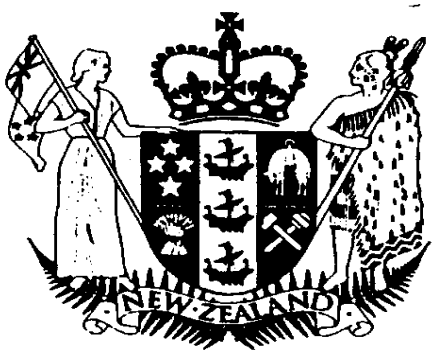

Report of the

HEALTH AND DISABILITY COMMISSIONER

Te Toihau Hauora Hauatanga

For the year ended 30 June 1999

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

19 October 1999

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 1999.

Yours faithfully

Robyn K Stent
Health and Disability Commissioner

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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 under review was an exciting and challenging one. It saw a fundamental shift in attitudes and awareness of providers and many members of the public about the Code of Rights. Recognition and understanding of both the Act and the Code, as well as continuing debate on a number of issues in the media, has led to a greater use of the legislation by many New Zealanders. It is therefore pleasing to present the Annual Report for the year ended 30 June 1999 which will be my last full report to Parliament during my term as Commissioner.

Background

First Commissioner

As the first Commissioner it has been my task to make this law a "living" piece of consumer legislation. I have been required to implement and maintain the law in a balanced way. In fulfilling this task consideration has been given to the following important factors:

- Balancing public protection and individual resolution.
- Strategic direction to ensure the high level goals of the legislation are achieved. In particular, that consumer feedback is encouraged to improve service quality.
- Education and information through "branding" and appropriate public relations mechanisms within the framework of an Act of Parliament.
- Managing demand within limited funding, achieved by focusing on "facilitation" rather than "doing", thereby meeting the Act's fundamental empowerment goals.
- Establishing simple processes to meet the needs of consumers and providers while maintaining the Commissioner's standing among technical, medico-legal, academic and policy agencies.
- Balancing the inherent conflicts around the Commissioner's responsibilities to establish consumer rights, administer those rights and form impartial opinions on breaches of the rights.
- Acceptance that the consumer watchdog role will not always be popular and of the inherent difficulties in maintaining staff focus and morale in this environment.

Achievements

Since the Health and Disability Commissioner was established in December 1994 the Commissioner and staff have worked hard to establish the identity of the legislation and the effectiveness of the Office. Over this time a number of achievements have been recorded:

- The Health and Disability Commissioner has had significant input into policy and legislative change.
- A Code of Rights has been finalised and is now well known.
- The Advocacy Service has been established. Advocates actively promote rights and assist consumers.
- A functioning office with processes and procedures, computerised information and communication systems, training and induction systems has been established.
- The Office has established a public profile and presence with both providers and consumers.
- A rigorous investigation process is operating, although there remains much scope for improving time frames.
- A review of the Act and Code has occurred and the resulting report has been tabled in Parliament.
- Consumers are now using the Code to achieve 'low level resolution', to obtain information and to provide feedback to providers.
- The number of significant individual complaints about services, previously highlighted in the media, has dropped as consumers use the Act and Code to resolve issues. Further, the "use" of consumer complaints by groups wishing to achieve political leverage, or for lobbying or employment purposes, has decreased significantly. In such cases the Commissioner actively enquires into the individual circumstances to review the service issues.
- Jurisprudence on the Health and Disability Commissioner Act is developing. The High Court has upheld the Commissioner's right to initiate a major investigation.
- A culture based around commitment and productivity has been established within the Office.

Annual Strategies

Since the commencement of the Act, actions and activities by the Commissioner have been founded on a Strategic Plan. Each year there has been a different priority for strategic direction and a strategic pathway established. All strategies have been pursued through effective action plans. The highlights are summarised as follows:

June 1996

In the first year a strong foundation of management, systems, communication, structures and procedures was built. A lot of effort went into designing and starting new systems. Demand for services was low because people were not aware of the Commissioner and the Act was not fully effective without a Code of Rights. The Draft Code was completed following extensive consultation. It was tabled in Parliament and passed as law on 1 July 1996.

June 1997

In Year Two demand increased rapidly, as always happens when a new service appears, with a proportion of complaints arising from pent-up demand which had not previously been satisfied through other available channels. A significant number of complaints could not be handled as they occurred before 1 July 1996, however, there were pressures on resources to manage the fast growing demand on the Office. The High Court judgment in March 1997 established the Commissioner's watchdog role.

June 1998

In Year Three demand continued to increase. Within the Office the priority was to deliver an efficient, quality service. The Canterbury Health Report confirmed the importance of the Commissioner's independent watchdog role in the sector. Significant resource went into discussion with other official agencies and into the obtaining of legal advice in an endeavour to ensure effective processes which meet the Act's objectives. This was only partially successful. Further, the Office did not fare as well internally. Processes were hampered by large uncompleted investigations and recruitment of new staff did not occur quickly enough to meet demand.

June 1999

In Year Four, as expected, consolidation of demand occurred as education became more effective and the Commissioner became an established part of the "health scene" in New Zealand. The increased awareness of the Code by both consumers and providers resulted in more low level resolution, as intended by the legislation. The focus of education moved to the more detailed principles underlying the Code. The Director of Advocacy negotiated new advocacy service contracts. Internally the Commissioner altered processes, built on experiences, advanced into new ground in the area of proceedings, appointed a General Manager, recruited additional investigation staff and consulted on the review of the Code and Act.

June 2000

The new year focuses on consolidating the Health and Disability Commissioner's functions, processes and systems to ensure effective and efficient outputs for the public. The General Manager is responsible for managing this process, which includes reducing outstanding files to a manageable level, reducing the turnaround of files, clearing all old files, and drawing on the accumulated knowledge of the past 3 years to ensure facilitation of improved quality in the sector. New advocacy service providers will focus on delivering top quality, effective, front-end service and the expanding emphasis on proceedings will provide an impetus to change professional behaviours. The high level emphasis of the Office will shift towards educating the more disadvantaged and disempowered consumers.

Special focus during the year will be on the mental health sector and the Pacific Island community.

Highlights of 1999

Each functional area within the Commissioner's office has reported in detail within this report. The highlights are as follows:

Advocacy

The initial advocacy service contracts came to an end on 30 June 1999. The Director of Advocacy had the challenge of maintaining services during the year while tendering and renegotiating for new advocacy service providers. The legal requirement to contract with independent providers is difficult, as an effective advocacy service depends on planning, management and continuity of individual advocates. This difficulty is highlighted in the Commissioner's report reviewing the Act. In that report I have recommended structural change to recognise that individual advocates are the heart of an independent advocacy service and provision of their services cannot be renegotiated every two to three years like other marketable services in a competitive environment. The Director undertook the difficult challenge of contracting for new providers and monitoring existing services in a professional manner which ensured quality advocacy was available until the changeover occurred. I take the opportunity of congratulating and offering my thanks to all advocates who have worked under this legislation over the last three years. Their outputs and dedication have increased awareness of the rights of consumers and enabled resolution of thousands of complaints. The Commissioner has been criticised for reducing the funding to advocates from 1 July 1999. However, protection under the Health and Disability Commissioner Act is by means of education, advocacy, investigation, recommendations and prosecution. The Commissioner's focus in each of these areas will vary in emphasis from year to year with the long-term aim being the empowerment of the New Zealand public. Advocacy received priority in terms of funding from the establishment of the Office and it is now appropriate that a proportion of this funding be reallocated to other functional areas.

Education

Education activities changed focus during the year, from awareness to knowledge-based activities. The increased number of technical papers presented and the educational workshops (rather than conferences held in previous years) reinforced this change in direction. The increase in availability of the Commissioner's papers, responses to enquiries and formal opinions has been facilitated by their inclusion on the website and is acknowledged as

a valuable education resource. The number of people accessing the web site increased to in excess of 5000 per month by year end. Media coverage during the year highlighted debate around Code issues, particularly informed consent, and this was a welcome breakthrough. The level of media releases, media comment, publications and the Code and Act review increased the profile of the Commissioner, the Act and the Code.

Kaiwhakahaere

The Kaiwhakahaere continued to provide excellent advice on all internal operations in addition to promoting rights and quality expectations to Maori. The Kaiwhakahaere's ability to give the message in simple terms was internationally recognised following her plenary session on behalf of the Commissioner at the Australian Health Commissioner's Conference in Tasmania. Additionally, the production of a paper demonstrating how the Code and Te Tiriti work effectively together represents an important written resource to complement the face to face activities undertaken by the Kaiwhakahaere. This paper is a valuable tool available to providers and consumers to assist understanding of tangata whenua issues.

Investigations

This area of operation was the most challenging during the year. The overall throughput of completed files increased from 743 to 1162, an increase of 56%. Included in these figures was an increase in the most difficult complaints, being those where a formal opinion is reached. These formal opinions increased from 68 in 1998 to 185 in 1999 (an increase of 172%).

While the open files at year end increased from 778 to 790, those files subject to active investigation dropped from 760 to 748. Complaint files are not closed until recommendations are met, or proceedings complete. Unfortunately, while significant inroads were made into processing and finalising investigations, the number of older files continued to grow and this problem is being actively addressed this year. As an awareness of the rights and advocacy grows, there is a continuing trend of complaints being resolved at a low level without reference to the Commissioner. This is a positive outcome and is to be expected, given the aim of the legislation. Regrettably, however, the total number of complaints to the Commissioner did not drop, with those received being more complex and less able to be resolved quickly. This is clearly indicated by the change in status of closed complaints - last year 45% (335 closures) required detailed investigation, while in 1999 55% (647 closures) fell into this category.

The increase in correspondence with medical defence lawyers and interfaces with the Police, Coroners and other statutory bodies stretched resources as parties threatened litigation and demanded more information in an adversarial

manner. Large amounts of correspondence with the Ombudsmen has also occurred. Despite receiving some guidance from the High Court on the issue of disclosure of information, requests for information have not reduced and processing these requests continues to be time-consuming.

By the end of the year the investigation team sizes had been increased, with senior investigators' workloads being reduced to ensure increased supervision and training of staff and improved quality of work. A special project which focused on finalising opinions was successful. However, the ultimate responsibility for completing opinions rests with the Commissioner, who under the Act is unable to delegate the making of reports and recommendations. This operates as a considerable barrier to the efficient finalisation of investigations.

Overall, while efficiency and output has shown spectacular improvement, quality and throughput must continue to show significant gain if the Commissioner is to meet the Act's purpose. Recommendations made to the Minister following the review of the Act are critical to the successful operation of the legislation and need swift passage through the parliamentary process. It must be recognised that efficient handling of complaints is not a matter which money alone can fix.

Legal

The legal division also achieved significant outputs during the year. Submissions on policy matters were 128% above target and the 104 formal responses to enquiries exceeded targets by 188%. Additionally, the team gathered material from throughout the Commissioner's operation for use in this year's workshops. Preparation of the consultation document for the review of the Act and Code was a major undertaking, and was completed on time. It demonstrated the depth of knowledge now available on the Act and Code after only three years of operation. Much of the information in this document, when read in conjunction with the final report, provides invaluable discussion on the legislation. During the year, two high profile High Court hearings occurred, resulting in a decision that the Nursing Council's disciplinary process is capable of being more public and clarifying the disclosure processes between the Director of Proceedings and Commissioner. A considerable amount of work was undertaken within the legal division in respect of these matters to minimise external expenses.

Proceedings

This was the first year of full time activity in the area of proceedings. A total of 48 files have been referred to the Director for consideration (2 in the year ended 1997, 12 in the year ended 1998 and 34 in the year ended 1999). As to be expected with a new Act, difficulties of interpretation arose as referrals

increased. The process of transfer of files to the Director of Proceedings, who is independent from the Commissioner, was tested in the High Court, resulting in a delay in the transfer of some files. Further, the success rate of proceedings was not as high as planned and the Director of Proceedings reports on this in her report. From the Commissioner's perspective, I have been disappointed in some of the professional board/tribunal's decisions. The differences between consumer legislation and professional legislation is not readily understood by health professionals. Consumers prefer to reach resolution with the individual provider rather than appearing in actions to establish the boundaries of acceptable professional behaviour. Increasingly consumers do not want to appear in cases before professional bodies and, while this may cause health professionals to breath a sigh of relief, the importance of peer review at all levels will be denigrated if such proceedings decrease. I expect that future proceedings will continue to test the boundaries of professional accountability.

