

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



*A resource for
public consultation
February 2004*

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Statement from the Commissioner

E ngā mata-ā-waka o te motu, tēnā koutou katoa.

All groups throughout the land, greetings to you all.

Purpose of review

I am currently undertaking a review of the Health and Disability Commissioner Act (the Act) and the Code of Health and Disability Services Consumers' Rights (the Code) to consider whether any changes are necessary or desirable. Under sections 18 and 21 of the Act I am required to undertake these reviews and report my findings to the Minister of Health.

Changes since the 1999 review

The first review of the Act and Code was undertaken by the inaugural Commissioner, Robyn Stent, in 1999. That review and the Cull Report on the Review of Processes Concerning Adverse Medical Events in 2001 have resulted in a number of changes to the Act as part of the 'Health Practitioners Competence Assurance' legislative reforms.

The changes are set out in the Health and Disability Commissioner Amendment Act 2003 (HDC Amendment Act). The Commissioner's complaints resolution processes, in particular, will be significantly improved. There will be more flexibility to deal with complaints appropriately so that the powers of investigation are used as effectively as possible and reserved for appropriate cases. The reforms also provide for better agency interaction to protect the public and minimise unnecessary duplication of process. The changes come into force on 18 September 2004 and will apply to complaints in respect of which no investigation has been commenced before that date.

A change is currently pending in relation to Right 7(10) of the Code, which deals with informed consent for the storage and use of body parts and substances. The change, which provides for a limited exception subject to the approval of an ethics committee, is discussed at page 42.

Focus of the review

This review includes discussion of the Act and Code based on my own experience of their operation as well as feedback received from consumers, providers, and others. The main concerns I had with the operation of the Act and the Code have been addressed by the changes introduced by the HDC Amendment Act and the amendments to Right 7(10). In my view, there is little need for further amendment at this stage.

As a preliminary comment to this review, the Ministry of Health has also commented:

The Ministry considers that the amendments made to the Health and Disability Commissioner Act by the Health Practitioners Competence Assurance legislation will considerably streamline the complaints system, provide the Health and Disability Commissioner with more flexibility in dealing with complaints, and improve the exchange of information between agencies on public safety concerns. Given these

reforms, the Ministry has no suggestions about any further amendments that are necessary or desirable to the Health and Disability Commissioner Act.

The recent decision by Cabinet to amend Right 7(10) of the Code to allow for exceptions from the informed consent provisions for the storage, preservation or use of bodily substances or body parts obtained in the course of a health care procedure, in relation to research and auditing and evaluation activities, addresses any immediate concerns about the workability of the current Code. The Ministry therefore has no specific suggestions about amendments to the Code.

The timing of this review is less than optimal, especially in relation to Part IV of the Act. There is little point in considering whether changes to existing provisions are necessary or desirable, when they will change in September 2004. Similarly, it is difficult to evaluate the effectiveness of provisions that are not yet operational.

For that reason, in my view, further amendment is not necessary or desirable at this stage. However, I have outlined the key changes and highlighted some remaining matters that seem to me to require consideration.

Your feedback

It is important to receive your input. I welcome discussion on any aspect of the Act or Code, regardless of whether the matter you wish to raise is specifically discussed in this document. I do suggest, however, that you focus your feedback on how the Act will operate once the changes come into effect.

You may wish to obtain background material to assist in making your comments. For example, copies of the Act (1994, No 88) and the HDC Amendment Act (2003, No 49) are available from any Bennetts Bookshops, and the Code is available from my office. For those with access to the internet, the HDC website (www.hdc.org.nz) provides links to this discussion document, the Code, the Act, and the HDC Amendment Act. The Act and the HDC Amendment Act may be accessed at www.legislation.co.nz.

A series of consultation meetings in the main centres and some regional cities commence in March 2004. You are welcome to attend any of these meetings, the details of which are included in Appendix B.

How to have your say

To simplify the process of providing me with your comments, this document has been structured into separate parts, and questions have been presented at the end of key sections. The questions are listed at the end of the document in Appendix A. You may wish to use this list as a guide when formulating your comments.

Written submissions may be e-mailed to hdc@hdc.org.nz or posted to:

Review of the Act and Code
Health and Disability Commissioner
PO Box 12299
WELLINGTON

Submissions must reach my office no later than **Friday, 30 April 2004**.

Confidentiality

The final report to the Minister will contain a list of submissions received and may refer to individual submissions. If you wish your submission, or any part of it, to be treated confidentially, please indicate this clearly. The Health and Disability Commissioner is subject to the Official Information Act and

copies of submissions may therefore be released on request. Any request for withholding information on the grounds of confidentiality or any other reason will be determined in accordance with that Act.

