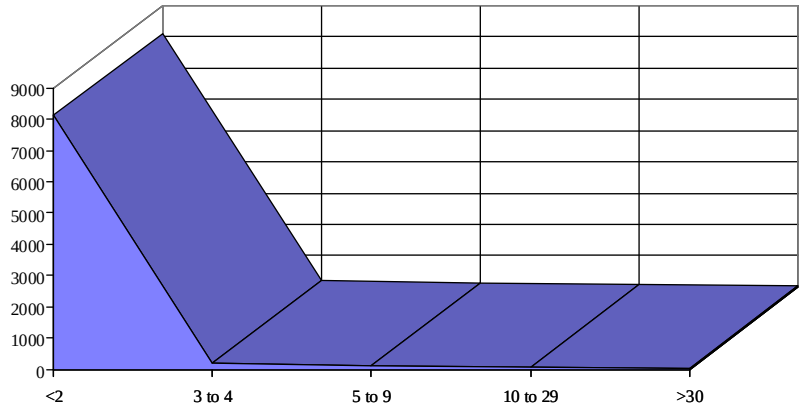
The Commissioner's database system has shown inadequacies, particularly the problems associated with multiple consumers, multiple providers and multiple outcomes. While it is necessary to remain consumer focused, and therefore ensure that each consumer receives just one report, the database reporting facilities require improvement to ensure more appropriate reporting of providers and outcomes.

Database development commenced during the 1997/98 financial year and will be completed in November 1998. This will allow a more sophisticated ability to report on outcomes by individual providers and provider occupations. For example, it will allow the tracking of an individual provider through various employers and allow appropriate reports to be made to interested parties as a result. It will also allow reporting on vicarious liability by employers, which is not able to be separately reported upon at present.

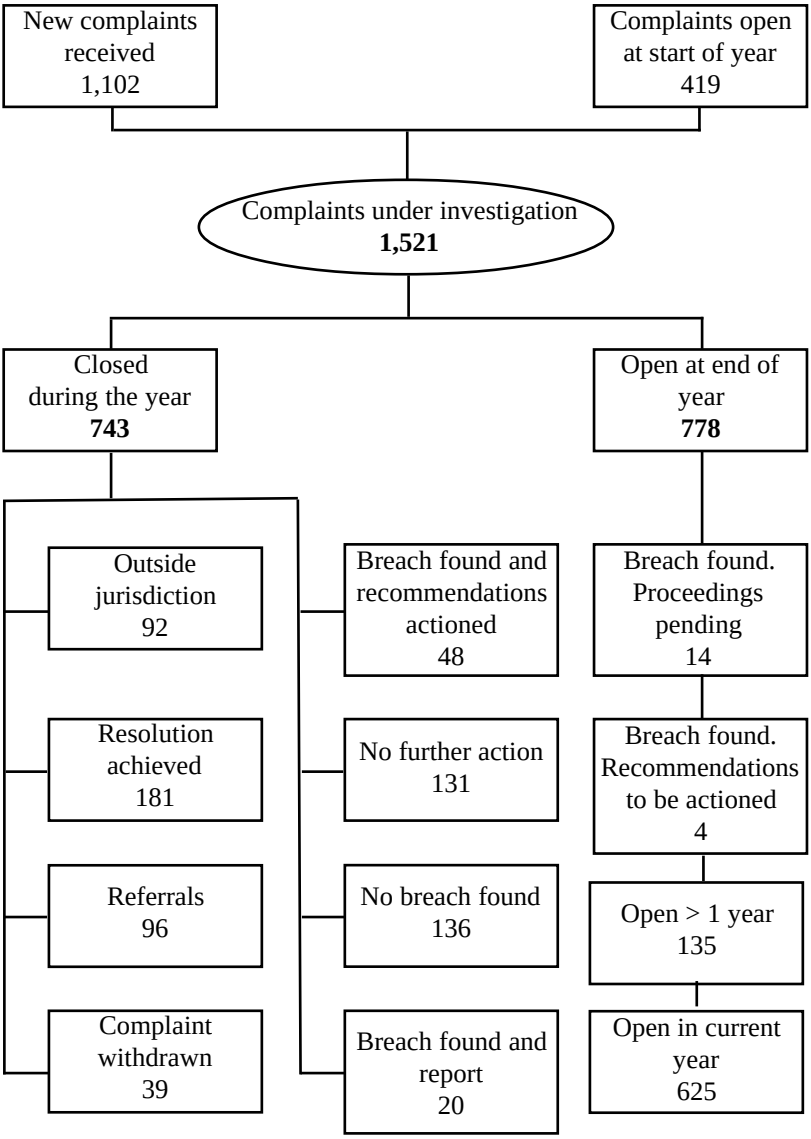
Weeks to close complaints



Days to close enquiries



COMPLAINTS PROCESSED TO 30 JUNE 1998



REPORT OF THE DIRECTOR OF PROCEEDINGS

Introduction

During the year the first appointment to the position of Director of Proceedings occurred. Initially, as the numbers were small, a barrister was appointed for 10 hours per week on a short term contract.