Proceedings before the Complaints Review Tribunal have also not been particularly successful. Due to the limitation on the award of damages resulting from ACC cover for personal injury, few complaints are taken to the Complaints Review Tribunal and, following decisions to date, consumers are not particularly keen for matters to go before that tribunal. Given that the ability to obtain damages is limited, the Act does not readily enable the Commissioner to mediate and seek an agreed settlement. Further it is impossible to mediate in those cases where the matter must go before a professional body. Again, the review of the Act will hopefully address these matters. Finally, I note that the Commissioner has initiated a judicial review of the Complaints Review Tribunal in respect of comments made by the Tribunal about the Commissioner in a particular case.

Finance and Information Technology

In order to keep administration as efficient as possible, this area was restructured and activities moved to the Auckland office. The investigations database was upgraded to provide improved reporting, although it is still not providing adequate statistical analysis of the considerable permutations which can emanate from one complaint. Significant systems support was required for the smooth transfer of computer systems from nine advocacy service providers to three on 30 June 1999. Further improvement in terms of physical hardware upgrades are necessary in the current year to keep pace with growth and to finalise preparedness for Y2K issues. Telephone communications systems were renegotiated during the year to maximise efficiencies. Most importantly, the control of overhead costs was maintained.

Human Resources

From a human resource perspective, steps were taken to establish diversity in staffing and to reduce and manage some of the stress inherent in working within a complaints environment. After three years of full operation, a number of staff resigned for a variety of reasons. This was not unexpected and the year ended with all vacancies filled and good staff morale. I wish to thank all managers and staff for their commitment over the year. I have valued their honesty, and constant dedication to the vision inherent in the legislation. Additionally, managers and staff have been very supportive of me personally in the role of Commissioner and this has been a constant source of strength to me.

Conclusion

In conclusion, this year highlighted a number of particular issues and moved the legislation to a new place in its life, with a lot of focus on the Commissioner. Many views held by lobby groups and the health establishment were challenged during the year. Public debate about informed consent was a highlight and, as the established views of special interest groups were challenged, further discussion on detailed aspects of the Code occurred. The move from simple "awareness" of the Code to an increased knowledge of the regulation is a welcome one. The review of the Code and the annual survey indicate additional education must occur to improve healthcare and disability service providers detailed understanding of rights. To encourage this, a new web site has been established to allow ready public access to resources and opinions. Professional groups and educational institutions must take on this education role if they are to keep up with growing consumer demands. The public is increasingly aware that through the Code, they can not only demand good service but can expect the same level of quality from the health and disability sectors as that received from other sectors of the economy.

In my view, the overall quality of health care and disability support service delivery in New Zealand is very good. Certainly, compared to issues faced by the Australian Commissioners, the New Zealand public fares well. The professionals providing health and disability services are caring and dedicated to their vocation. We must recognise that providers of healthcare and disability services are no more infallible than the rest of society. They can, and do, make mistakes. Nevertheless, there are areas where improvement is required as a matter of priority and, in my view, these include the following:

- Further documentation of standards in order to establish benchmarks and monitor performance.
- Improved and consistent record keeping at all professional levels.
- More continuous education, with deregistration of health professionals

who do not maintain their professional expertise.

- Professional colleges ensuring that their terms of governance include the monitoring of members' competence and the ability to remove members who do not keep to date with current practices, or who are deregistered.
- The need for review and improvement of health professional regulatory enactments. This must be given priority in the legislative timetable.
- Organisations providing health and disability services must ensure care is co-ordinated, record keeping adequate and that a specific individual is responsible for the overall care of every consumer.
- In addition to improving systems, organisations must ensure delivery of health and disability services is based on individual responsibility at all levels.
- Health professionals must receive more communication training, both at medical school and elsewhere, including continuing education programmes. Such training should be a compulsory requirement of registration.
- Continually monitoring behaviour and practices to ensure service is to the "whole" person and not simply care of the "condition" or care "focused on the disability."

The Health and Disability Commissioner Act is unique and wonderful consumer legislation. It creates an environment for change and improved delivery of service to the New Zealand public. For it to continue to be successful, government must address the issues raised in the report resulting from the Commissioner's review of the Act and Code. Without prompt implementation of some of the recommendations in that report, the watchdog role of the Commissioner will become less effective, hindering this important element in quality improvement of health and disability services in New Zealand.

In conclusion, I wish to thank the many individuals and organisations who have assisted in the successful implementation of this legislation.

PUBLIC AWARENESS AND ACCEPTANCE

Promotion and Education

As part of the Commissioners' role to educate and promote, throughout the past year a total of 2,939 (1998=1898) public presentations were delivered by Health and Disability Commissioner and advocacy services staff. These presentations, highlighting both the Code of Rights and the role of the Health and Disability Commissioner, were made to a wide cross section of representative consumer and provider groups.

Major activities throughout the year included:

- Six 'Workshops 99' conferences which this year were held in Auckland, Wellington and Christchurch. These conferences, which were well attended, focused on Code and Act issues relating to Informed Consent and Standards.

- A major review of the Health and Disability Commissioner Act and Code of Health and Disability Consumers' Rights, which included a nationwide series of public consultation meetings, hui and fono. As part of this review process the Commissioner also held meetings with the senior management of all Hospital and Health Service providers.

- The Commissioner's monthly column in GP Weekly, a newspaper for general practitioners. This year the Commissioner used this column to address a wide range of topical issues affecting the medical profession.

- Publishing of the Commissioner's Opinions, with identifying features removed, on the HDC web site, and circulation of such Opinions to interested parties where appropriate.

- A significant increase in the public profile of the Commissioner, as a result of media reporting, radio/television interviews and responses to media enquiries.

- The Commissioner addressing several major conferences and workshops throughout the year including: a Critical Care Symposium (Australia), 12th World Congress on Medical Law (Hungary), Health Services Ombudsman (London), Institute of Internal Auditors, National Ethics Committee Conference, 7th Annual Medico-Legal Conference, New Zealand Council for Healthcare Standards Conference, HDC '99 Workshops (all New Zealand).

- The advocacy service continuing to fulfil a vital educative role in informing providers and consumers about the Code of Rights and the role of advocacy services.

Educational Resources

Over the past year the Commissioner has continued to provide a range of educational resources to both consumer and provider groups. 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 being distributed 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 and another language - (these currently include 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.
- The Commissioner's internet web-site (www.hdc.org.nz) which includes the Code of Rights, the Health and Disability Commissioner Act, Opinions, speeches, articles, media releases and other significant itemsof public interest for both consumers and providers. In the 1998-1999 year, this site underwent a major upgrade which included a searchable database to enable the access of Commissioner Opinions by Right and by Provider. This web-site continues to generate enormous educational opportunities with the 'hits' per month increasing from 2000 per month at the beginning of the year to over 5000 per month by year's end.

- As part of the Commissioner's educational initiatives, a large number of Opinions with identifying features removed were provided to 'Workshop '99' participants and to consumer and provider groups on request.

- The Commissioner, through her Legal Section, continues to provide a range of formal responses to enquiries related to both Act and Code issues.

Public Acceptance

The past year has seen a continued growth in demand for information and educational resources, from both consumers and providers. As at the end of June 1999, a total of 153,053 (1998=142,218) units of educational resources were distributed by Commissioner staff, including over 3,800 copies of the Act and Code Review document. Resources continued to be provided free of charge to consumers. Specifically, resources either sold or provided free of charge were:

Publication Type	**Number**
Videos	207
'Your Rights' leaflets	53,375
Code Regulation leaflets	59,865
Advocacy service leaflets	6,667
Pocket cards	26,724
Posters	1,831
Audio Tapes	47
Canterbury Health Ltd Report	118
Act/Code Review consultation document	3,815
Annual Report	390
Provider Packs	14
Total	**153,053**

Media Trends

This year, activities involving the Commissioner have produced significant interest in print, radio and television. In September 1998 a decision by the Commissioner to call for more transparency and openness in professional disciplinary hearings, resulted in significant media attention (in October alone, 22 references in print media). This level of interest continued throughout the year, stimulated by the Commissioner's decision to issue regular media releases informing the public of scheduled disciplinary hearings, and other matters perceived to be of high public interest.

In early 1999, media coverage of the Act and Code review process was substantial, with the Commissioner appearing on television and radio, and

print media reporting the process widely. The review process produced a high public profile for the Commissioner, with reporters keen to seek comment on both the review and a range of other health and disability sector issues. The production of an Act/Code Review document provided an important focal point for discussion both by the public and the media.

Other significant media activity this year revolved around events such as the Liam Williams-Holloway case (37 media references to HDC in February alone), 3rd Generation Pill, the RML Investigation and the Ascot Hospital enquiry. This activity ensured maintenance of a high public profile creating opportunities for consumers and providers to become better informed regarding the Act, Code and role of the Commissioner.

At a recent health reporters seminar, feedback received was that ongoing development of the Commissioner's internet web-site (www.hdc.org.nz) is providing both media and public with greater electronic access to information regarding the operation of the Commissioner, the Act, and the Code. An interesting trend which emerged during this seminar, was that reporters believed they were now developing a better understanding of the role of the Commissioner and the importance of the Act and Code. It is also clear there is now an increasing tendency for media to refer to this web-site when seeking background information for a story.

A further trend this year has been towards a sustained increase in numbers of media enquiries made to the Commissioner's office, requesting both comment from the Commissioner on issues of public concern and information related to specific complaints under investigation. On occasions the Commissioner has confirmed that she is investigating a specific complaint, but as a general rule continues to adhere to a 'no comment' policy when asked to confirm she is carrying out an investigation. This policy is designed to acknowledge both principles of natural justice, and the interests or wishes of the consumer involved.

While it is the right of any party to a complaint to disclose and discuss their issues with whoever they choose, as a general rule it remains the 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). One notable exception this year was the case of a General Practitioner who chose to make details of the investigation being conducted into his actions widely known to the media. In this event, the Commissioner decided it was also in the public interest to name him and to make her Opinion in this case a matter of public record. The Commissioner reserves the right to continue to do this on a case by case basis.

