The value of HDC investigation

From time to time commentators raise concerns about the potential for complaints and complaints systems, particularly those of the HDC, to contribute to the practice of 'defensive' medicine. Recently the role of HDC in assessing quality, safety, and accountability through its investigation function was questioned. I acknowledge the need to guard against the potentially negative effects of complaints processes, particularly in respect of the current delays HDC is facing. However, HDC's statutory powers to investigate are crucial for the protection of consumers' rights and play an important role in quality and safety — not least because they are the only mechanism through which breaches of the Code of Rights are determined. Moreover, I do not regard stopping investigations as an appropriate strategy to manage pressure on HDC resources.

The establishment of the Code of Rights and of HDC marked a turning point in public attitudes towards medical practice in New Zealand — shifting the focus from the medical practitioner to the patient. The Code of Rights sets the benchmark for consumer-centred care in Aotearoa New Zealand, and the protection of these rights benefits everyone, including providers and our system.

Serious patient rights violations continue to happen, and, in this respect, there can be no complacency about consumers' rights — we must be vigilant. Significant increases in complaint numbers, and the seriousness of many complaints, indicate that the Code of Rights is as relevant now as the day it came into force.

HDC's unique role in the system

HDC is an independent Crown entity established to promote and protect the rights of people using health and disability services. Our independence from Government and service provision enables HDC to be an effective and impartial guardian of consumers' rights. In New Zealand's no-fault system for treatment injury, HDC is the key independent avenue for people to raise their concerns about health and disability services formally.

HDC closes around 3000 complaints a year. While we are focused on supporting early resolution between providers and consumers where appropriate, HDC commences around 170–180 investigations annually. Around 75% of these investigations result in a finding that a provider breached the Code of Rights. A small number of these breach findings also result in a referral to the Director of Proceedings to consider whether legal proceedings should be taken in the Health Practitioners Disciplinary Tribunal (for regulated providers) and/or the Human Rights Review Tribunal, noting that a consumer can access the Human Rights Review Tribunal for legal remedies only following a breach finding by HDC.

HDC receives an enormous breadth of complaints — ranging from relatively minor concerns through to concerns about near misses, serious physical and/or psychological harm, significant public safety issues, and serious professional conduct concerns. We have a wide discretion and broad range of powers to respond to these issues.

While many complaints are about the standard of care provided (Right 4), many more are about the other elements of service delivery captured by the Code, such as dignity, respect, communication, informed consent, and the management of complaints or adverse events by providers. These are

elements of health care that often are not captured by quality and safety initiatives or other forms of error reporting.

Commentators often focus on HDC's role in relation to regulated medical professionals. However, we consider complaints about a broad range of providers, including disability services, prison health services, aged care providers, private hospitals, and complementary medicine services (eg, massage therapy). Many of the complaints HDC receives are about unregulated or private providers for whom, in many cases, it is the only available independent accountability and public protection mechanism.

In respect of regulated providers, HDC works closely with the regulatory authorities, and any complaints that primarily are about an individual provider's competence or fitness to practise will be referred to those authorities. However, often health care is provided in a team environment, rather than by a single professional. In these cases, HDC considers the contribution of organisational failings to individual behaviour — that is, often our investigations seek to place individual behaviour in its systemic context. Systems and organisations are found in breach of the Code of Rights far more often than are individuals.

The needs of complainants can be similarly diverse. In this context, the importance of accountability should not be ignored, noting its particular value to the consumer and whānau affected by the breach. Many people, in making a complaint to HDC, speak of wanting an independent assessment of their care, which adverse event reporting does not satisfy. HDC's complainant experience survey has found that people who go through HDC's investigations process often highlight that the independent inquiry process and sense of accountability has helped to bring a sense of closure and helped to restore their trust in the system.

It is also common for a complainant to express a strong desire to prevent their experience from happening to other consumers, and to want shortcomings in their care addressed. The value of the HDC process in generating change, and achieving quality improvement, should not be underestimated.

Accountability in a learning system

Accountability, where required, is an important aspect of a learning system. Accountability mechanisms and access to justice are important for maintaining public trust in the health and disability system and ensuring that people's resolution needs are met, and their rights upheld. A learning system needs a range of mechanisms to ensure that people and organisations are held to account where needed, risk is escalated appropriately, public safety is protected, recurrent behaviour and systemic issues are addressed, and change occurs.

HDC's use of legislative powers to effect change following a complaint is one of the central ways in which we protect consumer rights. An important means by which HDC effects quality improvement is through the making and monitoring of recommendations, and the fact that 96% of HDC's recommendations are complied with is evidence that providers see the value in their implementation (noting of course that providers always get the opportunity to comment on recommendations before they are made).

HDC also seeks to influence quality improvement through the publication of our investigation opinions and other public comment, including by raising awareness of rights and highlighting consumer voice.

HDC has significant powers to undertake investigations in the absence of a complaint, as we have done recently into delays in cancer services in the Southern region. This report and subsequent comment have received significant national exposure and served to shine a spotlight on the systemic issues at play. The investigation highlighted the need for sustained focus on the region's cancer management plan, and placed patients, rather than fiscal management, at the centre of the issues.

Complaints also allow us to understand the experience of consumers in a direct way that may not be captured elsewhere. HDC closely monitors the trends that appear across complaints, often identifying systemic failings that impact directly on consumers and public safety. We work closely with other agencies, particularly HQSC and Health NZ, to share complaint trend information and take a collaborative approach to issues of shared concern. We also work with the Coroner and other investigative agencies to ensure that our processes are not duplicated.

In short, not only does HDC resolve complaints about the infringement of peoples' rights under the Code, but we use the findings to improve the quality of services, at the individual provider level and across the health and disability system. These functions, and the significant legislative powers of HDC, should not be discounted, and are as important now as they were when the Code of Rights was first introduced, particularly in the context of an increasing number of serious complaints, and a health and disability system under significant pressure and change.

Morag McDowell
Health and Disability Commissioner
NZ Doctor, 12 June 2024