In June 1998, a full time Director was appointed due to the increase in referrals from the Commissioner.

Function

Under Section 49 of the Health and Disability Commissioner Act 1994, the Director of Proceedings has the following functions:

(a) to decide, on referral from the Commissioner, whether to institute disciplinary proceedings; and/or

(b) whether to issue proceedings before the Complaints Review Tribunal.

(c) when determining whether to issue disciplinary proceedings, the Director of Proceedings must:

  (i) give the health care provider or disability services provider an opportunity to be heard.

  (ii) regard the wishes of the complainant and the aggrieved person in relation to the matter.

  (iii) regard the need to ensure that appropriate disciplinary proceedings are instituted in any case where the public interest so requires.

Complaints Review Tribunal

This is a tribunal set up to consider claims from the Human Rights Commission, Privacy Commissioner and more recently the Health and Disability Commissioner. The Tribunal considers whether the Code of Rights has been breached. If a breach is found then the Tribunal can award damages (compensation) to the consumer. Before awarding damages the Tribunal must take into account the penalty, if any, given by the disciplinary body. The Health and Disability Commissioner Act says that action can be taken in the Complaints Review Tribunal and/or a disciplinary body in any order. It was the practice this year to take action before a disciplinary body and not issue proceedings before the Complaints Review Tribunal until receiving notice of the penalties given by the disciplinary body.

At year end no cases had been taken to the Complaints Review Tribunal.

Referrals

In 1997/98, there were 12 referrals (2 in 1996/97) from the Commissioner. At 30 June 1998 the status was as follows:

		ACTION		STAGE OF PROCESS			
	Referrals	Action to be determined	Charges laid	Hearing pending	Part heard	No action taken	Successful prosecution
Medical Practitioners	7	2	5	0	1	2	4
Dentist	2	-	2	2	-	-	-
Pharmacist	1	-	1	1	-	-	-
Nurse/Midwife	2	-	2	-	1	-	1
Optician	1	-	1	1	-	-	-
Podiatrist	1	-	1	-	-	-	1
	14	**2**	**12**	**4**	**2**	**2**	**6**

At 30 June, of the 14 referrals, two referrals in respect of medical practitioners had not been heard and therefore the Director of Proceedings had not decided what action to take. Of the other 12 referrals, 6 had been successfully prosecuted in professional disciplinary hearings. Two cases were part-heard and hearings were pending for the last 4.

REPORT OF THE DIRECTOR OF ADVOCACY

Introduction

The second year of advocacy has been one of consolidation focusing on creating a greater awareness of advocacy in the general community and with providers. Considerable emphasis has been placed on promotional work and improving consistency in advocacy practice.

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 located in the community. The services vary in size between 1.5 and 9 full-time equivalent advocates.

Preliminary work has begun on policy work for the Advocacy Service Purchase Strategy to prepare for when the current agreements expire. This will be a major focus for the Director during the 1998/99 year.

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 and policy updates from the Director during the year.

Staffing

The agreements provide for 33 full-time equivalent advocates which comprise 58 advocates, the majority of whom work part-time. The employment of part-time advocates continues to provide a full time Advocacy presence across the often large geographical service regions.

During the year a 1.5 FTE increase in the HAT Wellington and Auckland services was negotiated until the end of the Agreement in June 1999. A further 0.2 FTE advocates has been appointed by Advocacy Service Hawkes Bay from April 1998 for the provision of a Maori advocate.

Training

Best Practice Training was held for all advocates in Wellington for two days in March 1998. This was a valuable opportunity for all advocates to come together to share ideas on Advocacy practice and to have training on such issues as an update on the Code and giving presentations. Advocacy service providers continue to have regular staff meetings to review casework and to provide ongoing training.

A hui for advocates who are Maori was held in Rotorua in August 1997 to discuss issues surrounding the provision of advocacy for Maori within their service areas. Training was provided to help services give high quality presentations to consumers and providers. Services have also run Treaty of Waitangi training sessions for all staff during the year.

Monitoring and Operation of Advocacy Services

The Director monitored compliance with the Advocacy Service Agreement and the performance standards in the Performance and Monitoring Manual through quarterly and annual reports from advocacy services. Six monthly visits were made to all services by the Director.

A Social Audit of the services was carried out in 1997, following the completion of the Annual Report for each service for 1996/97 year. The Audit was conducted by an independent auditor who assessed consumer satisfaction and service management practices, and compliance with the Advocacy Guidelines, Standards and Agreement. The Audit highlighted performance issues for individual services to review. It also gave the Director an overview of the performance of the National Advocacy Service.