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."*

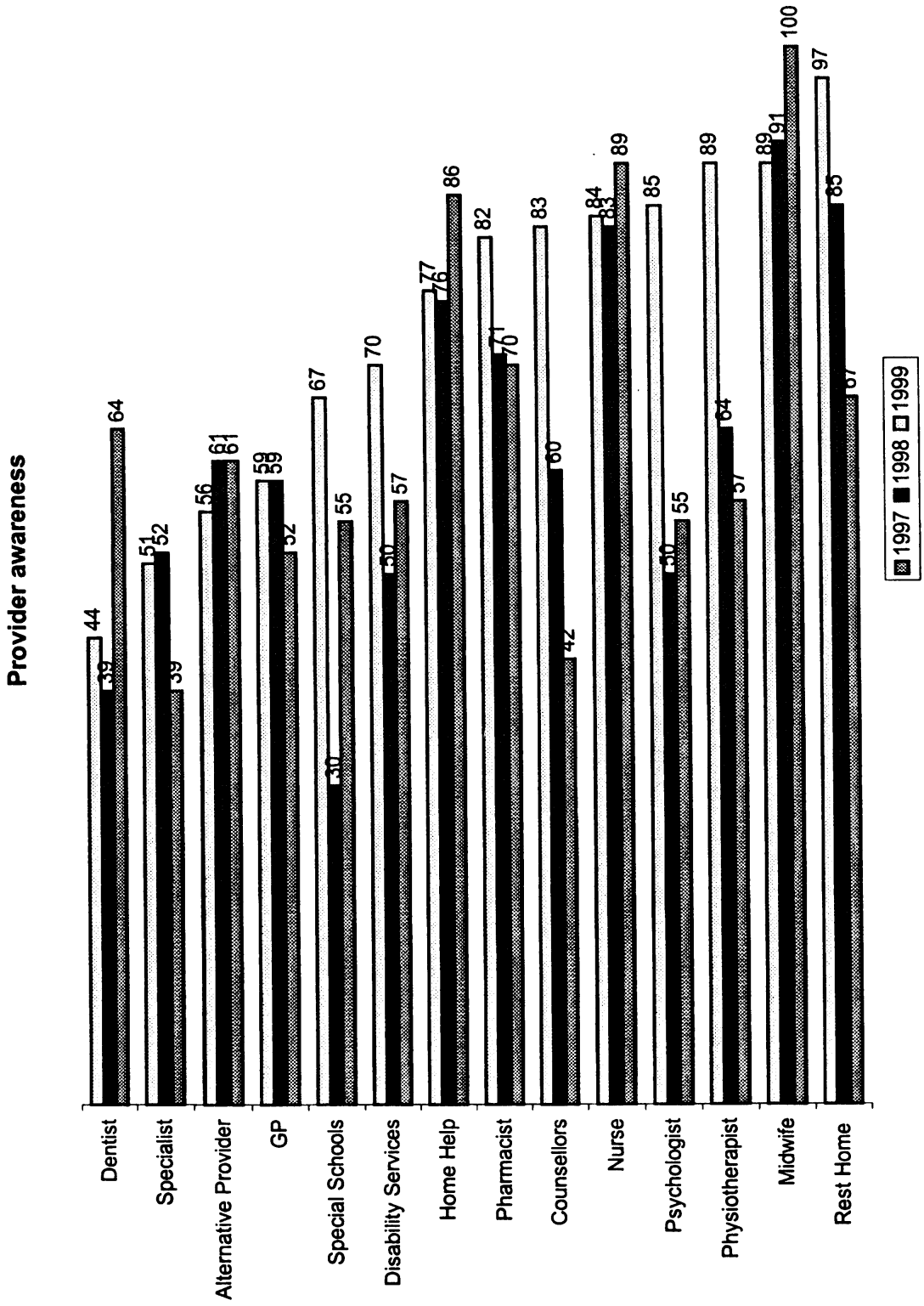
In the 1998-99 year, targets for this key result area again focused on activities conducted by the Commissioner - the number of presentations and educational resources delivered to consumers and providers. The awareness survey conducted in 1998 was repeated in order to provide valuable information about the Commissioner's progress in this area of her activities. This year's Awareness Survey was conducted throughout June-July 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

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. Results this year indicate a steady increase in public awareness of the Code and the role of the Commissioner. In comparison with 1997-98, there has been an increase in the numbers of people who have seen resource/educational materials and those who are aware of the advocacy service and its role.

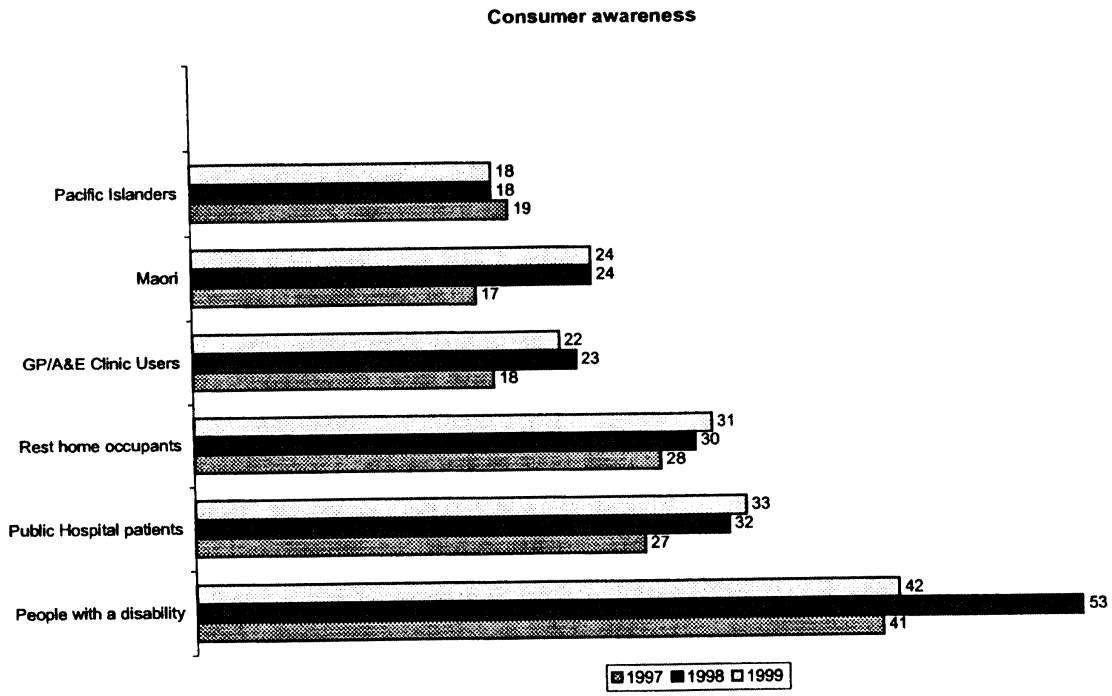
Provider awareness

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?'. Specifically 73% (1988 64%) of providers are more aware of the Code. The results (compared with 1998) are shown below. Overall awareness amongst health providers show improvements across all measures. The number of health providers recalling any of the specific rights has increased by 6% to 53% while the average number of rights recalled has increased significantly, reflecting a greater depth of knowledge and understanding.



Consumer awareness

Consumers were interviewed using telephone, mail and personal interview. Sample sizes were similar to the 1998 survey. Across the consumer groups, awareness of the Code remains stable. Levels of awareness were slightly lower among Pacific Island consumers (18%), than Maori (24%).



Knowledge of rights

Both providers and consumers were asked to identify rights covered in the Code. There have been increases in recall of a number of rights among health providers. Nurses, rest home workers and psychologists had the highest recall, while dentists and specialists were among the lowest. Among consumers, people with disabilities had the highest level of recall.

Recall of Commissioner's educational resources

Sample groups were asked if they had seen any of the Commissioner's posters, leaflets or videos. Overall, the result for health providers represented an increase on previous years, with nurses, midwives, public hospital workers and rest home staff rating very highly and dentists and alternative health providers somewhat lower.

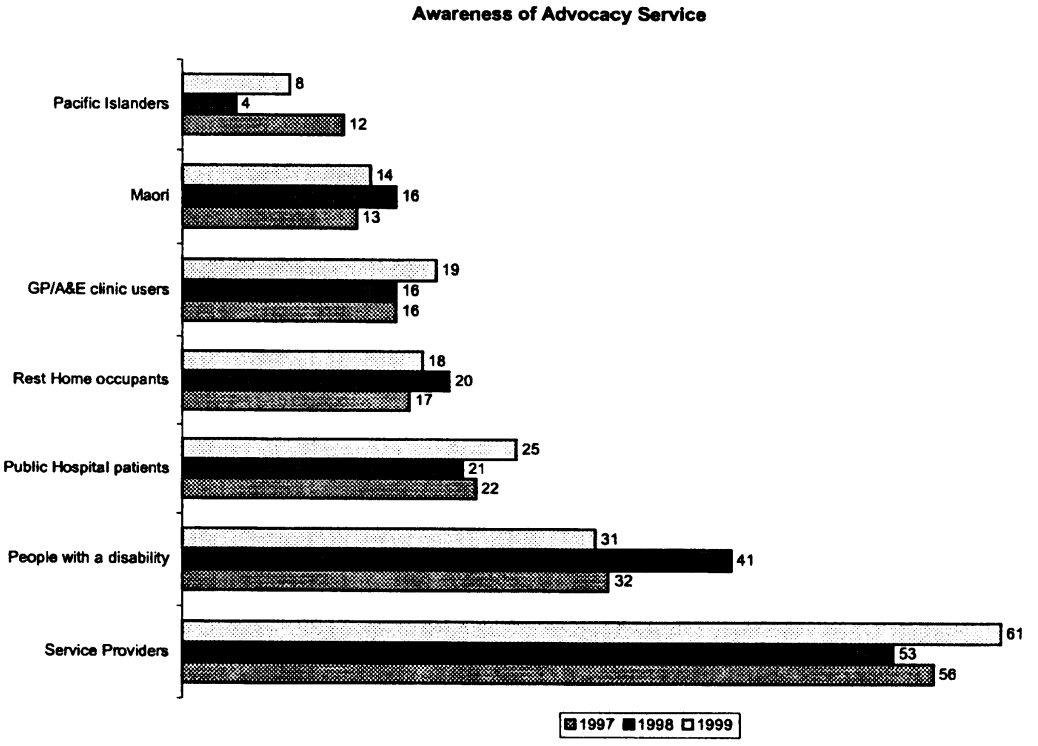
Awareness of the Commissioner

Sample groups were asked if they knew who the Commissioner was. Approximately 33% knew the Commissioner's name. Highest recall was amongst psychologists, midwives, counsellors, nurses and pharmacists.

Lower recall was amongst specialists and disability service people.

Awareness of advocacy service

The chart below illustrates awareness of the advocacy service associated with the Health and Disability Commissioner. Health providers again had the highest awareness of this service, in particular nurses, rest home staff and midwives. Among consumer groups results for 1998/1999 remained generally consistent.



Future Awareness Focus

In the 1999/2000 year the Commissioner has decided the educational focus will be on key target groups of Maori, Pacific Island Nations and Mental Health consumers and providers. In addition, educational and promotional activities will continue to focus on increasing levels of Act and Code awareness amongst all consumers and providers, particularly where it is indicated that current levels of awareness are low, such as Dentists and Specialists.

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

The education promotion focus for the Kaiwhakahaere for 1998 – 1999 year has been changing attitudes. For Maori consumer groups, this has been through the delivery of empowerment education programmes where consumers and their whanau are empowered to use education resources and information to resolve issues or concerns for themselves. The process for access to Advocacy service and the Health and Disability Commissioner has been emphasised as a means of support.

The Kaiwhakahaere delivers education training to Maori providers with an emphasis on encouraging providers to use the Code of Rights pro-actively as a contribution to improving the quality of service to consumers.

The Kaiwhakahaere continues to network and attend national hui as a promotional activity. She has presented at several conferences, including those which are not specifically hui Maori. She has worked with Aboriginal people in Queensland on the invitation of Queensland Health Rights Commissioner and their aboriginal liaison worker. The Kaiwhakahaere represented the Commissioner by presenting two papers at the second National Health Care Complaints conference in Tasmania, which focused on improving quality services to indigenous people and those with a disability.

In this year the Kaiwhakahaere has also worked to consolidate the implementation of the Treaty principles within the management and operations of Health and Disability Commissioner. This has been done through regular training with staff and monthly meetings with managers.

The Kaiwhakahaere attended Act and Code review meetings and hui with the Commissioner and was present at the Commissioner's meetings with HHS general management teams.

Te Kanohi kitea (face to face interaction) is the most effective method of communication/education about the Code and Commissioner's processes amongst iwi Maori, Taura here and Urban Maori Authorities. It is significant to note the increase in Maori access to Health and Disability Commissioner and the public 'Maori' perception of Health and Disability Commissioner as a safe organisation to approach.

Human Resources Services

Health and Disability Commissioner has a policy of Treaty of Waitangi inclusion throughout all its operations. All advertisements and job descriptions have a Treaty requirement. All staff are accorded a powhiri, with senior staff being given a formal powhiri by Health and Disability Commissioner Kaumatua and the Commissioner. Staff training in cultural safety and working with Maori is regular and all staff receive Treaty training at least once a year. The Kaiwhakahaere participates in all staff induction and meets regularly with the Human Resources Manager.

Advocacy

Regular advice continues to be provided to the Director of Advocacy. Treaty of Waitangi, and working with Maori are performance requirements within Advocacy contracts. Maori are employed in services which have a large Maori population.

Monthly meetings continue, as well as ad hoc advice as needed.

Investigations and Mediation

The Kaiwhakahaere gives advice on all complaints from Maori consumers and complaints against Maori providers. She has regular meetings with investigations teams to review process and for updates. The Kaiwhakahaere will also conduct an interview for investigations as requested. She has processed enquiries in Te Reo Maori.

