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The Health and Disability Commissioner

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Tēnā Koe

Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights

Introduction

1. Tōpūtanga Tapuhi Kaitiaki o Aotearoa, the New Zealand Nurses Organisation (*NZNO*) welcomes the opportunity to comment on the Review of the Health and Disability Commissioner Act 1994 (*the Act*) and the Code of Health and Disability Services Consumers' Rights (*the Code*).

2. NZNO has consulted its members and staff in the preparation of this submission, including Professional Nursing Advisors and Medico-Legal Lawyers.

3. NZNO supports the Act and Codes' purpose and function as it looks to ensure the best care is provided to all health consumers within Aotearoa New Zealand. However, this should not occur at the expense of the right to natural justice of the very health professionals who provide care to the same health and disability services consumers of Aotearoa New Zealand.

4. NZNO notes the review is limited by virtue of its scope. Thoughts and feedback are welcome in relation to four topics as to whether the Act or Code should be amended and any operational comments. We submit that the review process would benefit from additional questions that are related to areas of the Act and Code that the Health and Disability Commissioner and their staff may have observed the public have questions about, or with those the Health and Disability Commissioner's (HDC) office itself has issues.

5. The review is being undertaken at a time when the Government has cut the HDC's funding in its 2024 Budget. The axed funding represents a 16.5% reduction in the HDC's overall budget of $17.5m[1]. The Health and Disability Commissioner (HDC) is dealing with a backlog of complaints

[1] https://www.stuff.co.nz/nz-news/350315730/terribly-short-sighted-govt-cuts-struggling-health-watchdogs-budget

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which has pushed waiting times out to as long as three years. It was revealed that 11% of the complaints the HDC receives take two years or more to resolve.

Topic 1 Supporting better and equitable complaint resolution.

1.1 Did we cover the main issues about supporting better and equitable complaints resolution?

6. NZNO acknowledge there needs to be a means of supporting complainants to make their complaint to the most appropriate body. It is recognised that it is difficult for many consumers, family and whānau to give feedback on services they have been unhappy with. There is also the sense that some complaints could be effectively addressed by the organisation and do not need escalation to the HDC. How can the natural justice principle of addressing concerns at the lowest possible level be enhanced? Some health practitioners have complained that the process is weaponised, because being under investigation for more than a year requires nurses to declare that they are under investigation in their application to renew their Annual Practising Certificate with the Nursing Council of New Zealand (*NCNZ*) until an outcome is known. In addition to providing different options for addressing complaints, there needs to be increased capacity for those complaints to be resolved.

7. NZNO submit that it is a breach of natural justice and procedurally unfair for the HDC complaints assessment process to identify an individual nurse and make a referral to NCNZ without first notifying the nurse of the complaint and the HDC's concerns and giving the nurse an opportunity to address the complaint and proposed referral. Once the HDC becomes aware of a nurse's identity in relation to concerns about that nurse's competence or fitness to practice, it should contact the nurse to inform the nurse of its concerns and invite individual response in relation to the complaint. The HDC has instead on several occasions assumed that the employer has contacted and informed the nurse which does not necessarily occur.

8. From practical experience it has been noted that our members are being given less and less time to respond initially to the complaint with little consideration given to the constraints upon their timeframes such as working on night duty, less time to consider expert opinions that have been sought which can have a serious impact on their professional practice and career, and less time to consider and respond to an adverse comment under section 67 of the Act.

9. NZNO recommends an amendment to the Code specifically to include gender diversity in rights of dignity and respect; services that consider the needs, values, and beliefs of gender diverse people; and freedom from discrimination, coercion and harassment, exploitation, etc. Anecdotally it has been reported that discrimination and a lack of respect and dignity in health care is a significant issue for gender diverse individuals, and that their mental and physical health suffers as a result. Many in the lesbian, gay, bisexual, transgender, and queer community (LGBTQ community) community suffer poor physical health, in part because they are

reluctant to see health care practitioners when they need to because of past experiences. Many gender diverse individuals report being misgendered, or having their gender identity dismissed, questioned or disrespected, and their health concerns trivialised or misunderstood, by health care practitioners.

1.2 What do you think of our suggestions for supporting better and equitable complaints resolution, and what impacts could they have?

10. NZNO recognises that it could be useful to acknowledge the situation where a child's parents are no longer in a relationship, and where there may be conflict between the parents about treatments e.g. accessing childhood vaccinations. The consultation document implies that family / whanau are of one view when giving consent on behalf of children, when this is not always the case.

11. NZNO agree with the suggestion to incorporate the concept of upholding mana into the purpose statement of the Act. We also suggest that this principle includes the concept of upholding mana for all involved in the complaints process, including health practitioners.