Establishing consistency among the ten services continues to be a challenge.

The Audit showed there are high levels of satisfaction among consumers who have used the Service. Providers' views of the Service were often influenced by confusion over the role of advocates. Many providers saw advocates as investigators, mediators or arbitrators rather than advocates who support the consumer to resolve their concerns and complaints. As a result of this finding, more emphasis is being placed on networking and developing good working relationships with providers, which will ultimately benefit consumers. The expectations of both consumers and providers are being managed by ensuring that the role of advocates is better understood.

Performance monitoring has become more robust and consistent with the provision of data definitions and standard reporting formats for all services. Recording and monitoring of activity by both the Director and the services will be enhanced by the implementation of improvements in October 1998, to the ECDS database which is used to record enquiries and complaints. Another database will also be made available to advocacy services in February 1999 to assist them to record presentations and networking which is currently recorded manually.

Promotion

Promotional work still continues to be of high priority for advocacy services. During the year 1,696 presentations were given to consumers and providers. This is a 33% decrease compared with promotional activity in the 1996/97 year. There have been two main factors in this decrease. When the services began in July 1996, there was little individual case work and more time was available for presentations. Individual casework has increased during the 1997/98 year, thus leaving less time for promotional work. The services are now no longer new and are receiving fewer invitations to present. Consequently, they are required to be more creative in seeking out promotional opportunities. These opportunities have been in the form of having stalls with advocates in attendance at such events as the Canterbury Easter Show and the Aoteoroa Festival. Static displays have also been put up in hospital foyers and public libraries, publicising the Code of Rights and Advocacy with leaflets to take away. Staff turnover in some areas has also affected presentation levels.

Enquiries and Complaints

The service handled 5,029 complaints and 5,909 enquiries during 1997/98. This represents a 23% increase in the number of complaints and a 7.5% decrease in enquiries compared with 1996/97. Both consumers and providers who are motivated to resolve concerns at low levels have found the involvement of advocates in this process useful. Concerns raised with providers at low level can have a positive impact on changing attitudes and ensuring health and disability services are more consumer focused.

Advocates, under section 30 of the Health and Disability Commissioner Act 1994, may report to the Commissioner any issues which they believe should be brought to her attention. Reports have been made to the Commissioner this year which in some instances have led to her undertaking investigations.

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. These referrals have doubled since last year with a total of 196 referrals being made by the Commissioner to Advocacy Services.

Activity by Region

Service	**FTE**	**Complaints**	**Enquiries**	**Presentations**
Northland	2	116	292	170
Auckland	9*	1,183	623	286
Waikato	2	144	604	113
Bay of Plenty/ Gisborne	3.5	383	506	171
Hawkes Bay	1.7*	133	465	84
Taranaki, Wanganui Manawatu	3	407	854	225
Wellington	3.5*	385	397	229
Nelson/Marlborough	1.5	163	452	90
Canterbury/ West Coast	5	1,525	852	201
Otago Southland	3.5	590	815	125
Total 1997/98	**34.7**	**5,029**	**5,909**	**1,696**
Total 1996/97	**33**	**3,953**	**6,377**	**2,751**

* part year only

LEGAL SERVICES

1997/98 was another busy year for the Commissioner's legal section, which provided 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. During 1997/98 the legal section also took on responsibility for the preparation of speech notes and conference papers for the Commissioner and commenced editing opinions which result from investigations undertaken by the office to remove any identifying features. It is anticipated that these will soon be available for public distribution and will act as a valuable educational tool. Many edited opinions have already been distributed as part of the educational materials made available by the Commissioner at various conferences.

A consequence of the growing awareness of the Commissioner's wide powers and jurisdiction under the Health and Disability Commissioner Act has been an increasing tendency for legal challenge of the Commissioner's actions as the boundaries of the Act are tested. The interface of the Act with other pieces of legislation is also being tested. As one of the aims of the Commissioner is to clarify these interfaces and boundaries for the future smooth running of the office, the Commissioner has not been averse to herself seeking clarification through the courts. All this has led to an interesting and busy time for the legal staff.

The large number of general enquiries to the Commissioner was reflected in the number of formal responses to enquiries about the Act and Code of Rights prepared by the legal section. These dealt with a diverse range of subjects and totalled 107 for the year. This well exceeded both the annual target and last year's output.