Policy Advice

The Kaiwhakahaere contributes to policy advice, submissions and opinions written by the Commissioner. She provides input to legal advice bringing a Maori and consumer perspective to legal discussion. In conjunction with legal officer, the Kaiwhakahaere has produced a paper demonstrating how the Code and Te Tiriti work together.

Director of Proceedings

The Kaiwhakahaere has provided advice to the Director of Proceedings particularly with regard to processes when dealing with Maori consumers.

Working with Maori

The Kaiwhakahaere provides information, education and training to all divisions within the Health and Disability Commissioner. This is for the practical implementation of Te Tiriti o Waitangi, and appropriate methods of working

with Maori. Regular training about cultural safety is provided. The Kaiwhakahaere has organised hui where the Commissioner and other staff have an active role. Mental Health has been the focus for Health and Disability Commissioner in 1998, and the Kaiwhakahaere has participated in several conferences and seminars with an emphasis on Tangata Whaiora.

People with a Disability

The recent Colmar Brunton survey indicates an increase of awareness of the Code and the Health and Disability Commissioner's office. Consumers of Disability support services and Mental Health Consumers/Tangata Whaiora see the Code as being able to protect and promote their rights.

Pacific Island People

Education, promotion and confidence in theHealth and Disability Commissioner continue to be a challenging area for the Kaiwhakahaere in relation to Pacific Island people. Links have been established with key people and groups. The Kaiwhakahaere provides support to Pacific Island consumers and providers in the complaints process. The cultural norm for Pacific Island people makes it difficult for them to complain, and the concept of the Code of Rights is hard to accept. However, upon receiving information Pacific Island people are grateful for knowledge about their rights.

Other Ethnic Groups

Some progress has been made in establishing links with other ethnic groups. The Kaiwhakahaere has worked to create awareness of the Code and Health and Disability Commissioner with some groups. The needs of refugees are different from new immigrants. Interpreter services to Health and Disability Commissioner processes are currently being refined.

Kia Ora.

ENQUIRIES AND INVESTIGATIONS

Enquiries

The Health and Disability Commissioner operates an enquiry line through its Wellington and Auckland offices. A toll-free call line (0800 11 22 33) enables callers to contact dedicated enquiries staff.

The Enquiries and Complaints Database System (ECDS) is used to record details of both enquiries and complaints. This allows the Commissioner to track and monitor enquiries.

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.

7,889 enquiries were received during the year.

Actions taken on enquiries	**Number**	
	1999	**1998**
Became a complaint	9	209
Open	27	0
Provided a formal response	163	262
Provided verbal and written information	803	1,345
Provided verbal information	5,211	5,284
Referred to advocacy	258	374
Referred to communication/education	99	98
Referred to another agency	740	3
Sent written information	579	927
TOTAL	**7,889**	**8,502**

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.

On occasion, enquiries later become a complaint. This year, a more careful analysis of the nature of the call meant a substantial number of calls were

directly entered as a complaint.

Formal responses to enquiries include requests for information about the Health and Disability Commissioner and clarification or interpretation of various sections of Health and Disability Commissioner Act 1994. This category includes formal responses by Legal Services. Such formal responses are a significant part of the educational role of the Commissioner, ensuring the Rights are understood, in an attempt to pro-actively ensure the delivery of quality services to New Zealanders.

The provision of general information to callers is categorised by the provision of information, in either verbal or written form. The introduction of additional coding categories this year meant fewer calls were allocated to this general description.

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

To recognise the substantial referral activity of the Commissioner's enquiry staff, calls more appropriately dealt with by another agency are now separately noted. Assisting callers to locate the most appropriate authority is a regular occurrence for the enquiry team, and demonstrates the need for a "general" enquiries line in the health sector, particularly on public health issues.

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

The large reduction in enquiries overall reflects the increased knowledge of the public (providers in particular) of the Act and Code. At a local level, enquiries are processed by advocacy services.

Investigations

The investigation activity of the Commissioner continued to increase, and during the year additional staffing was employed in order to deal with the increasing workload, and the complexity of the complaints.

Investigations staff are divided into 3 teams [2 in Auckland and 1 in Wellington] and each consist of 4 investigation officers under the leadership of a Senior Investigator.

During the second half of the year, attention was paid to improving workflow and productivity, resulting in a substantial increase in the number of closed complaints.

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 Summary

During the year, the Commissioner continued to receive an increasing number of complaints, but was able to close nearly that same number, leaving a similar level of open complaints as the year before.

A significant increase in outputs occurred, with 1,162 complaints completed. This represented a 56% increase in completed work. However the number of complaints still open remains too high and the timeframes for closure of complaints too long. This will be a primary focus for next year.

It was pleasing to note that at 30 June 1999, the number of open complaints was only 12 higher than the year before, in spite of peaking at over 1000 open files early in 1999. The office was able to make significant progress on reducing this backlog in the latter part of the financial year.

Complaints	**1999**	**1998**	**1997**
Open at the beginning	778	419	0
New during the Year	1,174	1,102	1000
Closed during the Year	1,162	743	591
Open at the End	**790**	**778**	**419**

Source of Complaints

Although complaints direct from individual consumers represent the source of most complaints, there are many other ways the Commissioner is notified about issues.

In particular, health registrations boards are required to send all complaints to the Health and Disability Commissioner and may not take any action until the Commissioner has determined what action (if any) is to be taken under the Act

Received From	**Open**	**Closed**	**Total**	**Last year**
Chiropractic Board	2	1	3	4
Dental Council	4	5	9	21
Dental Technicians Board	3	1	4	-
Medical Council	32	41	73	82
Medical Radiation Technologists Board	-	-	-	1

Nursing Council	6	13	19	39
Occupational Therapy Board	-	1	1	1
Opticians Board	-	1	1	1
Pharmaceutical Society	7	9	16	16
Physiotherapy Board	-	1	1	6
Podiatrists Board	-	-	-	2
Psychologists Board	2	8	10	16
Subtotal [Professional Boards]	**56**	**81**	**137**	**189**
Accident Compensation Corp	22	17	39	30
Advocacy	38	37	75	96
Commissioner's Initiative	-	-	-	9
Disability Consumer	-	5	5	6
Disability Provider	3	2	5	-
Employee	-	3	3	8
Friend	4	2	6	17
Health Consumer	256	362	618	420
Health Funding Authority	-	-	-	8
Health Provider	9	28	37	42
Human Rights Commissioner	1	5	6	1
Lawyer	16	13	29	18
Member of Parliament	15	-	-	-
Member of Public	5	17	22	23
Minister of Health	-	1	1	4
Ministry of Health	1	3	4	-
Ombudsman	-	6	6	6
Police	3	-	3	-
Professional Association	1	1	2	9
Regional Licensing Office	-	2	2	10
Relative	87	87	174	191
Subtotal [Other Sources]	**446**	**591**	**1,037**	**913**
TOTAL	**502**	**672**	**1,174**	**1,102**

The reduction in complaints sourced from professional bodies recognises the awareness of the public resulting in direct complaints to the Commissioner.

Providers Complained About

Complaints may involve more than one health provider, and so the 1,174 complaints received involved 1,331 providers. Many of these involved the employer of a provider, as under section 72 of the Act, the employing authority has vicarious liability for the actions of an employee or agent.

Provider	1999	1998
Accident & Emergency Centres	8	-
Accident Compensation	18	-
Acupuncturist	2	2
Alternate Therapist	3	-
Ambulance Officer	1	-
Ambulance Services	3	4
Anaesthetist	6	10
Cardiologist	1	5
Caregiver	6	13
Chiropractor	6	8
Counsellor	6	3
Dental Service	7	-
Dental Nurse	2	-
Dental Technician	7	2
Dentist	46	59
Dermatologist	4	3
Dietician	-	1
Ear Nose & Throat Specialist	4	4
General Practitioner	251	279
General Surgeon	15	-
Geriatrician	-	1
Gynaecologist	13	22
Home Service Provider	-	8
Health Funding Service	18	15
House Surgeon	7	-
Medical Administrator	-	16
Medical Centre	12	-
Mental Health Provider	12	-
Midwife	19	41
Naturopath	-	2
Needs Assessor	2	3
Neurologist	9	13
Nurse	38	98
Obstetrician	7	24
Occupational Therapis	3	3
Ophthalmologist	9	4

Optometrist	1	4
Orthopaedic Surgeon	20	18
Osteopath	1	-
Other Health	141	110
Other Disability	33	47
Other Non Health	-	43
Paediatrician	8	6
Pharmacist	34	52
Pharmacy	26	-
Physician	34	46
Physiotherapist	8	11
Plastic Surgeon	6	7
Podiatrist	2	6
Prison Service	15	10
Private Hospital	12	9
Psychiatrist	19	33
Psychologist	26	25
Public Hospital	269	207
Radiologist	2	9
Radiology Technician	-	1
Registrar	14	16
Rest Home	75	61
Rest Home Licensee	4	-
Rest Home Manager	13	42
Rheumatologist	2	-
Social Worker	3	3
Surgeon	12	35
Urologist	6	2
TOTAL	**1331**	**1446**

Outcome of Complaints

There were 1,162 complaints closed during the year. Of these, 378 did not involve an independent investigation, 221 were resolved during the process and 563 were the subject of an investigation.

	1999	**1998**	**1997**
No Investigation			
Referred to a Health Professional Body	55	68	153
Outside Jurisdiction	240	92	103
Referred to Privacy Commissioner	28	8	9
Referred to Human Rights Commissioner	3	1	-
Referred to Ombudsman	-	1	2

Referred to Other Agency	52	18	25
Subtotal	**378**	**18**	**292**
Resolved			
Complaint resolved by parties	86	67	42
Complaint withdrawn	26	39	53
Mediation	14	7	5
Resolved with Advocacy	95	107	27
Subtotal	221	220	127
Investigation			
Breach and Report	144	48	25
No Breach Found	182	136	34
No Breach Found, detailed written report	41	20	16
No Further Action	196	131	87
Subtotal	**563**	**335**	**162**
TOTAL CLOSED	**1,162**	**743**	**581**

No Investigation

There are a number of reasons why there is no investigation following a complaint. A complaint may be outside jurisdiction [240], because it concerned events prior to 1 July 1996, did not relate to the provision of a health or disability service, or involve a breach of the Code. It may be more properly referred to a health professional body [55] for action, or to another agency such as the Privacy [28] or Human Rights Commissioner [3].

Resolved or Withdrawn

In many cases [86], consumers and providers resolve the complaint between themselves during the process, which is a positive outcome. In some complaints[26], consumers chose not to proceed or to withdraw their complaint. Major public safety issues may be an issue the Commissioner follows up on or continues an investigation. The Commissioner can refer the matter to an advocate, either prior to or during an investigation, if this seems an appropriate way to achieve resolution. Some 95 complaints were referred and resolved through this service this year.

Advocacy represents a way to empower the consumer to resolve complaints with the provider, when there is no concern about public safety. Often the issue is a communication one, and can be best resolved directly between the parties. Advocates provide regular reports to the Commissioner on outcomes of referred complaints.

Mediation, using both internal staff and external mediators was used on 14 occasions during 1999. This is a trend which is expected to increase in future, particularly with complex complaints where a formal mediation is relevant and an advocacy referral not an option.

Investigation

Following investigation of a complaint, the Commissioner reviews the evidence and makes a decision as to whether there has been a breach of the Code.

In 144 complaints, the Commissioner decided that a breach occured. In such cases, the Commissioner's opinion is reported to the parties, with such recommendations as the Commissioner may think fit. Other interested parties, such as the appropriate health professional body or the Health Funding Authority also receive a copy of the report. The Commissioner may also refer the file to the Director of Proceedings in order to consider further action under the Act.

In 182 complaints, the Commissioner concluded there was no breach of the Code. In these cases, the provider was able to demonstrate that their actions were reasonable or there was insufficient evidence to find the Code was breached. In a further 41 complaints, a detailed report was provided to the parties, to assist their understanding of the conclusion and to provide an educational resource.

Of the complaints closed, 196 resulted in no further action. In these cases, there were either further remedies available to the consumer, or a continued investigation into the matter was not appropriate. In many cases significant investigation was undertaken prior to this decision.