12. Many nurses involved in responding to a complaint find the process very stressful and can suffer a loss of dignity and mana during the investigation process. This can occur even when the nurse is not the subject of a complaint but may simply have been involved in the provision of care that is being investigated. Health practitioners involved in responding to a complaint in an investigation are often unaware of other enquiries being made into the actions of other practitioners or the wider systemic context in which care was provided. They often appear as though there is intense scrutiny on their personal involvement.

13. Investigations often arise following a serious adverse event in the provision of healthcare. Whilst not wishing to diminish the impact on the family / whānau following such an event, health practitioners involved can also suffer associated distress and sometimes trauma. An HDC process following such an event can exacerbate this distress / trauma.

14. Coupled with this, investigations by nature involve a high level of scrutiny of care provided by individuals. This is often in less-than-ideal circumstances, for example an understaffed shift. Most health practitioners hold very high standards for themselves and take even the most minor criticism very personally, even when they know the care they might have provided could have been improved.

15. Following investigation, many nurses accept HDC recommendations and the full report which often acknowledges all the circumstances contributing to the care provided, they often give feedback that the investigation process was much worse than the outcome. Stress caused by the process is exacerbated by delay.

16. Many nurses responding in an HDC investigation lose confidence in their practice. In some cases, this has resulted in nurses deciding to leave the profession. Extending the definition and the purpose of the Act to include upholding the mana of all those involved in the process would support other initiatives to retain the mana of the health practitioner throughout the process.

Strengthen the Advocacy Service

17. NZNO agree with suggestions to strengthen the Advocacy Service and acknowledge the role the Advocacy Service already provides in facilitating early resolution of complaints. We note the comments that the Advocacy Service exists to mitigate the power imbalance between people and providers.

18. Occasionally we note that HDC staff may not be alert to power imbalances that exist within healthcare providers. Nurses involved in responding to complaints are usually an employee of the health provider where the employer may be the subject of investigation. It can sometimes occur that some health care organisations, not wishing to examine their own processes or systemic factors that may have contributed to the complaint, ask that the nurse meets with the complainant. Many complainants are not aware of the context in which healthcare is provided and may themselves fail to see that wider factors may have influenced the care they received. This can sometimes result in an employee nurse being seen as the *source of the problem* and taking far greater accountability than what is proportionate to their role in the care provided.

19. NZNO would ask that education is provided to Advocacy Service staff and other HDC staff of power imbalances that exist within healthcare providers.

Protect against retaliation

20. Whilst we agree that complainants should not see the potential for retaliation as a barrier to obtaining healthcare, we do not consider that a separate non-retaliation clause is necessary. We agree with comments in the consultation document that retaliation against a complainant would already be a breach of Right 1, Right 2 and Right 4 of the Code. An explanatory document may assist complainants.

21. Consideration of the cultural needs of the health and disability workforce should also be recognised, with more than 50% of nurses being internationally qualified. Many recent immigrants who are health care providers will be adjusting to working in Aotearoa New Zealand and will require support to understand and participate in the process. For those who are on work visas, their situation will require support that may not be readily accessible to them. Furthermore, the proposed protection from retaliation clause may be difficult to implement due to health services often being delivered according to assessed need, and there being inherent differences between the health needs of consumers.

22. In addition, there may be perceptions by consumers or family and whānau of differences in how health services are delivered when in fact, the nature of services provided to another consumer should be confidential to that consumer. Finally, while the principle of non-retaliation is what we would expect to prevail, mandating it may prove challenging. There may be some services and settings where it may not be possible to have an alternative person provide health services to a consumer (e.g. in remote or rural settings; in a service requiring practitioners with specific skills that are not widely available, etc.).

1.3 What other changes, both legislative and non-legislative, should we consider for supporting better and equitable complaints resolution?

23. The templated Code and information about the right to complain requires the inclusion a space for organisations to identify their own complaint process, so that the HDC processes are not a *victim of its own success* in alerting consumers to how to complain to the HDC before complainants have considered whether to first make a complaint to the provider.

Decision making processes

24. NZNO would be assisted by more information relating to the current internal processes within the office of the HDC for making decisions relating to the complaints. For example, NZNO have been advised on multiple occasions that a matter has been referred from the Complaints Assessment Team to the Investigation Team for *further consideration* as to whether an investigation will be commenced. It is unclear how the Complaints Assessment Team's assessment as to whether to investigate differs from the Investigation's Team's assessment. An understanding of what occurs at each stage, and who makes the decision would allow for increased participation in the process.

25. Occasionally we see that several HDC staff appear to be involved in making decisions relating to the complaint process / investigation where the decision itself appears relatively minor. NZNO are unclear what the internal HDC approval process is for decisions relating to complaints resolution / investigation but there may be opportunity to reduce delays.