Submissions also addressed a wide range of proposed policy and legislative initiatives in the health and disability sector. The number of submissions (46 in total) was also well in excess of annual targets. Given the diversity of matters arising for comment, priority continued to be given to those matters which most directly impact on consumers' rights to quality health and disability services, or which relate to the Health and Disability Commissioner Act. Submissions have included comments on the following:

- Human Assisted Reproductive Technology Bill
- Medical Council's report on maintaining doctors' competence
- Implementing the Coalition Agreement on Health

- Ministry of Health's review of the health sector occupational regulation statutes
- UNESCO draft declaration on the human genome and human rights
- Mental Health Commission Bill
- Ministry of Health review of official visitors
- National Health Committee's project on access to infertility services
- Ministry of Health's review of structure and placement of ethics committees
- Ministry of Health's consumer safety project ('Taking Care II')
- Privacy Commissioner's guidance notes for agencies in the mental health sector
- Health Information Privacy Code 1994
- Ministry of Health's proposal to extend limited prescribing rights to nurses
- Review of the Privacy Act 1993
- Hazardous Substances and New Organisms Act 1996
- Ministry of Women's Affairs report for the Convention on the Elimination of Discrimination against Women Committee
- Ministry of Health's review of the mental health regulatory framework
- Nursing Council's draft framework for competence-based practising certificates for registered nurses
- Nursing Council's draft framework on guidelines and competencies for post registration nursing education
- National Health Committee's report on the provision of support services for people with disabilities
- Ministry of Health's proposal for an Intellectual Disability (Compulsory Care) Bill
- Penal Institutions Regulations 1998
- Department of Corrections report on options for opioid substitution treatment (methadone) in prisons
- Mental Health Foundation consumer information initiative
- Ministry of Health's national child health strategy
- Privacy Commissioner's guide on Health Information Privacy: A Practical Guide for the Health Sector
- Health Occupational Registration Acts Amendment Bill

A significant event for the legal section as for the rest of the office was the undertaking and completion of the investigation into Canterbury Health Ltd. Beginning with the High Court action the previous year challenging the Commissioner's ability to undertake the investigation, the investigation raised a number of legal questions which had to be worked through in conjunction with the Commissioner's external legal advisors. It is testimony to the care with which the investigation was undertaken that no legal challenges of the Commissioner's opinion arose at the end of the process.

Planning began during the year for review of the Health and Disability Commissioner Act and the Code of Rights. Commencement of review of the Act was delayed somewhat to allow Part IV of the Act, which only came into force on 1 July 1996, to be fully tested and so enable feedback on its efficacy as part of the review. This review process will be given priority in the coming year.

EXECUTIVE SERVICES

Activities covered by Executive Services include systems administration, payroll, human resources, budgeting, accounting services and co-ordination of planning and general administration. The year ending 30 June 1998 was a period of consolidation for most of the administrative systems and provided an opportunity to commence reviews and refinement of policies and procedures in place since the establishment of the office.

Considerable energy was spent throughout the year in addressing computer related issues. In 1996 the Office of the Health and Disability Commissioner established two offices in Auckland and Wellington. The two offices are set up as individual LANs connected together via a 64k leased line. The 10 remote advocacy sites around the country connect into either Auckland or Wellington via Lotus Notes Dial In. This gives a network of 96 users. Activity levels have exceeded expectations and together with knowledge based on 2 years of operational experience indicate that significant upgrading is necessary to both hardware and software. A project to deliver the software upgrade was well underway at year end.

The Auckland office was in the centre of the power blackout in February/ March 1998. A skeleton staff worked from the office in very trying conditions during most of the blackout while the majority of the Auckland staff members worked from their homes. A nation-wide telephone service was maintained from the Wellington office. It is to the credit of the staff involved that monthly output levels during this time were among the highest on record.

The Office of the Health and Disability Commissioner commenced the year with an establishment of 29 staff. As demand for the services of the office grew additional staff, mainly in the investigation area, were taken on. The office finished the year with an establishment of 35.5 staff. A full time Director of Proceedings was appointed in June 1998 replacing the previous part-time position.