Conclusion

Thank you for your contribution to this review process. I look forward to hearing your views. Should you have any queries, please contact my office.



Ron Paterson
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

27 February 2004

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A. Framework of the Act and Code

The Health and Disability Commissioner Act

The Health and Disability Commissioner Act was enacted on 20 October 1994 to promote and protect the rights of health and disability services consumers and, to that end, to facilitate the resolution of complaints relating to infringements of those rights.¹

The Act established the office of the Health and Disability Commissioner, an independent statutory Ombudsman, provided for the drafting of the Code of Health and Disability Services Consumers' Rights,² and set up a process for dealing with complaints about alleged breaches of those rights. The Director of Advocacy and the Director of Proceedings, both of whom are independent of the Commissioner, are also appointed under the Act.

Objectives of the Act

The Act provides the Commissioner with the power to inquire into, investigate, make recommendations and resolve complaints by consumers about providers of health and disability services. The Act is broad ranging and covers all providers of health and disability services — public or private, registered or unregistered. Consumers are widely defined to cover all users of health or disability services, not simply patients in traditional hospital and community settings.

The Act is deliberately consumer focused. It recognises the imbalance of knowledge and power between consumers and providers and seeks to achieve a greater level of partnership between these groups to ultimately improve service quality.

Operation of the Act

The Act balances a number of different aims. On one hand, the Act provides a mechanism for consumers to resolve suitable complaints directly with the service provider. On the other, it seeks to ensure proper accountability of health and disability service providers by maintaining the role of an independent public watchdog. It also encourages, through education and publicity, an increased awareness of consumer rights, and supports improvements in the overall quality of services.

Effect of the Act

As awareness of the Act and Code continues to increase, the positive effects of the Act are being seen. Consistent with the Act's focus on low-level resolution, the majority of complaints that do not raise public safety issues are being resolved through advocacy and mediation or with assistance from the Commissioner. For example, in the year ending 30 June 2003, 31% of complaints³ were closed without investigation as a result of the complaint being withdrawn, or being resolved by the Commissioner, through advocacy, or by agreement between the parties.

When investigation is necessary, and this results in a Commissioner's report on a breach of the Code, there is good evidence that these reports are increasingly being used by providers as a tool for education and quality improvement. The Commissioner also contributes to quality improvement by distributing

1 Section 6

2 The Code is set out in the Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996

3 354 out of 1,152 complaints in the year ending 30 June 2003

key reports to agencies in the health and disability sector and advocating on behalf of consumers at a systemic level in policy and media debates. This plays a significant role in influencing developments in the medico-legal and regulatory environments.

While the steady volume of complaints from consumers continues,⁴ providers have demonstrated a greater willingness to participate in the process. In relation to individual breaches of the Code, the Commissioner most commonly recommends that the provider apologise to the consumer, and review his or her practice in light of the final report. Over the last three years there has been a steady reduction in the number of recommendations relating to apologies, reflecting a greater willingness on the part of providers to offer an apology before the matter reaches final report stage.

Recent statistics

In the year ended 30 June 2003, the Commissioner received 1,159 complaints about 1,383 providers. The most common complaints concerned services provided by public hospitals and general practitioners,⁵ reflecting the high level of contact these providers have with the general public.

Of the 1,159 complaints received, 345 resulted in investigations. However, only 261 of those cases resulted in a written report, as a number of complaints were resolved during or after the investigation process. Of the 261 complaints that led to a written report, 113 resulted in a finding that a breach of the Code had occurred. In the remaining 148 matters, it was decided that either the matters complained of did not give rise to a breach of the Code, that the provider acted reasonably in the circumstances,⁶ or that there was insufficient evidence to establish the complaint.

Of the 113 matters where a breach of the Code was found, 27 resulted in one or more providers being referred to the Director of Proceedings to consider disciplinary action.

Few matters result in discipline

This low percentage of referrals for disciplinary action⁷ is consistent with the dramatic decline in medical discipline since the Act and the Code came into operation in 1996 and since the implementation of competence reviews by the Medical Council.⁸ The New Zealand system emphasises the rehabilitation of practitioners, rather than punishment, and is consistent with modern understanding of the nature of error and the importance of a culture of learning to improve patient safety.