Triage of complaints referred to the HDC under s64 Health Practitioners Competence Assurance Act 2003

26. NZNO acknowledge the efforts outlined in the consultation document to strengthen the triage process to focus on equity, identification of systemic issues, and supporting early resolution where possible.

27. NZNO consider that an agreed practice or protocol would greatly assist in the making of timely and consistent decisions regarding further inquiry of notifications received from a regulatory authority under section 64 of the Act.

28. From our own observation decisions as to whether the HDC makes further enquiries or refers the complaint back to the regulatory authority can take quite some time, in some instances the process of making this decision has taken up to 12 months. We also note cases of apparent inconsistency in these decisions. As an example, complaints relating to an alleged relationship between a health practitioner and patient have been variously referred back to the regulatory authority or retained by the HDC. We are unclear of the criteria for making these decisions.

29. For instance, we consider that complaints that amount to a breach of the health practitioner's professional Code of Conduct are best dealt with by regulatory authorities. Processes for investigating conduct under the Act are better suited to such allegations which can have serious consequences for the health practitioner. This includes the right for the health practitioner to meet with the Professional Conduct Committee considering the complaint.

30. NZNO suggest that written practices are established between the HDC and regulatory authorities for making section 64 decisions. A clear written practice / process will facilitate more consistent decision making and assist HDC staff to make such decisions in a timely manner.

Clinical Navigators

31. NZNO acknowledge the initiative to introduce clinical navigators to help guide people in the complaints process and support this. Clinical navigators may also be of assistance to HDC staff including complaints assessors, investigators, as well as staff working in the Advocacy Service.

Expert reports

32. Our observation is that expert reports obtained by the HDC in relation to nursing care can be very critical of the practice of individuals and often fail to acknowledge the circumstances in which care was provided, and factors such as the relative inexperience of the nurse who is the subject of critique. At times it appears that this may be a result of the expert assessor's limited understanding of their role as an expert and the wider investigation process. For example, we regularly raise concerns that the expert advisor has not clearly distinguished between *best practice* and an *acceptable standard of care* or has not acknowledged the circumstances in which care was provided that would affect their assessment of the level of any departure from the accepted standard of care.

33. The process of responding to such concerns, and the expert assessor then having the opportunity to reply can add considerably to the investigation time.

34. It is our observation that while expert advisers will be considered *experts* in the clinical field in which they are commenting, many appear not to have had previous experience in providing independent assessment of care or reports used in legal proceedings / investigations. We consider that many of the issues that we regularly identify in relation to expert adviser reports could be minimised if better education and guidance was available to the expert adviser about

not only their responsibilities as an expert advisor but also the role their report will play in the investigation. We would suggest for example that there could be a short online training course available to expert advisers and written guidance to expert advisers about their role. We consider this would assist more efficient investigation processes.

Health practitioners' comments sought through their employer

35. NZNO note the existing practice where individual health practitioners are usually asked for comment through their employer. Although, we accept this practice for initial stages of the complaints assessment or investigation process we are concerned that in some cases response to adverse comment or even a breach finding about a nurse in provisional report is sought via an employer. We have previously raised concern that we consider this practice inconsistent with section 67 of the Act.

36. Not only does this contribute to delay (as it can take time for the health practitioner to receive the correspondence through their employer), but we consider the process to be unfair. In rare cases it has resulted in the nurse receiving insufficient notice or their employer has communicated the approach to them in a way that fails to convey relevant information. While we do not consider there is an issue with this practice where the health practitioner is one of a number of health practitioners the subject of the same adverse comment, where the health practitioner is the primary subject of the complaint correspondence should be sent to them directly as a matter of a fair and equitable process.

Topic 2 Making the Act and Code more effective for, and responsive to, the needs of Māori

37. This section covers issues of Kawa Whakaruruhau – Cultural safety and reflects the often-poor experiences Māori have when seeking the health care they need. These poor experiences clearly impact on the well-being and are a factor in the disparities in health outcomes between Māori and non-Māori. The review identifies how the HDC, the Act and the Code can be more responsive and therefore more effective for Māori whānau.

38. The review notes the importance of te Tiriti o Waitangi in shaping how effectively the health sector and the HDC can improve the wellbeing of Māori. The Review goes a long way to identifying key factors that would improve the responsiveness of the HDC. Like many reviews, however, the focus on the specifics of te Tiriti rather than the whole, as a covenant.

39. The Review is clear and should lead to significant progress in engaging Māori with the HDC and the Code. It does, however, focus on individual patients and health care workers, which leaves the systemic problems for Māori often ignored. The systemic bias towards culture and western science places non-Europeans at a disadvantage. This is described as institutional racism and has been identified as a significant factor in the low level of access to health services.

40. Institutional racism empowers and reinforces personal racism of health workers and reflects a Eurocentric world view. This is much harder for the HDC and the Code to respond to; but options should be explored. One option would be to consider class actions on behalf of communities who receive demonstrably substandard care.