EXPENDITURE BY TYPE

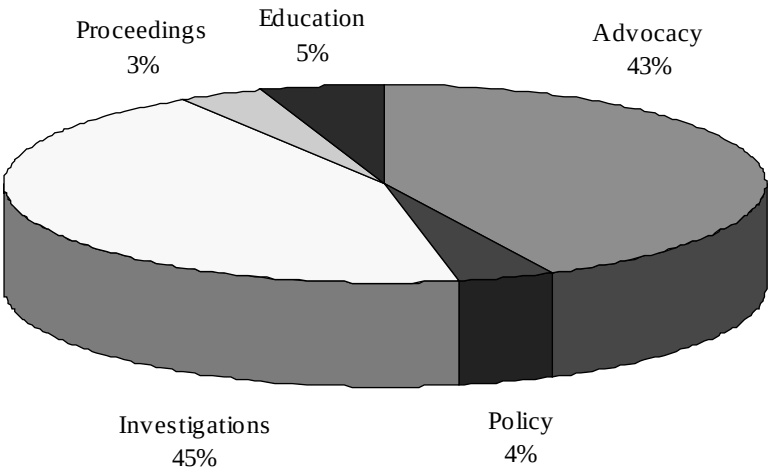
The office started the year in anticipation of a budget deficit of $828,000 as no extra funding was contributed by Government to finance the major review of Christchurch Hospital undertaken during 1997 and 1998. In total that review cost the Health and Disability Commissioner $1.51 million. As a result of higher than anticipated interest income and significant pruning of expenditure in other areas an operating surplus of $82,000 was achieved. Expenditure on advocacy service contracts represented 37% of total expenditure and staff costs a further 31%. A breakdown of expenditure by major expenditure groupings for the last three years is given in the following chart. Service contracts, staff costs and occupancy costs (collectively 71.24% of total expenditure in 1997/98) largely represent committed expenditure. Much of the remaining 28.76% (or 1.8mil) is discretionary. The very high percentage of committed expenditure severely limits the office's ability to meet ad hoc or large one off expenditure demands such as the Canterbury Health investigation or the upcoming review of the Code and Act as required by statute.

	1996/97	**1997/98**
Service Contracts	$2,320,892 41.17%	$2,359,467 37.27%
Audit Fees	$6,000 0.11%	$6,000 0.09%
Staff Costs	$1,653,062 29.32%	$1,970,596 31.12%
Travel & Accom.	$178,016 3.16%	$166,996 2.64%
Depreciation	$320,625 5.69%	$338,463 5.35%
Occupancy	$173,944 3.09%	$185,040 2.92%
Communications	$482,338 8.56%	$446,581 7.05%
Operating Costs	$503,122 8.92%	$858,409 13.56%
TOTAL	$5,637,999 100.00%	$6,331,552 100.00%

Figures GST exclusive

EXPENDITURE BY OUTPUT

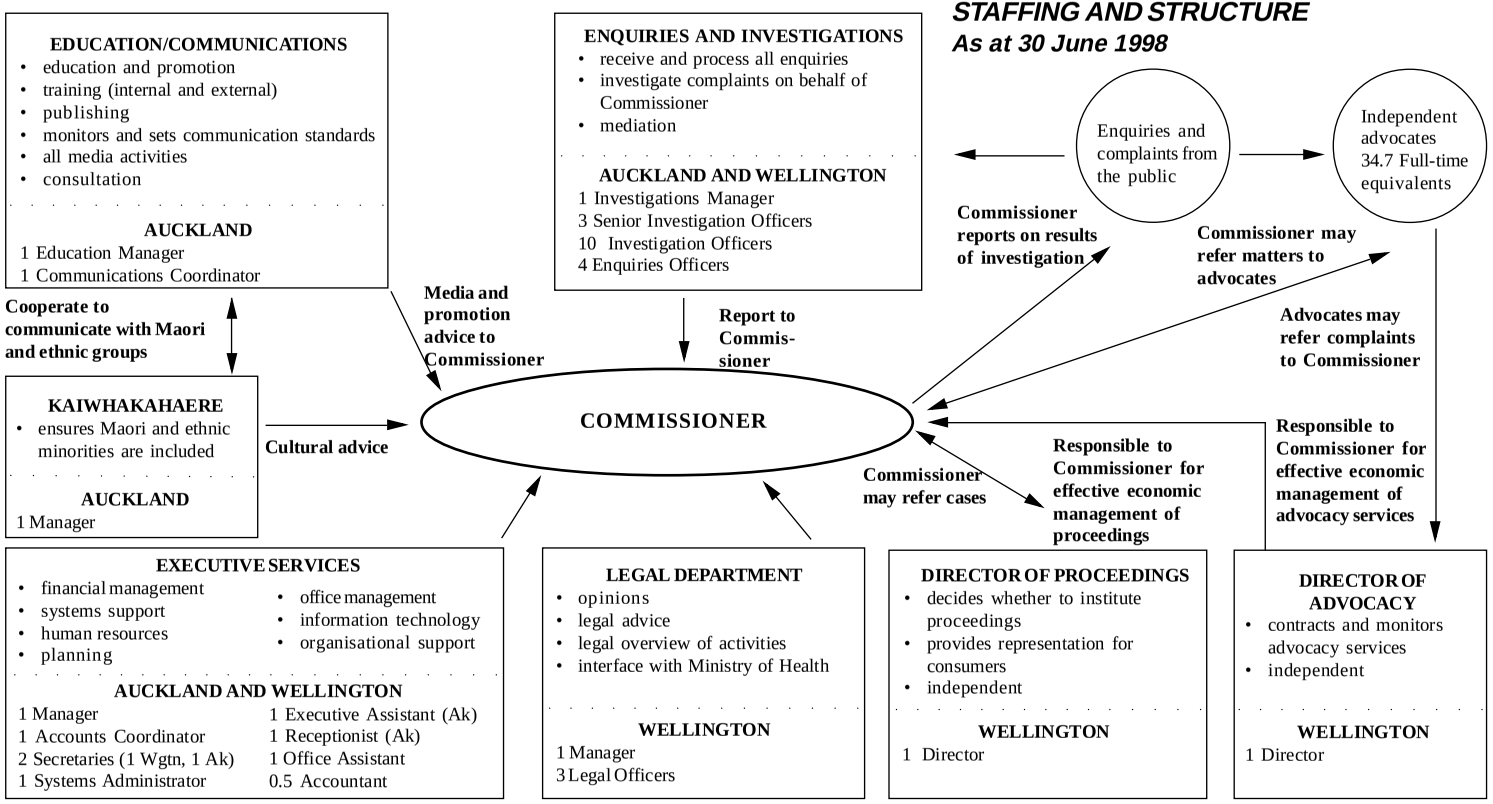
The Health and Disability Commissioner has only one output class however the office delivers 5 interrelated sub-outputs. A breakdown of expenditure by these sub-outputs is given in the chart below.