The Commissioner's process does not seek to name, blame or shame individual providers. In fact, multiple studies have shown that the overwhelming majority of errors are made by well-trained, conscientious people who are trying to do a good job, but are caught in a faulty system that set them up to make a mistake.⁹

The Act allows the Commissioner to find an organisation in breach of the Code, in recognition of the role that systems play in the delivery of health care and disability services. Where an organisation is found to have breached the Code, the three most common recommendations are that the organisation

4 Approximately 1,200 complaints each year

5 Of 1,383 complaints received in the year ending 30 June 2003, 243 complaints concerned general practitioners and 355 complaints concerned public hospitals

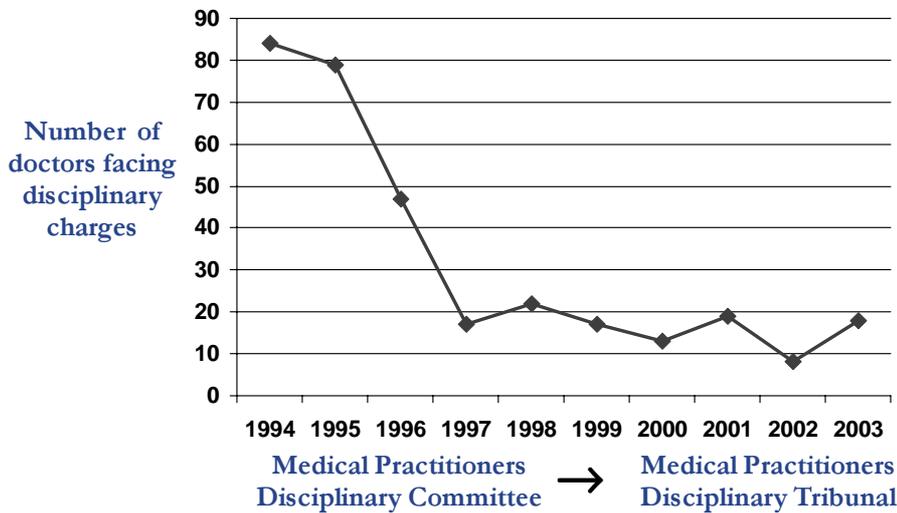
6 Clause 3 of the Code of Health and Disability Services Consumers' Rights

7 27 referrals out of 1,159 complaints received (2.3%)

8 This useful remedial tool will be available to other registration authorities under the Health Practitioners Competence Assurance Act 2003

9 Leape, L, "Preventing Medical Accidents: Is 'systems analysis' the answer?" *American Journal of Law and Medicine* 27 (2001) p 148.

review its policies and/or practices in light of the Commissioner’s report, provide the consumer with a written apology, and provide its staff with further education or training in a specific area. Over the last three years, some form of audit (internal or external) has been recommended in around 10% of breach reports involving public hospitals.



Health complaints in other jurisdictions

Independent commissions for considering and resolving complaints about health services have also been set up in the Northern Territory, Victoria, Queensland, Western Australia, New South Wales, Tasmania and the ACT.

The Australian commissions have certain key features in common:

- they encourage resolution of the complaint at point of service;
- they provide informal processes to resolve the complaint in preference to formal investigations;
- they carry out a preliminary assessment of complaints to ensure they are resolved at an appropriate level;
- the main method for formal resolution is conciliation;
- investigation of complaints primarily occurs where there are significant issues of competence or public safety;
- the governing statutes provide for recommendatory processes rather than determinative powers.

In Australia, the focus is on formal conciliation as a means of resolving complaints. Complaints are investigated only if conciliation is unsuccessful in resolving the matter. In New Zealand, the Commissioner does not have a formal role as an independent conciliator. Complaints are often “settled” with the assistance of advocates before they are referred to the Commissioner, but the advocates’ role is not impartial.

Although Tasmania, Queensland and the Northern Territory have Codes of patients’ rights, only the New Zealand Code is embodied in legislation. The Health and Disability Commissioner Act is also unique in that it is the only legislation in Australasia that specifically provides an independent advocacy service for health and disability consumers. Although it is not provided for in its governing legislation, the New South Wales Commission has introduced a similar patient support service as an administrative initiative. This service enables anyone dissatisfied with health services to seek assistance from a patient support officer, who will assist the patient in resolving his or her concerns directly with the provider.