41. This is certainly an issue for the HDC and hopefully this review will raise practical ways to improve Māori patient experience.

2.2 What do you think about our suggestions for making the Act and the Code more effective for, and responsive to, the needs of Māori, and what impacts could they have?

42. NZNO support steps that enhance a health providers' understanding of bias and institutional racism.

Topic 4 Considering options for a right of appeal of HDC decisions

4.2 What do you think about our suggestions for considering options for a right of appeal of HDC decisions, and what impacts could they have?

43. Of the two options suggested in the consultation document, NZNO prefers a statutory requirement for review of HDC decisions. The current suggestion identified in the consultation document is that this requirement is comparable to the provision in the Health Care Complaints Commission Act 1993 (New South Wales). However, we note that the New South Wales provision only allows this right to the complainant. As a matter of a fair and equitable process, and in acknowledgement of the potential consequences to a health practitioner who is the subject of a complaint, we consider that the right to seek review of a decision should also be available to health providers and health practitioners. We support the view that there should be a requirement that the original decision maker is not part of the review process.

44. NZNO have significant concerns regarding the suggestion of lowering the threshold for access to the Human Rights Review Tribunal (HRRT). Proceedings in the HRRT would not actually involve a review or appeal in relation to decision made by the HDC but would simply provide another avenue for health consumers to raise complaints.

45. Currently the only threshold required for HRRT proceedings in relation to the Code is that there has been a finding that a provider has breached the Code. The removal of that requirement would result in a right to take cases to the HRRT where the HDC has already investigated but determined that a breach of the consumer’s rights did not occur.

46. It is not unusual that complainants focus their complaint on the individual health practitioners who provided their healthcare. At times this is a result of limited understanding of the context in which care was provided which can include issues such as resourcing. We acknowledge the role the HDC currently plays in investigating not only individuals, but systemic issues within the healthcare system. It is not uncommon that following investigation, a breach finding may be made about the healthcare organisation but not the individual health practitioners. The removal of the requirement for a breach finding for HRRT proceedings would disproportionately affect individual health practitioners if complainants feel an individual has not been held accountable.

47. Effective processes for managing health practitioners who present a risk to public safety already exist under the Act. Many health practitioners already fear the prospect of legal proceedings as a result of the daily decisions they make often in emergency situations or in the context of resource constraints. There are already concerns about the difficulties in Aotearoa of attracting and retaining experienced nurses and we note significant concerns about the prospect of a further avenue for proceedings against them.

48. NZNO members currently hold indemnity insurance for HRRT proceedings as well as complaints made to the HDC through their membership with NZNO.

49. Members of NZNO do not pay separately for their indemnity insurance, it is included within the cost of their membership which also includes access to bargaining for collective employment agreements, industrial and professional services. Proceedings in the HRRT carry the potential for a financial award up to $350,000.

50. NZNO are concerned about the prospect of lowering the threshold of complaints made to the HRRT, where the hearings are public and there is the potential in limited circumstances that awards may be made for damages for losses suffered, including injury to feelings, humiliation, and loss of dignity. This risks the process becoming like that in the US (litigation-style awards and public dissection of events, many factors of which may be beyond the individual practitioner/s' influence.

Topic 5 Minor and technical improvements

5.1 What do you think about the issues and suggestions for minor and technical improvements, and what impacts could they have?

51. NZNO questions the expansion of the definition of *aggrieved person* to include the whānau of a deceased person. For example: one view supports processes not being so restrictive as to close off opportunities for the family and whānau of an individual who dies during the delivery of health care delivery. However, that needs to be balanced with the family and whānau of a deceased individual receiving appropriate advice and support about the factors that contributed

to the death and whether there is a reasonable basis for making a complaint. We would be concerned if family and whanau's grief about death blinded them to the inevitability of the health consumer's situation and became weaponised as a way for the providers to be held to an unreasonable standard of care.

5.2: What other minor and technical improvements, both legislative and non-legislative, should we consider?

52. NZNO has a view that the other proposed improvements appear reasonable (a-c and e-i)

5.3: What are your main concerns about advancing technology in relation to the rights of people accessing health and disability services?

53. It is difficult to know what the risks of advancing technology without knowing the capability of that technology or the circumstances in which it is implemented. We seek consideration for all new technological developments to be *tested* and *pass* some form of ethical approval where potential issues for all stakeholders are identified and debated to ensure the interests of all parties are upheld.

Conclusion

54. NZNO supports the Act and the Code in relation to promoting and protecting the rights of health and disability consumers. The review provides a timely opportunity to ensure the Act and Code remain *fit for purpose* and address any issues that arise.

Thank you for the opportunity to contribute to your consultation process.

Nāku noa nā

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