Breach Complaints

144 complaints resulted in a breach of the Code. The following table shows the different service types involved in these breaches.

	1999	1998
Accident and Emergency	6	1
Ambulance	1	-
Anaesthesia	1	-
Alcohol and Drug Services	1	-
Chiropractic	-	1

Counselling	-	2
Dental	10	1
Dermatology	2	-
Disability Services	2	-
Gastroenterology	1	-
General Medical	10	3
General Practice	30	12
Home Services	1	-
Intellectual Disability Services	4	4
Medical Administration	2	-
Mental Health Services	2	2
Midwifery	7	-
Naturopathic	-	1
Needs Assessment Services	-	1
Neurology	2	-
Nursing	4	-
Obstetrics and Gynaecology	4	1
Ophthalmology	1	-
Orthopaedic	3	1
Other Health	1	1
Paediatric Medicine	1	-
Pharmaceutical	22	7
Physiotherapy	2	-
Plastics	2	-
Podiatry	1	-
Psychology	1	-
Psychiatry	-	1
Radiology	1	-
Rest Homes	10	9
Surgical	8	-
Urology	1	-
TOTAL	**144**	**48**

Age of Open Complaints

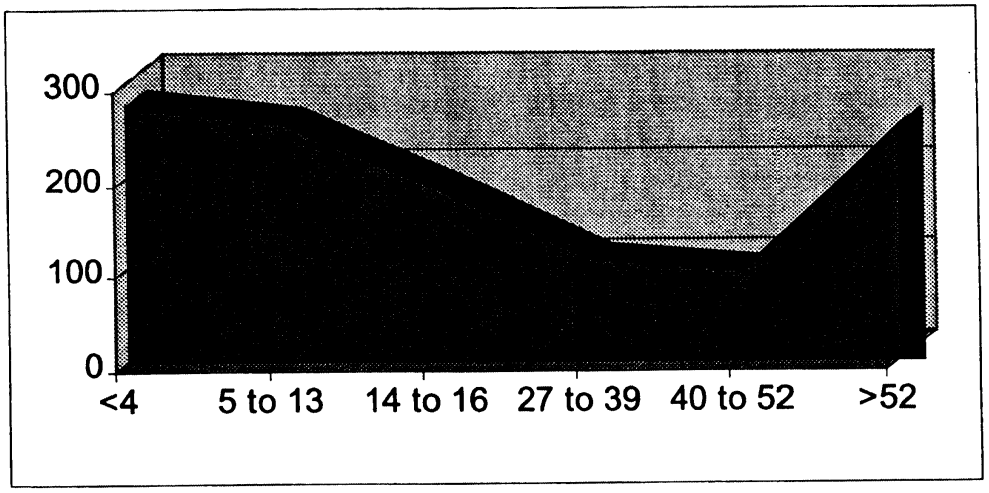
The age of the open complaints was as follows;

Date Complaint received	**Number**
1997	52
1998	236
1999	502
TOTAL	**790**

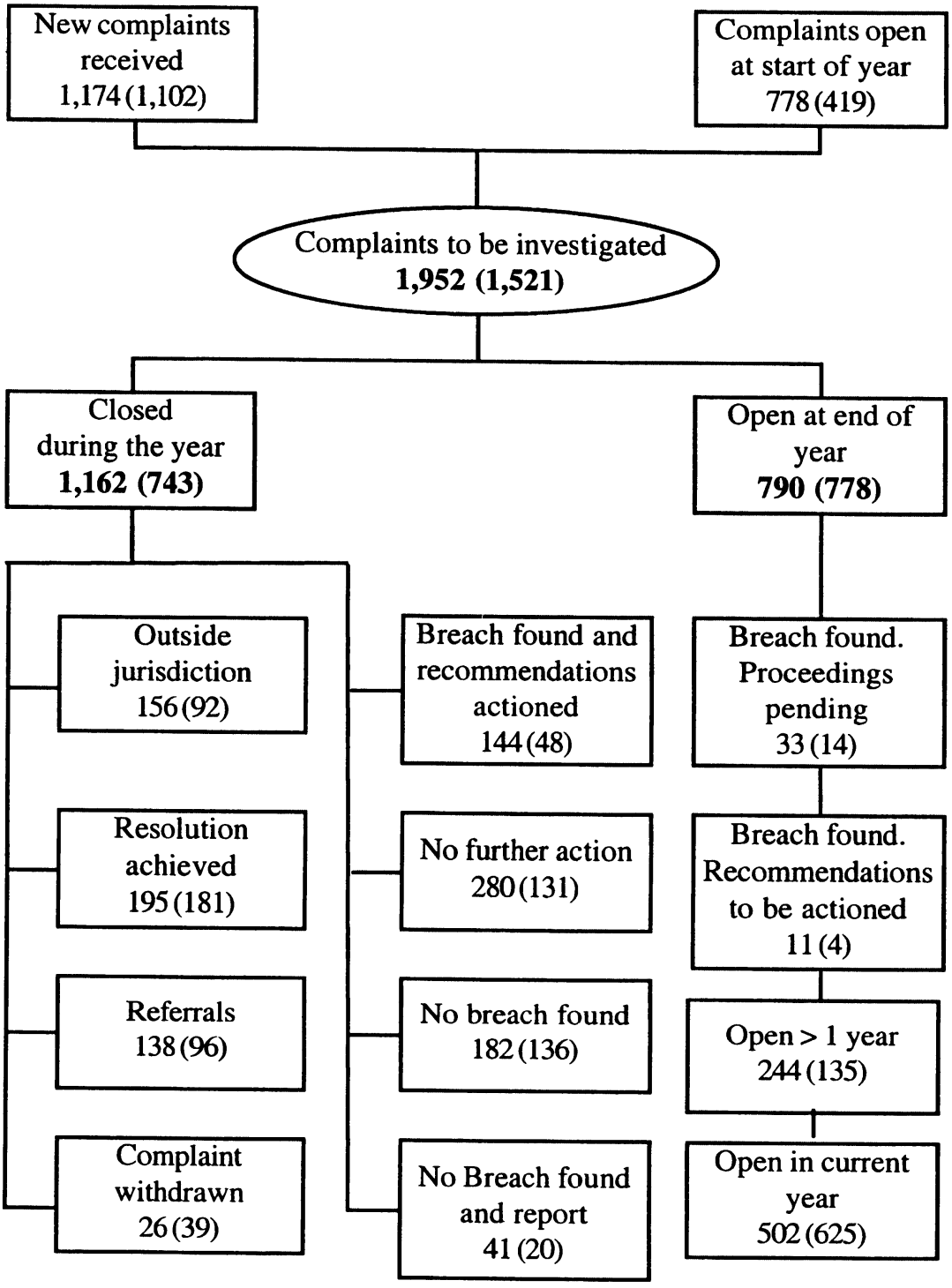
Of the 52 files still open from the 1997 year, 12 are with the Director of Proceedings, 5 were awaiting recommendations and provisional opinions had been sent out for 9.

Age of Closed Complaints

61% of all complaints received by the Commissioner are dealt with in 16 weeks of receipt. Others take longer to close due to the complexity of the complaint, the need to wait for the findings of other parties and so on. The office succeeded in closing a large number of older files during the year, as demonstrated in the chart below.



COMPLAINTS PROCESSED TO 30 JUNE 1999



Brackets indicate last year's figures

REPORT OF THE DIRECTOR OF PROCEEDINGS

Introduction

Under Section 49 of the Health and Disability Commissioner Act 1994, the Director receives cases referred from the Commissioner and determines whether or not to institute disciplinary proceedings.

This is the year the first full time Director of Proceedings was appointed. The Director received 34 new referrals, compared with 12 in the previous year.

In recognition of the increased workload a short term secondment of a barrister and solicitor from private practice occurred in May 1999, pending a permanent appointment to provide assistance to the Director.

The Director also commenced working with disciplinary bodies to establish procedures and protocols for dealing with matters arising from the Commissioner's referrals.

Section 49 Requirements

Pursuant to s.49 of the Health and Disability Commissioner Act, a health provider has the right to be heard by the Director of Proceedings before the Director makes any decision on whether or not to issue any proceedings. The majority of providers have exercised this right, frequently deciding to meet the Director in person.

Procedures were developed to ensure the Director of Proceedings' files are robust. The Director of Proceedings also engaged a stenographer to record all s.49 hearings and provide a transcript, thereby fast tracking decision making processes, and aiding briefed counsel in preparation of cases.

Disciplinary Proceedings

In 1998-99 the Director of Proceedings laid 20 charges before the relevant disciplinary bodies. Of cases completed, 55% resulted in successful prosecutions.

It is important to remember while the law in respect of professional misconduct in relation to all the disciplinary bodies essentially says that an error, negligence or misconduct of a health professional may or may not amount to professional misconduct; it is question of degree. The legal test is that there must be a significant departure from accepted professional standards and that departure calls for disciplinary sanction.

This year has highlighted the importance of the Commissioner's Opinion as opposed to disciplinary action. Clearly there may be inappropriate behaviour or wrong-doing which is not acceptable, but equally the disciplinary bodies are restricted by legal tests for professional misconduct. The Commissioner has no such restraint and can speak. This year has highlighted the fact that if boundaries are to be pushed by the Director, and as a result professional standards are to be changed, then this will be effected not through the disciplinary bodies but through the Complaints Review Tribunal.

Complaints Review Tribunal

This Tribunal considers claims arising from breaches of the Human Rights Act, Privacy Act and the Health and Disability Commissioner Act. The Tribunal considers the case and can make a statutory declaration that the Code of Rights has been breached. If a breach is found, then the Tribunal can award damages (compensation) to the consumer. In awarding damages, the Tribunal takes into account the penalty, if any, imposed by the relevant disciplinary body. This year two cases were taken before the Tribunal with mixed success.

The first case taken related to a doctor who had had a sexual relationship with his patient. The patient subsequently attempted to commit suicide by drug overdose on two occasions. The doctor attended the patient, kept no record of the episodes requiring treatment, nor the event itself and failed to take toxicology samples or refer his patient to any other medical assistance. The Director of Proceedings sought damages on behalf of the patient.

The Complaints Review Tribunal found Rights 2, 4(2) and 4(5) had been breached by the doctor, but in view of penalties already imposed by the professional body, did not award damages. Substantial costs were however awarded against the Director of Proceedings, a decision later upheld on appeal.

The second case related to a midwife who was the lead carer in the pregnancy of the consumer whose baby suffered severe cerebral damage during birth, and died approximately six weeks later.

The Complaints Review Tribunal found the midwife had breached Right 4(1), 4(2), 4(4) and 4(5).

Damages for humiliation, loss of dignity and injury to feelings and exemplary damages were sought and the Complaints Review Tribunal awarded damages of $20,000 to the consumer in this respect. Exemplary damages were also sought but not considered by the Tribunal. Both the Director of Proceedings and Counsel for the defendant have filed a notice of appeal in respect of the decision.

While the complaints from the Tribunal made statutory declarations that the Code was breached and the decisions appear to be in the consumer's interests, in both cases, the consumer was not satisfied with the result. This leaves open the very real question as to whether taking matters to the Tribunal is in the consumer's interest. In most cases, awards of damages payable by the Tribunal are limited by the application of ACC legislation, and consequently no action was taken before this Tribunal.

PROFESSIONAL TYPE	Referrals	ACTION			STAGE OF CHARGES LAID				
		Considering	No Action to be taken	Charges Laid	Hearing Pending	Part Heard	Disciplinary Decision Pending	Unsuccessful Prosecution	Successful Prosecution
Medical Practitioners	23	12	1	10			2	4	4
Dentists	4	2	1	1					1
Pharmacists	6	3	2	1					1
Nurses	8	2	1	3	1			1	1
Podiatrist	1			1					1
Optometrist	1			1	1				
Dental Technician	1	1							
Clinical Dental Technician	2	2							
Chiropractor	1			1			1		
Physiotherapist	1		1						
Totals	**48**	**22**	**5**	**20**	**2**		**3**	**5**	**10**

*Two of these successful prosecutions are subject to appeal

REPORT OF THE DIRECTOR OF ADVOCACY

Introduction

Key features of the third year of Advocacy have been:

- maintaining and improving consistency in advocacy practice
- consolidating work processes
- increasing the profile of advocacy services and the Code to both consumers and providers
- recontracting for services.