The following table¹⁰ illustrates the differences between the Australian jurisdictions and the New Zealand model:

	NT	NSW	VIC	QLD	WA	ACT	TAS	SA	NZ
Health Commission	•	•	•	•	•	•	•		•
Formal investigation	•	•	•	•	•	•	•		•
Formal conciliation	•	*	•	•	•	•	•		
Advocacy		•							•
Part of Ombudsmen's office	•						•	•	
Act includes services for aged	•					•			•
Act includes services for disabled	•					•			•
Consult with Boards	•	•	•	•	•	•	•		•
Prosecutorial function		•							•
Assessment timeframe	•	•	•	•	•		•		
Extension of assessment option		•	•	•					
Code	•			•			•		•
Act under review	•	•			•	•	•	•	•
* In NSW the conciliation function is carried out by a separate body. The conciliation process is also substantively different to the formal conciliation models in other jurisdictions.									

The Code of Health and Disability Services Consumers' Rights

The Code of Health and Disability Services Consumers' Rights sets out 10 legally enforceable rights of all consumers of health or disability services. These include the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to effective communication, to be fully informed and to give or withhold consent, to services of an appropriate standard, and to complain.

The Code rights are not absolute. It is a defence for providers to prove that they have taken "reasonable actions in the circumstances". Relevant circumstances include "the consumer's clinical circumstances and the provider's resource constraints".¹¹

Breach reports

In the year ended 30 June 2003, 33% of complaints that were investigated resulted in a finding that a breach of the Code had occurred.¹² Inadequate information, poor communication, inappropriate clinical standards and poor record keeping are the key themes in the majority of breach reports.

10 Based on a table from "A Discussion Paper to Seek Input from the Public to the Review of the Health and Community Services Complaints Act 1998" published by the Health and Community Services Complaints Commission, Darwin, August 2003

11 Clause 3 of the Code of Health and Disability Services Consumers' Rights

12 113 breach reports out of 345 complaints investigated

B. The Act

1.0 Preliminary provisions

1.1 Overview

Sections 1–7 of the Act set out some preliminary provisions dealing with such matters as definitions and the purpose of the Act. These provisions establish the conceptual basis that underpins the rest of the Act.

1.2 Definitions: sections 2–4

Section 2 sets out a series of definitions that are used to give a standard meaning to words or phrases that occur frequently in the Act, such as “health consumer”, “disability services consumer”, “disability services” and “health services”. Other definitions appear in section 3 (“health care provider”) and section 4 (“registered health professional”).

A good set of definitions is important for the effective operation of the Act. The definitions assist in interpreting and applying all other provisions in the Act, as well as those in the Code. The definitions of “provider”, “consumer” and “services”, for instance, largely determine the scope of application of the Act and Code.

1.2.1 New definitions

The HDC Amendment Act will introduce three new definitions to bring the Health and Disability Commissioner Act into line with the terminology used in the Health Practitioners Competence Assurance Act.

Previously, health professional bodies existed under their individual health registration enactments (eg, the Nursing Council was established under the Nurses Act 1977). Those enactments have been repealed and health professional bodies (now called “authorities”) operate under the Health Practitioners Competence Assurance Act. Given this legislative change, there is no longer a need to define a “health registration enactment” in section 2 of the Health and Disability Commissioner Act, and it will be repealed.

Similarly, the definition of a “health professional body” in section 2 will be repealed and replaced with “authority”. The definition of an “authority” will be the same as in section 5 of the Health Practitioners Competence Assurance Act — the body that is responsible for the registration and oversight of practitioners of a particular health profession.

Finally, the definition of a “registered health professional” in section 4 will be repealed and replaced with “health practitioner” in section 2. A “health practitioner” is given the same definition as in section 5(1) of the Health Practitioners Competence Assurance Act, and will include:

- a former health practitioner;
- a person who was registered under a former health registration enactment; and
- a person who is receiving training or gaining experience under the supervision of a health practitioner.

1.2.2 Unregistered providers

As a preliminary comment to this review, one District Health Board noted that unregistered providers, such as social workers, are not covered by the Health Practitioners Competence Assurance Act. That is correct but does not affect the Commissioner’s jurisdiction.

The definition of a “health care provider” in section 3 of the Health and Disability Commissioner Act is very broad. It includes hospitals, health practitioners and “any other person who provides, or holds himself or herself or itself out as providing, health services to the public or to any section of the public, whether or not any charge is made for those services”. Both registered and unregistered providers are covered by this definition, and the Health Practitioners Competence Assurance Act has not changed the scope of the Commissioner’s jurisdiction in this regard.

Question 1

Are the definitions in the Act adequate and appropriate? If not, what changes do you suggest?

1.3 Purpose of the Act: section 6

Section 6 sets out the purpose of the Act:

The purpose of this Act is to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights.