This represents direct allocation of overheads to the various divisions. The allocation does not consider the educational function of recommendations from investigations or distribution of opinions.

STAFFING AND STRUCTURE

As at 30 June 1998



STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 1998

Actual 96/97 $		Actual 97/98 $	Budget 97/98 $
	Revenue		
6,116,444	Operating Grant Received	6,119,111	6,119,111
228,983	Interest Received	269,044	100,000
30,608	Publications Revenue	25,669	20,000
6,376,035	**TOTAL OPERATING REVENUE**	**6,413,824**	**6,239,111**
	Less Expenses		
2,320,892	Advocacy Service Contracts	2,359,467	2,400,472
6,000	Audit Fees	6,000	9,000
-	Bad Debts written off	4,213	-
1,653,062	Staff Costs	1,970,596	2,224,678
178,016	Travel & Accommodation	166,996	249,770
320,625	Depreciation	338,463	362,801
173,944	Occupancy	185,040	194,057
482,338	Communications	446,581	573,835
503,122	Operating Costs	854,196	1,052,818
5,637,999	**TOTAL OPERATING EXPENSES**	**6,331,552**	**7,067,431**
738,036	**Net Operating Surplus**	**82,272**	**(828,320)**

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 1998

Actual 96/97 $			Actual 97/98 $	Budget 97/98 $
	Crown Equity			
2,035,524	Accumulated Funds	**(Note 1)**	2,117,796	1,207,204
788,000	Capital Contributed		788,000	788,000
2,823,524	**TOTAL CROWN EQUITY**		**2,905,796**	**1,995,204**
	Represented by Current Assets			
55,989	Bank Account		226,809	40,453
2,295,508	Call Deposits		2,436,835	1,680,324
20,064	Prepayments		12,814	10,000
19,336	Sundry Debtors		40,787	25,000
123,288	GST Receivable		96,581	83,568
2,514,185	**Total Current Assets**		2,813,826	1,839,345
	Non Current Assets			
746,082	Fixed Assets	**(Note 3)**	490,108	504,268
3,260,267	**Total Assets**		3,303,934	2,343,613
	Current Liabilities			
436,743	Sundry Creditors	**(Note 2)**	398,138	348,409
2,823,524	**NET ASSETS**		**2,905,796**	**1,995,204**

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 1998

Actual 96/97 $		Actual 97/98 $	Budget 97/98 $
2,029,488	Opening Equity 1 July 1997	2,823,524	2,823,524
738,036	Plus Net Operating Surplus (Total Recognised Revenue and Expenses)	82,272	(828,320)
56,000	Equity funding received from Government as a contribution towards the purchase of fixed assets.	0	0
2,823,524	Closing Equity 30 June 1998	**2,905,796**	**1,995,204**

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 1998

Actual 96/97 $		Actual 97/98 $	Budget 97/98 $
	Cashflows from Operating Activities		
	Cash was provided from:		
6,116,444	Operating Grant	6,119,111	6,119,111
228,983	Interest on Short Term Deposits	269,044	100,000
29,632	Income Received	(21,451)	(5,664)
30,608	Publications revenue	25,669	20,000
6,405,667		6,392,373	6,233,447
	Cash was applied to:		
(1,194,396)	Payments to Employees	(1,600,790)	(1,750,341)
(4,595,012)	Payments to Suppliers	(4,380,023)	(4,992,839)
(5,789,408)		(5,980,813)	(6,743,180)
616,259	**Net Cashflows from Operating Activities (Note 4)**	**411,560**	**(509,733)**
	Cashflows from Financing Activities		
	Cash was provided from:		
56,000	Capital Contribution	0	0
56,000	**Net Cashflows from Financing Activities**	**0**	**0**
	Cashflows from Investing Activities		
	Cash was provided from:		
5,520	Sale of Fixed Assets	5,026	0
	Cash was applied to:		
(211,265)	Purchase of Fixed Assets	(104,439)	(120,987)
(205,745)	**Net Cashflows from Investing Activities**	**(99,413)**	**(120,987)**
466,514	**NET INCREASE IN CASH**	**312,147**	**(630,720)**