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 1998/99 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

The ten service agreements which were in place for the provision of nationwide advocacy services, expired in June 1999.

The Advocacy Guidelines and standards outlined in the Performance and Monitoring Manual provided a framework for the delivery of Advocacy. This was also supplemented by policy updates and support from the Director during the year.

Recontracting

During the year a major exercise for the Director was undertaking a recontracting process to ensure that Advocacy service contracts were in place from 1 July 1999. The Commissioner notified the Director that from 1 July 1999, the funding for Advocacy would be reduced from around $2.6 million in a non contracting year to $2million per annum. This had a significant impact on the amount of service which could be purchased under the new purchasing arrangements in comparison to what is currently being delivered. It has also affected the physical accessibility of advocacy services which will operate out of fewer sites from 1 July 1999.

A call for registrations of interest for the provision of advocacy services under the Health and Disability Commissioner Act 1994, was advertised in the major newspapers in October 1998. A Request for Proposal was prepared and advertised in the major newspapers in December 1998 for four service delivery regions in New Zealand. Proposers were able to submit proposals for combined regions. Documentation packages were sent to those who had registered their interest who did not have a conflict of interest, and those who responded to the advertisement. The closing date for proposals was early February 1999. Following the evaluation of the proposals and negotiations, three new providers were notified in mid May 1999 and began establishing their services in the four larger regions. The transition from nine service providers to three went smoothly with minimal disruption to consumers.

The three new providers are:

Health Advocates Trust	Auckland and Northland
Advocacy Network Services	Central and Lower North Island
Advocacy Services South Island Trust	South Island

There were a number of changes to the contracting arrangements for Advocacy services compared with the previous Advocacy agreements.

- There is a reduction in the number of service delivery regions from ten to four.
- The allocation of resources for the new contracts was made on the basis of population to ensure fairness and equity across New Zealand.
- The previous agreements were based on the delivery of full time equivalent hours of service.
- The new contracts are volume based for the delivery of the following outputs with closure performance measures:

  Enquiries (closed)
  Complaints (open)
  Presentations/displays
  Networking contact visits.

- A new set of Advocacy Service Standards and an Operating Manual were also developed for the recontracting process.

All new service providers operate an 0800 number to assist consumers to have access to advocacy services across the larger regions. Where there is no permanent advocacy presence in an area, a visiting service will be provided.

Staffing

The current advocacy agreements which expired on 30 June 1999 provided for 33 full-time equivalent advocates, however the majority of advocates worked part time. The employment of part-time advocates assisted with the provision of an Advocacy presence in many locations nationwide. During the year an additional 1.5 FTE was provided in the HAT Wellington and Auckland regions within their current funding. An additional 0.2 FTE was provided in Hawkes Bay from June – December 1998.

Training

As a result of 1998/99 being a contracting year, Best Practice Training was not held. Orientation Training was planned for the new service providers, however training was deferred as the new providers were familiar with the delivery of health and disability consumer advocacy services and a number of the current advocates were employed by the new providers. It is anticipated that training with the new providers will be held in November 1999.

A hui for advocates who are Maori was held in Rotorua in August 1998 to discuss issues surrounding the provision of advocacy for Maori within their service areas.

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 1998, following the completion of the Annual Report for each service for 1997/98 year. The focus audit wasconducted by independent auditors who assessed consumer satisfaction, service management practices, service provision to Maori and followed up on any service specific issues for individual providers which arose from the previous Audit in 1997. The Audit gave particular attention to the outcomes and outputs of Advocacy and highlighted performance issues for individual services to review. All services had worked on issues raised in the previous Audit. It also gave the Director an overview of the performance of the National Advocacy Service and progress made since the Audit in 1997.

There was some discussion in the Audit over the use of the empowerment model of Advocacy and whether this model fits the needs of all consumers. For example, Maori and Pacific Island consumers are not always comfortable with this model, as it does not fit with traditional support models. Empowerment Advocacy often requires significant resources to support consumers to undertake resolution themselves, however, it generally equips consumers to actively deal with any concerns they may have in the future. The model does need to be flexible enough to take account of individual needs when providing advocacy support.

High levels of consumer satisfaction were reported from regular surveys undertaken by advocacy services. There was however, some disappointment that advocacy services are not able to assist consumers with access to services issues and ACC entitlements.

The introduction of data definitions and standard reporting formats for all services has improved activity reporting and enhanced consistency. A database had been provided to advocacy services to record complaints and enquiries when they began working in July 1996. It had become apparent, following 18 months of using the database that, for technical reasons and ease of use, the database needed revision. The database was reviewed at the same time as the database used by the Investigations section of the Commissioner's Office was reviewed in mid 1998. A revised version of the ECDS database, was deployed to all services in October 1998. The database had been customised to fit Advocacy needs, and reports back indicate that the database now fits advocacy needs much better.

An electronic reporting system was also made available to advocacy service

providers in late 1998 which has made reporting more consistent and less time consuming than manual reporting systems. This reporting system will be further enhanced in the 1999/00 year for both the Director and advocacy service organisations. Further enhancements will be made to the ECDS to enable information on promotional work to be recorded and reported electronically from July 1999.

The Director set activity targets for all service providers for the 1998/99 year for enquiries, complaints, presentations and networking contacts. Theestablishment of targets led to an increase in activity for the majority of services compared with the 1997/98 year.

Networking Contacts

Networking contacts had not previously been recorded by advocacy services and relate to telephone contacts and visits to providers and consumer groups outside of contacts made regarding individual consumer complaints. Regular contacts are a good way to establish and maintain positive working relationships between advocacy services, health and disability service providers and consumer groups.

Advocacy services made 5,813 visits and telephone contacts to providers and consumer groups during the year. There is some variation in levels of networking activity which indicates that services may not have used the activity definition consistently.

Promotion

Promotional work still continues to be of high priority for advocacy services. During the year 2,345 presentations were given to consumers and providers. This is a 38% increase compared with promotional activity in the 1997/98 year. For some services with high levels of individual casework, promotional work has remained steady or decreased. A new consumer presentation package was provided to Advocacy services during the year by the Director.

As the services are no longer new, they received fewer invitations to make presentations. Consequently, they are required to be more active in seeking out promotional opportunities in less traditional areas. Opportunities have been in the form of having stalls with advocates in attendance at such events as A and P Shows and the Aoteoroa Festival. Static displays put up in such places as hospital foyers, public libraries and conferences publicising the Code of Rights have also been successful.

Enquiries and Complaints

The service handled 5,905 complaints and 9,871 enquiries during 1998/99.

This represents a 17% increase in the number of complaints and a 55% increase in enquiries compared with 1998/99. Advocacy services had not in the past recorded enquiries consistently. An improvement in recording and the use of consistent definitions have contributed to the significant increase in enquiries, as well as advocacy services becoming better known. While not all services record resolution rates, some are reporting up to 90% of complaints being resolved with Advocacy. Advocates, under section 30 of the Health and Disability Commissioner Act 1994, may report to the Commissioner any issueswhich they believe should be brought to her attention. Where appropriate, reports have been sent to the Commissioner for her information.

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. A total of 147 formal referrals were made by the Commissioner, to Advocacy Services during 1998/99. In addition to this, a number of telephone referrals were made to advocacy services as a result of calls to the Commissioner's 0800 telephone line.

Activity by Region

Service	FTE	Complaints	Enquiries	Presentations	Contacts
Northland	2	160	468	177	333
Auckland	9	1,561	1,966	662	2,134
Waikato	2	214	893	149	190
Bay of Plenty/ Gisborne	3.5	415	706	332	579
Hawkes Bay	*1.7	209	519	100	347
Taranaki, Wanganui Manawatu	3	543	1,129	186	314
Wellington	3.6	512	839	339	454
Nelson/Marlborough	1.5	260	518	45	147
Canterbury/West Coast	5	1,329	1,637	160	951
Otago/Southland	3.5	702	1,196	195	364
Total	**34.7**	**5,905**	**9,871**	**2,345**	**5,813**
Total 97/98	**#34.7**	**5,029**	**6,386**	**1,696**	**-**
Total 96/97	**33**	**3,953**	**6,377**	**2,751**	**-**

* *Includes an additional 0.2 FTE from June – December 1998*
\# *Includes an additional 1.7 FTE – part year only*

LEGAL SERVICES

1998/99 proved to be an exceptionally busy and productive year for the Legal division. As in previous years, legal staff provided behind the scenes support and advice to the Commissioner, managers and other staff spanning the range of functions and activities undertaken by the office. Formal advice was provided to the Commissioner and staff on the interpretation of various aspects of the Health and Disability Commissioner Act 1994, the Code of Rights and related legislation; numerous formal written responses were prepared to enquiries from the public and other agencies on the Act and Code; a significant number of submissions on legislative and policy proposals were drafted; complaint files and educational materials were reviewed; conference papers were prepared and presentations delivered.

In addition to the above activities which met targets (and in some cases exceeded) previous years, a significant number of additional activities were successfully undertaken by the Legal division during 1998/99. These are detailed below, but of particular note was the considerable work undertaken on the review of the Act and Code, the assistance given in the preparation of at least two judicial reviews, and the anonymising of all the Commissioner's opinions since the Code came into force for inclusion as an educational resource on the Commissioner's website.

Formal responses to enquiries

As the public becomes increasingly aware of the work of the office and the potential implications of the Health and Disability Commissioner Act and Code of Rights, so too do the number of enquiries to the Commissioner about the interpretation and application of this legislation. While the Commissioner is unable to give advance interpretations of the Act and Code, as this may be seen to pre-empt her investigation function, it is nevertheless the Commissioner's policy to give as much assistance as possible to those seeking guidance on the legislation.

As a consequence, considerable time and effort is put into providing comment on a wide range of topics, extending from such matters as 'not for resuscitation' orders to advice on complaints procedures. The demand for advice has been high and outputs from the Legal division for the past year in this regard almost tripled annual targets.

Submissions

Submissions drafted by the Legal division addressed a wide range of policy and legislative initiatives in the health and disability sector. The number of submissions made (41 in total) was also well in excess of annual targets. Priority was given to those matters which most directly impact on consumer rights to quality health and disability services, or which relate to the Health and Disability Commissioner Act. Submissions included comments on the

following:

- Nursing Council's draft framework and guidelines for competence-based practising certificates for registered midwives and registered nurses
- Health Occupational Registration Acts Amendment Bill
- Public Trust Office review (impact on Health and Disability Commissioner Act)
- Ministry of Health's review of Part VI of the Medical Practitioners Act 1995 (quality assurance activities)
- Mental Health (Compulsory Assessment and Treatment) Amendment Bill
- Ministry of Health's review of policy on the prevention and control of HIV/AIDS in New Zealand
- Dental Council's report on 'New Zealand Dental Workforce Analysis'
- National Health Committee's report on 'How should we care for the carers'
- Health Funding Authority's breast screening programme
- Department of Social Welfare's progress report on the International Year of Older Persons 1999
- Accident Insurance Bill
- Ministry of Health's public health legislation review
- Minister of Health's Hospital Services Plan
- Dental Council's strategic planning 1999
- Ministry of Health's rural health policy
- Ministry of Health's consultation document on nurse prescribing in aged care and child family health
- Te Puni Kokiri's draft information document 'Hauora o Te Tinana Me Nga Whekau'
- Health and Disability Services (Safety) Bill

- Intellectual Disability Compulsory Care Bill
- Standard New Zealand's draft health and disability sector standards
- Law Commission's review of the Coroners Act 1988
- Assisted Human Reproduction Bill
- Department of Labour's proposed definition of 'counsellor' as required by the Accident Insurance Act 1998
- Ministry of Health's review of the Alcoholism and Drug Addiction Act 1966
- Medicines Act 1981 Amendment Bill
- National Health Committee's maternity review
- NECAHR's draft guidelines on the use of stored semen
- National Health Committee's draft discussion document on health care for older people.

Testing legal boundaries

One 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 also continues to be tested.