The Act has a dual purpose: complaints resolution and education. In practice, the office reflects this duality in our mottos — “resolution not retribution” and “learning not lynching”.

The Commissioner’s broad educative function is reflected in the requirement to protect consumers and promote their rights. This is a specific function of the Commissioner under section 14.¹³ The Commissioner also has a specific complaints resolution function — to facilitate resolution of complaints.

The Commissioner receives around 1,200 complaints each year. One of the biggest challenges is to achieve “fair, simple, speedy, and efficient” resolution of complaints. With a focus on low-level complaint resolution, advocacy and mediation are useful tools for resolving complaints that raise no issues of exploitation, incompetence or public safety. The independent nationwide advocacy service has a success rate of around 75% in resolving complaints.

Complex or serious cases, particularly those involving multiple providers or systemic issues, are usually investigated. Balancing the objectives of “fair” and “speedy” is not always easy, as parties and witnesses must be interviewed, patient records reviewed and, where the appropriate standard of care is in issue, expert independent clinical advice is obtained. Most investigations result in a detailed written report to the parties. As a matter of natural justice, providers and any other person adversely affected by the report must be given an opportunity to comment before the report is finalised.

Both consumer and provider groups have identified concerns about the length of time it takes to complete the investigation process. The good news is that productivity has increased and the backlog of files has been dramatically reduced over the last three years. As at 1 January 2004, there were under 400 open files, of which around 200 were investigations. 87% of all files and 75% of investigation files were less than one year old. In 2000, there were over 500 open investigation files, including a significant number of very old files.

13 See the discussion on the Commissioner’s functions at paragraph 2.3 below

Good progress continues to be made in improving the quality and timeliness of investigations. Our caseload and timeliness figures compare very favourably with similar jurisdictions in Australia. The ongoing challenge is to resolve the majority of investigations within 12 months of receiving the complaint. I am confident that the changes introduced by the HDC Amendment Act will enhance timeliness.

Question 2

Is the purpose of the Act appropriate? If not, what changes do you suggest?

1.4 Reference to Treaty of Waitangi

Currently the Act does not refer to the Treaty of Waitangi or require all persons exercising functions and powers under the Act to have regard to the Treaty of Waitangi.

As Commissioner, I have striven to apply the Treaty principles of partnership, protection and participation through:

- training on the Treaty and the Māori world view for all staff
- offering staff the opportunity to attend te reo Māori classes
- recognition of Treaty principles within the Human Resource policy
- developing a desktop reference book, “He Tohu Ārahi i te Mahi Tahī ki te Māori” (Guidelines for Working with Māori)
- recognition of the Treaty in the advocacy service requirements
- developing guidelines for collecting Māori ethnicity data to ensure appropriate information is available for service planning
- an education focus on Māori consumers and use of appropriate educational materials

An amendment to the Act, to include specific reference to the Treaty of Waitangi, may enhance confidence in the role of the Commissioner and encourage Māori participation in the processes established by this legislation. This in turn may assist in improving the quality of services to Māori.

Question 3

Should the Act be amended to include an obligation that all persons exercising functions and powers under it have regard to the principles of the Treaty of Waitangi?

2.0 Part I: Health and Disability Commissioner

2.1 Overview

Part I of the Act, sections 8 to 18, explains the status, appointment, qualifications, term and functions of the Commissioner. The Health and Disability Commissioner is appointed by the Governor General, on the recommendation of the Minister of Health, to fulfil the Commissioner's functions as specified in the Act for a term of up to five years (renewable).

2.2 Deputy Commissioners: section 9

The Act also allows for the appointment of a Deputy Commissioner, who may undertake the functions of the Commissioner in his or her absence. There is currently provision for the appointment of only one Deputy Commissioner, and the Commissioner cannot delegate his investigative functions. The HDC Amendment Act will amend section 9 of the Act to provide for the appointment of more than one Deputy Commissioner¹⁴ and will allow the Commissioner to delegate any of his functions to a Deputy Commissioner.

I consider that this amendment will result in a more efficient allocation of resources and do not recommend any further changes.