STATEMENT OF CASH FLOWS - continued

For the year ended 30 June 1998

Actual 96/97 $		Actual 97/98 $	Budget 97/98 $
466,514	**NET INCREASE IN CASH**	**312,147**	**(630,720)**
1,884,983	Cash brought Forward	2,351,497	2,351,497
2,351,497	Closing Cash carried forward	**2,663,644**	**1,720,777**
	Cash Balances in the Statement of Financial Position		
55,989	Bank Account	226,809	40,453
2,295,508	Call Deposits	2,436,835	1,680,324
2,351,497		**2,663,644**	**1,720,777**

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 1998

Statutory Base

The financial statements have been prepared in terms of Section 41 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 the cost is incurred.

(b) Fixed Assets

Fixed Assets are stated at their historical 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 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 Annual Leave

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.

(j) Cost Allocation

The Health and Disability Commissioner has derived the net cost of service for each significant activity of the Health and Disability Commissioner using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to significant activities. Indirect costs are charged to significant activities based on cost drivers and related activity/usage information.

Criteria for direct and indirect costs

"Direct costs" are those costs directly attributable to a significant activity.

"Indirect costs" are those costs which cannot be identified in an economically feasible manner with a specific significant activity.

Cost drivers for allocation of indirect costs

The cost of internal services not directly charged to activities is allocated as overheads using staff numbers as the appropriate cost driver.

For the year ended 30 June 1998, indirect costs accounted for 23% of the Health and Disability Commissioner's total costs (1997 24%).

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 1998

Actual 96/97 $	Note		Actual 97/98 $
	1	***Accumulated funds***	
1,297,488		Opening balance	2,035,524
738,036		Net Operating Surplus	82,272
2,035,524		**Closing balance**	**2,117,796**
	2	***Sundry Creditors***	
367,991		Trade Creditors and Accruals	340,782
31,591		PAYE	0
37,161		Annual Leave	57,356
436,743			**398,138**

3 ***Fixed Assets***

1998	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	630,692	362,354	268,338
Computer Software	160,490	158,420	2,070
Communications Equipt.	28,408	18,545	9,863
Furniture & Fittings	134,910	58,353	76,557
Leasehold Improvements	163,825	75,470	88,355
Motor Vehicles	42,280	27,080	15,200
Office Equipment	62,154	32,429	29,725
Total Fixed Assets	**1,222,759**	**732,651**	**490,108**

Actual 96/97 $	Note		Actual 97/98 $

3 *Fixed Assets - cont.*

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**

4 *Reconciliation between Net Cashflows From Operating Activities and Net Operating Surplus*

738,036	Net Operating Surplus		82,272
	Add Non-cash items:		
319,962	Depreciation		321,043
	Movements in Working Capital Items		
(512,303)	Increase/(Decrease) in Sundry Creditors	(38,605)	
1,500	Increase/(Decrease) in Fixed Asset Creditors	16,924	
29,632	(Increase)/Decrease in Sundry Debtors	(21,451)	
(10,064)	(Increase)/Decrease in Prepayments	7,250	
48,833	(Increase)/Decrease in GST Receivable	26,707	
(442,402)			(9,175)
663	Net loss on disposal of assets		17,420
616,259	Net Cashflows From Operating Activities		**411,560**

Actual 96/97	Note		Actual 97/98
$	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 remaining commitment from 1 July 1998 is $2,345,483.

Operating Leases including leasehold improvements

Wellington $76,000 per annum until March 2006

Auckland $72,519 per annum until March 2002

	Classification of Commitments	
2,492,208	Less than one year	2,494,002
2,492,208	One to two years	148,519
422,524	Two to five years	354,908
285,000	Over five years	209,000
5,691,940		**3,206,429**

6 ***Contingent Liabilities***

As at 30 June 1998 there were no contingent liabilities (1997 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. The Health and Disability Commissioner has no currency risk as all financial instruments are in NZ dollars.

Actual 96/97 $	Note		Actual 97/98 $
	7	***Financial Instruments - cont.***	
		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:	
2,351,497		Bank Balances	2,663,644
19,336		Sundry Debtors	40,787
2,370,833			**2,704,431**
		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.	
	8	***Related Party***	
		The Health and Disability Commissioner is a wholly owned entity of the Crown. The Crown is the major source of revenue of the Health and Disability Commissioner.	
		There were no related party transactions.	