A notable feature of 1998/99 was the substantial increase in requests for information from investigation files and the increase in investigations by other agencies, such as the Office of the Ombudsmen and the Privacy Commissioner. Such investigations are to be expected and ultimately will result in a better understanding of the scope of the legislation. However, the time consuming nature of these investigations has inevitably meant that resources must be diverted from the Commissioner's primary functions in order to respond.

Legal boundaries have also been tested through the Courts, both in relation to the Commissioner's own legislation and in relation to other legislation impacting on the rights of health and disability service consumers. Of particular note over the past year was the successful High Court action against the Nursing Council, initiated by the Commissioner and the Director of Proceedings to determine the Council's ability to conduct its disciplinary

hearings in public.

Resulting from this action, the decision of Baragwanath J in Health and Disability Commissioner v Nursing Council 7/12/98, HC Wellington, 774/98 confirmed the ability of the Nursing Council under the Nurses Act 1977 to hold hearings in public as well as in private. The decision also set out a useful list of considerations to be taken into account by the Council when exercising its discretion in this regard, including recognition of the importance of transparency of judicial processes. Clarification of the application of these considerations to other health professional disciplinary bodies is expected over the coming year, with a challenge by the Commissioner of a decision the Chiropractic Board to hold a disciplinary hearing in private.

With regard to the Health and Disability Commissioner Act, the obligation to discover documents in disciplinary proceedings was considered by the High Court in *Health and Disability Commissioner v Medical Practitioners Disciplinary Tribunal* 9/12/98, Ellis J, HC Wellington, 141/98. The decision in this case explores the implications of the functional independence of the Commissioner and Director of Proceedings under the Act and assists in clarifying the extent of the Commissioner's obligation to give discovery of her investigation file in proceedings bought by the Director.

Contribution to the Commissioner's education functions

As in previous years all educational material produced by the Commissioner's office was reviewed prior to publication. In addition, a number of articles, reports and chapters for texts prepared by external agencies and individuals were reviewed and commented on. A number of articles were also directly prepared within the Legal division for inclusion in outside publications such as the Dental Council News and Employers Federation Newsletter.

The Commissioner's educational aims were also assisted by the preparation of more than 20 conference papers addressing the implications of the Commissioner's jurisdiction and Code of Rights in areas ranging from investigation processes, intellectual disability, mental health, psychology, children, informed consent, standards and Maori issues. A total of 31 presentations were delivered by legal staff to a variety of consumer and provider groups. Of particular note this year was the considerable effort put into the collation of resource material, preparation for and delivery of the 1999 Health and Disability Commissioner Workshops.

During 1998/99 emphasis was given to improving the availability of the Commissioner's opinions, resulting from investigations, through the

Commissioner's website. Such opinions provide a valuable educational tool for both providers and consumers and are an important means of developing awareness of the Code. The Legal division's contribution to this ongoing project has been to remove all identifying information from opinions in preparation for their inclusion on the website. As at the end of June 1999, 160 opinions had been anonymised ready for release.

Review of the Act and Code

A major project for the Legal division over the 1998/99 year has been the review of the Health and Disability Commissioner Act and Code of Rights. The Act has now been in force since 1994 and the Code since July 1996. The Act requires the Commissioner to undertake a review of both pieces of legislation at regular intervals, consider whether any amendments are necessary or desirable and report the review findings to the Minister of Health. This project began in the second half of 1998 and by the end of June 1999 was nearing completion.

As the content of the Code is governed by the Act, the Commissioner decided to undertake her initial reviews of these pieces of legislation simultaneously. To begin the review process, preliminary comments were sought from over 90 representative persons and organisations with an interest in health and disability service matters, including consumer and provider groups and relevant statutory agencies. Based on the comments received and on the Commissioner's own experience of the operation of the Act and Code, a public consultation document was prepared and submissions were again invited from interested organisations and individuals, as well as from the public at large. The consultation document was widely circulated, with 3, 800 copies being distributed.

To aid feedback, the consultation document discussed a wide range of issues, set out the Commissioner's proposed recommendations for change, and included suggested drafting for implementation of these recommendations. The document sought to achieve a balance between addressing legal issues in a sufficiently detailed way on the one hand, and being readable and easily understood by non-legal readers on the other. General feedback indicated that the document was favourably received and approximately 220 submissions were made in response to it.

Release of the consultation document coincided with both national and local media releases announcing the reviews. An audio cassette of the consultation document was also made avavilble for distribution through the Royal New Zealand Foundation for the Blind.

In addition to the invitation for written submissions, feedback on the reviews

was obtained during a series of meetings held throughout the country by the Commissioner and Kaiwhakahaere. These included 12 public meetings, 5 Maori focus groups, 3 Pacific Island focus groups, and 20 meetings with the Chief Executives and other managers of the various public hospitals. A freephone 0800 number for those wishing to request information or make an oral submission was also made available.

At the time of writing, submissions were being analysed and a report to the Minister prepared.

ADMINISTRATIVE FUNCTIONS

Finance

The Health and Disability Commissioner continued to maintain premises in Auckland and in Wellington. In February 1999, administrative functions including Accounting, Finance and Information Technology, were centralised in the Auckland office. Additional space was leased to accommodate the new arrivals.

As part of the re-location of administrative functions, the Commissioner's Financial Information System was upgraded to a newer version that is Y2K compliant and more user friendly.

Information Technology

The Commissioner continued to seek ways to use technology to improve effectiveness and efficiency. During the year, the telephone system was upgraded to take advantage of cost savings available by routing toll calls across the dedicated data service linking the two offices. Also, the Commissioner's proprietary workflow software was upgraded to provide additional functionality. At year-end, planning was well underway to manage technology issues related to the restructuring of Advocacy Services.

Y2K Compliance

The office has conducted surveys of hardware, software and suppliers to measure the extent of its Y2K risk. This process identified the need for hardware and software upgrades and on-going communication with banking, payroll and property suppliers. Remediation work is well underway with computer hardware and software upgrades scheduled for completion by 30 November 1999. Telecommunications equipment had been upgraded and other office equipment is already compliant. The Office if working with a consultant and suppliers to ensure that its Y2K preparations are in line with good practice for its risk profile and available resources.

HUMAN RESOURCES

The Health and Disability Commissioner commenced the year with an establishment of 35.5 staff. During February 1999 the Accounting and Information Systems functions were moved to newly leased premises in the Auckland office resulting in the appointment of a full time Accountant (previously part time), an Accounts Administrator, Accounts Clerk and a Helpdesk Administrator. Staff who had undertaken these roles in the Wellington office were either offered other positions or sought positions outside the office of the Health and Disability Commissioner, with the position of Executive Services Manager becoming redundant in November 1998. The office finished the year with an establishment of 37 staff, the additional personnel being in the investigations division. At year end there were 5 vacancies.

In addition to the administration area mentioned above, during the year a number of investigation staff resigned. The senior management team was stable with the exception of the resignation of the Investigation Manager in April 1999. With the appointment of a General Manager in March 1999, the decision was made not to reappoint an Investigation Manager but instead to allocate some of those functions to the three senior investigation officers.

As at 30 June 1999 there was high staff morale and increases in outputs over the last three months of the year assisted this.

The senior management team comprises of the following:

General Manager
Director of Proceedings
Finance and Technology Manager
Kaiwhakahaere
Director of Advocacy
Education/Communication Manager
Human Resources Manager
Legal Manager

Within the office each Manager is responsible for a functional area and the General Manager is responsible to coordinate activities and ensure smooth management processes for the Commissioner.

The functional responsibilities are:

Director of Advocacy
- Contracts and monitors advocacy services
- Trains advocates
- Promotes and publicises advocacy services
- Develops and ensures implementation of advocacy policy

Director of Proceedings
- Decides whether to institute proceedings
- Lays charges and appears at disciplinary hearings
- Issues and appears on CRT proceedings
- Provides representation for consumers

Education/Communication
- Education and promotion
- Training (internal and external)
- Publishing
- Monitors and sets communication standards
- All media activities
- Consultation

Finance and Technology
- Financial management
- Systems support
- Information technology

Human Resources
- Recruitment
- Office management and policies
- Organisational support

Kaiwhakahaere
- Ensures Maori and ethnic minorities are included
- Provides advice on education and promotion
- Advice to Commissioner and staff on Maori and Treaty matters

Legal
- Legal advice
- Formal responses to enquiries
- Submissions on policy and legislative developments
- Interface with Ministry of Health
- Preparation of conference papers

EXPENDITURE BY TYPE

The office started the year in anticipation of a budget deficit of $951,583 partly as a result of $200,000 budgeted for the review of the Act and Code to be undertaken in 1998/1999 as required by statute. However, due to higher than anticipated interest income and tight control of expenditure in other areas the operating deficit was limited to $52,669.

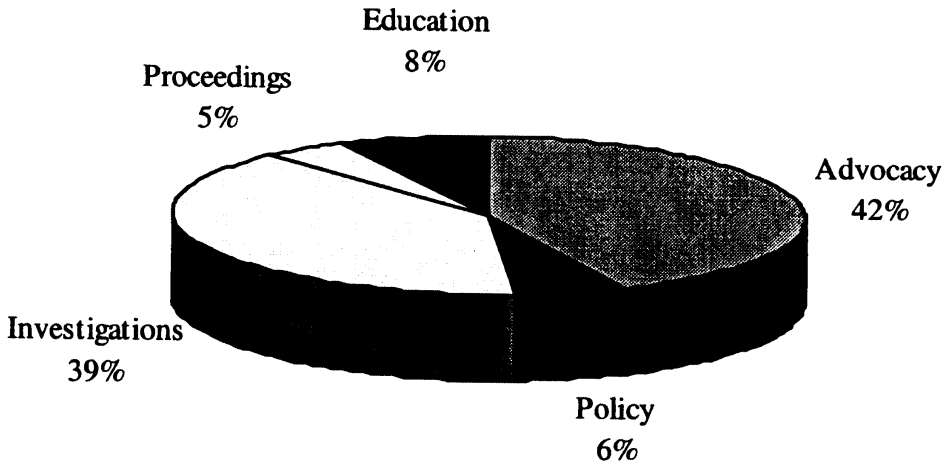
Expenditure is summarised by significant categories below. Service contracts, staff costs and occupancy costs (collectively 76.89% of total expenditure in 1998/1999) largely represent committed expenditure. Much of the remaining 23.11% (or $1.48 million) is discretionary. The very high percentage of committed expenditure severely limits the office's ability to meet ad hoc or large one off expenditure demands such as the review of the Code and Act started this year.

	97/98	98/99
Service Contracts	$2,359,467	$2,461,840
	37.27%	38.33%
Audit Fees	$6,000	$4,500
	0.09%	0.07%
Allowance for Bad Debts	$4,213	$2,467
	0.07%	0.04%
Staff Costs	$1,970,596	$2,269,792
	31.12%	35.34%
Travel & Accomodation	$166,996	$137,492
	2.64%	2.14%
Depreciation	$338,463	$268,166
	5.35%	4.17%
Occupancy	$185,040	$207,524
	2.92%	3.23%
Communications	$446,581	$549,170
	7.05%	8.55%
Operating Costs	$854,196	$522,636
	13.49%	8.13%
TOTAL	$6,331,552	$6,423,587
	100.00%	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.