2.3 Functions of the Commissioner: section 14(1)

Section 14(1) lists the general functions of the Commissioner. These are set out below in full because of their importance to the Act:

- (a) As a first priority, to prepare a draft Code of Health and Disability Services Consumers' Rights in accordance with section 19 of this Act:
- (b) In accordance with section 21 of this Act, to review the Code and make to the Minister any recommendations for changes to the Code:
- (c) To promote, by education and publicity, respect for and observance of the rights of health consumers and disability services consumers, and, in particular, to promote awareness, among health consumers, disability services consumers, health care providers, disability services providers, and purchasers, of the rights of health consumers and disability services consumers and of the means by which those rights may be enforced:
- (d) To make public statements and publish reports in relation to any matter affecting the rights of health consumers or disability services consumers or both, including statements and reports that promote an understanding of, and compliance with, the Code or the provisions of this Act:
- (e) To investigate, on complaint or on the Commissioner's own initiative, any action that is or appears to the Commissioner to be in breach of the Code:
- (f) To refer complaints, or investigations on the Commissioner's own initiative, to the Director of Proceedings for the purpose of deciding whether or not any further action should be taken in respect of any such breach or alleged breach:
- (g) Subject to section 15(2) of this Act, to make recommendations to any appropriate person or authority in relation to the means by which complaints involving alleged breaches of the Code might be resolved and further breaches avoided:
- (h) To prepare guidelines for the operation of advocacy services in accordance with section 28 of this Act:

14 Section 6 HDC Amendment Act

- (i) To make suggestions to any person in relation to any matter that concerns the need for, or the desirability of, action by that person in the interests of the rights of health consumers or disability services consumers or both:
- (j) On the Commissioner's own initiative or at the request of the Minister, to advise the Minister on any matter relating to
 - (i) The rights of health consumers or disability services consumers or both; or
 - (ii) The administration of this Act:
- (k) To report to the Minister from time to time on the need for, or desirability of, legislative, administrative, or other action to give protection or better protection to the rights of health consumers or disability services consumers or both:
- (l) To receive and invite representations from members of the public and from any other body, organisation, or agency on matters relating to the rights of health consumers or disability services consumers or both:
- (m) To gather such information as in the Commissioner's opinion will assist the Commissioner in carrying out the Commissioner's functions under this Act:
- (n) To do anything incidental or conducive to the performance of any of the preceding functions:
- (o) To perform such functions as the Commissioner is for the time being authorised to perform by the Minister, by written notice to the Commissioner after consultation with the Commissioner:
- (p) To exercise and perform such other functions, powers, and duties as are conferred or imposed on the Commissioner by or under this Act or any other enactment.

It is important for the Commissioner to have sufficiently broad functions to enable the purpose of the Act to be fulfilled, and section 14 has been amended by the HDC Amendment Act to expand the Commissioner's functions. I consider that the functions of the Commissioner are appropriate and do not recommend any further changes.

2.3.1 Promote and protect: sections 14(c) and 14(d)

The Commissioner is specifically required to promote, through education and publicity, respect for consumers' rights, and to make public statements and publish reports in relation to any matter affecting the rights of health consumers. As an independent statutory agency, the office of the Commissioner is well placed to advance consumers' interests and play a key role in shaping public policy debate.

Advocating on behalf of consumers

As a preliminary comment to this review, Women's Health Action has suggested that the Commissioner should develop a more active role as an advocate for classes of consumers and the public as a whole.

This aspect of the Commissioner's function is generally fulfilled in two ways — by making comments on matters of public interest to the media, and by making submissions on key policy documents and proposed legislation. The submission work is not always as visible to the public but is nevertheless an important part of the Commissioner's role in advocating for consumer issues. For example, in the year ended 30 June 2003, submissions by the Commissioner included:

- the Health Practitioners Competence Assurance Bill;
- a Mental Health Commission draft report on mental health issues for Asians in New Zealand;
- Ministry of Health discussion documents on promoting public health and managing communicable diseases;
- the Human Assisted Reproduction Technology Bill;

- a Medical Council draft statement on the presence of a third person in a medical consultation;
- a National Health Committee's discussion document on screening appraisal criteria; and
- draft standards on Home and Community Support and Ambulance Services.

Consumer education

As a preliminary comment to this review, the Ministry of Women's Affairs has suggested that the Code should be widely publicised. I agree that it is imperative for consumers to learn about their rights and how they can be enforced. Section 14(c) specifically requires the Commissioner to promote consumers' rights through education. This is an obligation to educate consumers and providers about consumers' rights and how those rights can be enforced.

General information about the Code and the Commissioner's processes is available through:

- booklets explaining the rights in the Code and how to make a complaint;
- posters and booklets sent to providers for display in public areas;
- a plain language poster, brochure and guide about the Code and HDC processes published in conjunction with IHC in 2002;
- a brochure on advance directives by mental health consumers produced in conjunction with the Mental Health Commission in April 2003;
- the HDC website which includes information on the Code, case notes of key decisions, and full copies of key opinions (www.hdc.org.nz/opinions); and
- a toll free number for both consumers and providers to make enquiries about any aspect of the Code or the Commissioner's process (0800 11 22 33).