Actual 96/97 $	Note		Actual 97/98 $
	9	***Exceptional item - Canterbury Health Ltd*** The Health and Disability Commissioner completed an investigation into Canterbury Health Ltd which was commenced during the year ended 30 June 1997.	
671,815		Canterbury Health Ltd	854,444

STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 1998

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 - increase providers' awareness of the Code and advocacy services.*

	Target	Actual
Presentations to: General provider groups	60	78
Disability service provider groups	5	5
Maori provider groups	20	38
Pacific Island provider groups	5	2
Contribute articles to provider publications	20	25
Produce and distribute opinions for educational purposes	24	31

Objective: *Consumer promotion - increase consumers' awareness of Code and advocacy services.*

	Target	Actual
Presentations to: General consumer groups	50	33
Disability consumer groups	10	7
Maori consumer groups	15	21
Pacific Island consumer groups	10	2
Other ethnic consumer groups	5	2

Objective: *General and health and disability sector awareness of Code and advocacy services.*

	Target	Actual
Presentations to other bodies	15	16
Present educational seminars	2	4
Distribute educational resources	50,000	142,218
Regularly updated internet site	Up to date	Up to date

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:	*Nationwide advocacy services provided.*
Target:	Nationwide advocacy service contracts are in force.
Actual:	Ten service contracts are in place which give nationwide coverage.

Objective:	*Training opportunities available for advocates during the year.*
Target:	Training opportunities available during the 1997/98 year.
Actual:	Best practice training held in Wellington for two days for all advocates in March 1998. Advocates have also been given presentation training and a hui was held for Maori advocates.

Objective:	*Effective management of contracts.*
Target:	Comment provided to the advocacy service providers on plans and reports sent to the Director.
Actual:	Comments made on all plans and reports sent to the Director.
Target:	Reports sent to the Minister every six months.
Actual:	Target met.
Target:	Joint review meetings held every six months.
Actual:	Target met.

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
Process complaints	1,500	1,102*1
Finalised within 16 weeks of receipt	65%	50.2%*2
Finalised with in 26 weeks of receipt	95%	74.2%
Process enquiries	8,400	8,502
Enquiries closed within 48 hours	90%	95.5%

*1 = new complaints received resulting in 1,446 investigations. 743 closed and 778 on hand at the end of the period.

*2 = closed within 13 weeks.

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

Target: Culturally appropriate enquiry and investigations service provided.

Actual: All staff participated in Treaty of Waitangi training as part of their induction and ongoing training. Complaints and enquiries involving consumers who identified as Maori were discussed with the Kaiwhakahaere to ensure that service delivery was culturally appropriate.

Interpreter and translation services are provided when appropriate.

Objective: *To review client satisfaction with the process.*

Target: Review by sampling and monitoring of concerns.

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

KEY RESULT AREA 4: PROCEEDINGS

Initiate proceedings in accordance with the Health and Disability Commissioner Act.

Objective: *Director decides upon referral from the Commissioner whether to take action before the Complaints Review Tribunal or before the Professional Disciplinary bodies.*

	Target	Actual
Success rate for proceedings	75%	100%

KEY RESULT AREA 5: 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	36	107
Submissions on policy and other legislation.	18	46
Undertake a review of the operation of the Act in accordance with Section 18		Planning undertaken

KEY RESULT AREA 6: 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:	Clear audit report signed 22 October 1997.
Target:	Policy manuals finalised.
Actual:	Manuals are developing documents which are frequently updated and therefore not absolutely finalised.
Target:	Annual report completed on time.
Actual:	Report tabled within the statutory deadlines on 4 November 1997.

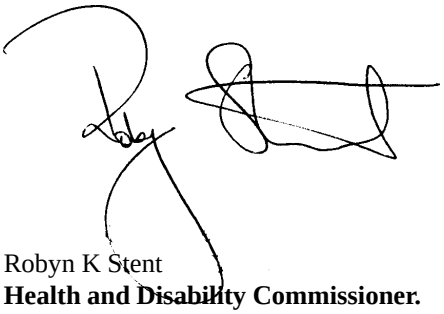
STATEMENT OF RESPONSIBILITY

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 1998.



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 1998

We have audited the financial statement on pages 44 to 62. 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 1998. This information is stated in accordance with the accounting policies set out on pages 49 to 51.

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 1998, the results of its operations and cash flows and the service performance achievements for the year ended 30 June 1998.

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 44 to 62:

- comply with generally accepted accounting practice *and*
- fairly reflect:
  - the financial position as at 30 June 1998 *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 1998 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