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 30 June 1999

Actual 97/98 $		Actual 98/99 $	Budget 98/99 $
	Revenue		
6,119,111	Operating Grant Received	6,147,556	6,148,444
269,044	Interest Received	200,090	192,101
25,669	Publications Revenue	23,272	10,000
6,413,824	**TOTAL OPERATING REVENUE**	**6,370,918**	**6,350,545**
	Less Expenses		
2,359,467	Advocacy Service Contracts	2,461,840	2,667,261
6,000	Audit Fees	4,500	7,000
4,213	Bad Debts written off	2,467	-
1,970,596	Staff Costs	2,269,792	2,114,212
166,996	Travel & Accommodation	137,492	259,023
338,463	Depreciation	268,166	301,785
185,040	Occupancy	207,524	194,712
446,581	Communications	549,170	723,813
854,196	Operating Costs	522,636	1,034,322
6,331,552	**TOTAL OPERATING EXPENSES**	**6,423,587**	**7,302,128**
82,272	**NET OPERATING SURPLUS (LOSS)**	**(52,669)**	**(951,583)**

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

STATEMENT OF FINANCIAL POSITION

As at 30 June 1999

Actual 97/98 $			Actual 98/99 $	Budget 98/99 $
	Crown Equity			
2,117,796	Accumulated Funds	(Note 1)	2,065,127	1,166,213
788,000	Capital Contributed		788,000	788,000
2,905,796	**TOTAL CROWN EQUITY**		**2,853,127**	**1,954,213**
	Represented by Current Assets			
226,809	Bank Account		164,933	100,000
2,436,835	Call Deposits		2,455,400	1,617,896
12,814	Prepayments		6,942	5,000
40,787	Sundry Debtors		0	25,000
96,581	GST Receivable		128,022	100,000
2,813,826	**Total Current Assets**		2,755,297	1,847,896
	Non Current Assets			
490,108	Fixed Assets	(Note 3)	390,358	373,578
490,108	**Total Non Current Assets**		390,358	373,578
3,303,934	**Total Assets**		3,145,655	2,221,474
	Current Liabilities			
398,138	Sundry Creditors	(Note 2)	292,528	267,261
398,138	**Total Liabilities**		292,528	267,261
2,905,796	**NET ASSETS**		**2,853,127**	**1,954,213**

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 1999

Actual 97/98 $		Actual 98/99 $	Budget 98/99 $
2,823,524	Opening Equity 1 July 1998	2,905,796	2,905,796
82,272	Plus Net Operating Surplus (Loss) (Total Recognised Revenues and Expenses)	(52,669)	(951,583)
2,905,796	Closing Equity 30 June 1999	**2,853,127**	**1,954,213**

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

STATEMENT OF CASH FLOWS

For the year ended 30 June 1999

Actual 97/98 $		Actual 98/99 $	Budget 98/99 $
	Cashflows from Operating Activities		
	Cash was provided from:		
6,119,111	Operating Grant	6,147,556	6,148,444
269,044	Interest on Short Term Deposits	200,090	192,101
(21,451)	Income Received	40,787	25,787
25,669	Publications revenue	23,272	10,000
6,392,373		6,411,705	6,376,332
	Cash was applied to:		
(1,600,790)	Payments to Employees	(2,101,364)	(1,951,727)
(4,380,023)	Payments to Suppliers	(4,166,813)	(5,212,162)
(5,980,813)		(6,268,177)	(7,163,889)
411,560	**Net Cashflows from Operating Activities (Note 4)**	**143,528**	**(787,557)**
	Cashflows from Financing Activities		
	Cash was provided from:		
0	Capital Contribution	0	0
0	**Net Cashflows from Financing Activities**	**0**	**0**
	Cashflows from Investing Activities		
	Cash was provided from:		
5,026	Sale of Fixed Assets	0	0
	Cash was applied to:		
(104,439)	Purchase of Fixed Assets	(186,839)	(158,191)
(99,413)	**Net Cashflows from Investing Activities**	**(186,839)**	**(158,191)**
312,147	**NET INCREASE IN CASH**	**43,311**	**(945,748)**

STATEMENT OF CASH FLOWS - continued

For the year ended 30 June 1999

Actual 97/98 $		Actual 98/99 $	Budget 98/99 $
312,147	**NET INCREASE IN CASH**	**(43,311)**	**(945,748)**
2,351,497	Cash brought Forward	2,663,644	2,663,644
2,663,644	Closing Cash carried forward	**2,620,333**	**1,717,896**
	Cash Balances in the Statement of Financial Position		
226,809	Bank Account	164,933	100,000
2,436,835	Call Deposits	2,455,400	1,617,896
2,663,644		**2,620,333**	**1,717,896**

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 1999

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 net realisable value after providing for doubtful and uncollectable debts.

(f) Leases

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

(g) Employee Entitlements

Annual leave is recognised on an actual entitlement basis at current rates of pay.

The Commissioner's remuneration and allowances are set by the Higher Salaries Commission who have determined tha the commissioner be paid an annual salary of $148, 500, superannuation up to a maximum of 10% of salary and allowances of $12, 700.

(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 1999, indirect costs accounted for 26% of the Health and Disability Commissioner's total costs (97/98 23%).

Statement of Changes in Accounting Policies

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

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 1999

Actual 97/98 $	Note		Actual 98/99 $
	1	***Accumulated funds***	
2,035,524		Opening balance	2,117,796
82,272		Net Operating Surplus (Loss)	(52,669)
2,117,796		**Closing balance**	**2,065,127**
	2	***Sundry Creditors***	
340,782		Trade Creditors and Accruals	186,058
0		PAYE	48,910
57,356		Annual Leave	57,560
398,138			**292,528**

3 ***Fixed Assets***

98/99	*Cost* $	*Accum Depn* $	*Net Book Value* $
Computer Hardware	714,492	521,887	192,605
Computer Software	201,114	162,784	38,330
Communications Equipt.	28,408	25,315	3,093
Furniture & Fittings	150,178	86,461	63,717
Leasehold Improvements	187,111	119,557	67,554
Motor Vehicles	42,280	35,536	6,744
Office Equipment	63,420	45,105	18,315
Total Fixed Assets	**1,387,003**	**996,645**	**390,358**

Actual 97/98 $	Note		Actual 98/99 $

3 ***Fixed Assets - cont.***

97/98	*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**

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

82,272	Net Operating Loss		(52,669)
	Add Non-cash items:		
321,043	Depreciation		268,166
	Movements in Working Capital Items		
(38,605)	Increase/(Decrease) in Sundry Creditors	(105,610)	
16,924	Adjustment for Fixed Asset Creditors	18,424	
(21,451)	(Increase)/Decrease in Sundry Debtors	40,787,	
7,250	(Increase)/Decrease in Prepayments	5,872	
26,707	(Increase)/Decrease in GST Receivable	(31,442)	
(9,175)			(71,969)
17,420	Net loss on disposal of assets		0
411,560	Net Cashflows From Operating Activities		**143,528**

Actual 97/98	Note		Actual 98/99
$	5	*Commitments*	$
		(a) Advocacy Service contracts	
		Ten contracts for the provision of consumer advocacy services ended on 30 June 1999. They were replaced by three performance based contracts effective from 1 July 1999 for a period of 24 months. The maximum commitment for the first 12 months from 1 July 1999 is $1,756,475.	
		Premises Leases including leasehold improvements:	
		Wellington $76,000 per annum until March 2006	
		Auckland $125,317 per annum until March 2002	
		Retail Agreements	
		Telecommunications equipment $42,630 per annum until January 2004	
		Classification of Commitments	
2,494,002		Less than one year	2,000,422
148,519		One to two years	2,000,422
354,908		Two to five years	461,878
209,000		Over five years	233,868
3,206,429			**4,696,590**

6 ***Contingent Liabilities***

As at 30 June 1999 there were no contingent liabilities (97/98 Nil).

7 ***Financial Instruments***

As the Health and Disability Commissioner is subject to the Public

Actual 97/98 $	Note		Actual 98/99 $
		Financial Instruments - continued	
		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.	
		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:	
2,663,644		Bank Balances	2,620,333
40,787		Sundry Debtors	0
2,704,431			**2,620,333**
		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 other related party	

Actual 97/98 $	Note		Actual 98/99 $
	9	***Exceptional items***	
		Last year,the Health and Disability Commissioner completed an investigation into Canterbury Health Ltd which was commenced during the year ended 30 June 1997.	
		This year the Commissioner began a Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights as required by statute. The sum of $105, 000 has been budgeted for the completion of the Review in the coming financial year.	
854,444		Canterbury Health Ltd	0
0		Act and Code Review to date	98,122
854,444			**98,122**

STATEMENT OF SERVICE PERFORMANCE FOR THE YEAR ENDED 30 JUNE 1999

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	50	52
Disability service provider groups	5	8
Maori provider groups	20	18
Pacific Island provider groups	5	2
Develop training/resource packages	4	3
Produce and distribute opinions for educational purposes	15	46

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

	Target	Actual
Presentations to: General consumer groups	50	58
Disability consumer groups	10	6
Maori consumer groups	15	16
Pacific Island consumer groups	5	3
Other ethnic consumer groups	5	4

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

	Target	Actual
Presentations to other bodies	15	21
Present educational seminars	2	6
Issue Media Releases	10	17
Distribute educational resources	60,000	153,053

	Target	Actual
Contribute articles to provider publications	20	20
Advertise in media as appropriate	7	7
Produce new eduational resources for consumer and provider groups	2	2
Regularly update internet web-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 1998/99 year.

Actual: Hui for advocates who are Maori
Orientation Training deferred until 1999

Objective: *Ensure effective management of contracts.*

Target: Comment provided to the advocacy services on plans and reports sent to the Director.
Reports have been sent 6 monthly to the Minister
Six monthly joint review meetings held with all services

Actual: Comment has been provided to advocacy services on plans and reports sent to the Director.
Reports have been sent 6 monthly to the Minister.
Six monthly joint review meetings held with all services

Objective: *Develop and implement a purchasing strategy for advocacy services to ensure new contracts in place from 1 July 1999.*

Target: New contracts are signed by 1 May 1999.
New contractors in place and operating by 30 June 1999

Actual: New contracts signed mid May 1999
New contractors in place and began new operations from 1 July 1999

Objective: *Ensure effective delivery of contracted outputs*

Target: 2000 presentations delivered to consumers and providers.
5,000 enquiries processed.
Consumers assisted with minimum of 5,500 complaints.
70% of all complaints received are resolved with advocacy *.
1500 Provider/Consumer contacts made.

Actual: 2,345 presentations delivered.
9,871 enquiries processed.
Consumers assisted with 5,915 complaints.
5,813 Provider/Consumer contacts made.

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

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	1,174
Open files over a year old	30	288
Completion rate for new Complaints		
Within 2 months	25%	41%+
Within 7 months	30%	10%*
Within 12 months	5%	6%#

+ within 3 months * within 6 months # within 12 months

	Target	Actual
Report on outcome of complaints	Monthly Report	Monthly Report
Process enquiries	8,600	7,889
Enquiries closed within 48 hours	90%	97%

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

Target: Provide independent and culturally appropriate enquiry and investigation services.

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: Regular contact maintained with consumers regarding the complaint process. Kaiwhakahaere involved with clients identified as Maori to review any concerns with the complaints process.

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	80%	55%

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	104
Submissions on policy and other legislation.	18	41
Undertake a review of the operation of the Act in accordance with section 18 and Code in Accordance with section 21.	Review of the Act and Code conducted simultaneously. Consultations process for the reviews completed. Submissions are being analysed and a report to the Minister prepared.	

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 1998.

Target: Policy manuals up to date.

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

Target: Annual report completed on time.

Actual: Report tabled within statutory deadlines on 13 November 1998.

STATEMENT OF RESPONSIBILITY

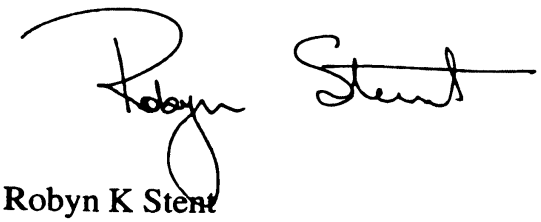
In terms of Section 42 of the Public Finance Act 1989:

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

2. We 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. We are 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 1999.

David E Turner
General Manager



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 1999

We have audited the financial statement on pages 56 to 74. 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 1999. This information is stated in accordance with the accounting policies set out on pages 61 to 63.

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 1999, the results of its operations and cash flows and the service performance achievements for the year ended 30 June 1999.

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 Karen MacKenzie, 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, including the Auditing Standards issued by the Institute of Chartered Accountants of 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.

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 56 to 74:

- comply with generally accepted accounting practice *and*
- fairly reflect:
  - the financial position as at 30 June 1999 *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 19 October 1999 and our unqualified opinion is expressed as at that date.

KMacKenzie

Karen MacKenzie
Audit New Zealand
On behalf of the Controller and Auditor-General
Auckland, New Zealand