As far as educating consumer groups is concerned, I have focused more recently on establishing educational relationships with consumer groups such as the New Zealand Cardiac Club, Challenge Trust and People First (IHC). There has also been a focus on delivering educational programmes to disabled, Māori and Pacific Island consumers.

In June 2003 an HDC Consumer Advisory Group was formed. The role of the group is to provide timely advice and feedback to the Commissioner on strategic issues, including:

- handling of consumer complaints about health and disability services;
- how to improve the quality of health and disability services;
- public interest issues where the Commissioner can take a lead;
- policy issues raised by the Commissioner; and
- promotion and education.

Provider education

Providers are educated through presentations to hospitals, university classes (in particular, to medical students), and provider groups, and by regular columns in provider publications. An emphasis has also been placed on using key opinions as an educational tool for provider groups working in a similar area. It is anticipated that future complaints may be avoided if providers are able to learn from the lessons of their peers.

Prior to closing a file, a check is made to ensure that any lessons learned from the individual case are being used to inform relevant parts of the health and disability sector. This is achieved by sending the relevant College or professional group, major employers (such as District Health Boards) and consumer groups anonymised copies of key decisions.

The decision as to who should receive a copy of the final report is made on a case-by-case basis. In 2003, around 80% of breach reports were sent to at least one professional College.

Other recipients of anonymised reports include coroners, the Mental Health Commission, the Accident Compensation Corporation, Quality Health New Zealand, consumer groups such as Women’s Health Action, the Federation of Women’s Health Councils of Aotearoa and the Maternity Services Consumer Council, and provider organisations such as the Resident Doctors Association.

These initiatives show that HDC is increasingly developing a dual focus on:

- the resolution of individual concerns; and
- brokering change and broader education, using consumer complaints as a window of opportunity for quality improvement in the health and disability sectors.

2.3.2 One-stop shop

The HDC Amendment Act introduces two new functions to section 14.¹⁵ The first is not a new role; however, it confirms the Commissioner’s function as the initial recipient of complaints about health care providers and disability services providers (new section 14(1)(da)). A number of consumers and providers have commented that it can be confusing when several agencies are involved in health care complaints and it is not clear who to complain to and what the respective roles of the agencies are. Section 14(1)(da) now confirms that the Commissioner is to act as the initial recipient of all complaints about health and disability services providers.

2.3.3 Complaints about events prior to 1 July 1996

Section 14(1)(e) of the Act will be amended to enable the Commissioner to consider “any action that is or appears to be in breach of the Code *or, in the case of conduct that occurred before the enactment of the Code, in breach of certain disciplinary standards*” (emphasis added).¹⁶

This expands the jurisdiction of the Commissioner into the previous domain of the health professional bodies. When the amendments come into effect, the Commissioner will have the power to consider patient care complaints about events that occurred before 1 July 1996.

As time moves on, fewer complaints are received about events that occurred before 1 July 1996. In the year ended 31 May 2002, the Medical Council received 70 complaints against doctors relating to events before 1 July 1996, a decrease from 382 such complaints the previous year.¹⁷ In the past two years, the Nursing Council has received approximately four complaints (relating to 11 nurses) where the conduct occurred before 1 July 1996.¹⁸

All such complaints will be considered by applying the duties or obligations that were binding at the time when the alleged incidents occurred.¹⁹ The length of time that has elapsed between the incident and the making of the complaint will also be considered by the Commissioner when deciding how to deal with the complaint.²⁰ In resolving these pre-July 1996 complaints, the Commissioner may refer the relevant health practitioner to the Director of Proceedings for the institution of disciplinary proceedings but not for proceedings before the Human Rights Review Tribunal.²¹

15 Section 7(2) HDC Amendment Act

16 Section 7(3) HDC Amendment Act (emphasis added). Section 14(1)(g) has also been amended to enable the Commissioner to receive complaints alleging a provider is or appears to be in breach generally (“of the Code” has been omitted).

17 Medical Council Annual Report, 2001/02, p 28

18 Personal communication from Investigator, Nursing Council

19 Section 217(4) HPCA Act

20 New section 38(2)(a)

21 New section 45(4)

It is important for the Commissioner to have sufficiently broad functions to enable the purpose of the Act to be fulfilled. I consider the functions expressed in section 14 are appropriate to achieve this purpose.

Question 4

Are the functions of the Commissioner appropriate? If not, what amendments do you suggest and why?

2.4 General requirement to consult

Section 14(2)(b) requires the Commissioner, in performing his or her functions, to consult and co-operate with other agencies concerned with personal rights, including the Ombudsmen, the Human Rights Commission, the Race Relations Commissioner, the Commissioner for Children, the Privacy Commissioner and the Director of Mental Health.

There has been considerable discussion over the years about the relationship between the Act and Code, which apply to all health and disability service consumers, and the Mental Health (Compulsory Assessment and Treatment) Act 1992, which also confers a number of rights on consumers of mental health services. As a preliminary comment to this review, the Ministry of Health has noted that there are practical issues regarding the respective jurisdictions of the Commissioner and the District Inspectors operating under the Mental Health (Compulsory Assessment and Treatment) Act.

My current practice is to consult on a case-by-case basis with District Inspectors when I receive a complaint from a mental health consumer subject to a compulsory treatment order, to determine the appropriate jurisdiction for dealing with the complaint. If a referral is necessary, this is actioned under section 59(4).²²

The Ministry of Health has also noted that the Intellectual Disability (Compulsory Care and Rehabilitation) Act, which comes into force in mid-2004, may raise further issues concerning the jurisdiction of District Inspectors. I note that section 97(4) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act requires the responsible District Inspector to notify the Commissioner of every complaint that concerns a breach of the Code. I therefore anticipate that a similar protocol will develop concerning complaints from consumers subject to that legislation.

I do not consider that the Act needs to be amended to specifically deal with the Commissioner's interface with District Inspectors.

2.5 Director of Proceedings

The Act provides for the appointment, by the Commissioner, of a Director of Proceedings. Section 15 provides that the Director shall act independently of the Commissioner in performing his or her functions, but be responsible to the Commissioner for the efficient, effective and economical management of the activities of the Director.

In performing the powers, duties and functions prescribed by the Act, the Director of Proceedings is currently allocated a budget by the Commissioner. As a preliminary comment to this review, the Director

²² Section 59(4) will remain unchanged by the HDC Amendment Act

of Proceedings has suggested that there may be potential for the independence of the Director's role to be compromised in having to negotiate with the Commissioner for the allocation of funding, and that such negotiations should occur directly with the Ministry of Health. I welcome any comments or feedback on this matter.

Question 5

Should the Director of Proceedings be able to negotiate funding directly with the Ministry of Health?

2.6 Delegation by the Director of Proceedings

Section 49 requires the Director of Proceedings to decide whether to institute proceedings or to take any of the other actions contemplated by the Act when a matter is referred by the Commissioner. The duty to make this decision cannot be delegated to counsel.²³

In practice, this means that every matter referred by the Commissioner must be personally reviewed by the Director of Proceedings before a decision can be made as to whether proceedings should be commenced or any other action taken. This has caused delays when a number of matters are referred by the Commissioner in close succession. The inability to delegate this function could also result in a conflict of interest in situations where the Director of Proceedings is required to review a matter involving a personal acquaintance.

As a preliminary comment to this review, the Director of Proceedings has suggested that the Act should be amended to enable the Director of Proceedings to delegate powers, duties and functions under the Act to enhance administrative efficiency and to provide an alternative in situations giving rise to a conflict of interest.

Question 6

Should the Director of Proceedings be able to delegate powers, duties and functions under the Act?

2.7 Review of operation of the Act: section 18

Section 18 requires the Commissioner to carry out a review of the operation of the Act and report the findings to the Minister. This is to occur at five-yearly intervals.

Given the level of resources necessary to conduct such a review, and the time required for legislative reform, I question whether ongoing reviews are necessary. Most New Zealand statutes have no such provision, or provide only for a one-off initial review (such one-off provisions are found in some of the

23 Section 47 allows the Director to appear or provide representation on behalf of a complainant either in person or through counsel

Australian complaints commission legislation). The Act will have had two reviews within 10 years. Given the expense and time associated with a review, and the fact that it is always possible for the Commissioner “to report to the Minister from time to time on the need for, or desirability of, legislative ... action ...”, it is suggested that the mandatory section 18 five-year review is no longer necessary. I welcome further discussion and comment on this matter.

Question 7

Is it necessary to retain a provision to review the Act every five years? If not, what interval do you suggest?

3.0 Part II: Code of Health and Disability Services Consumers’ Rights

3.1 Overview

Sections 19–23 cover the preparation, content, review and notification of the Code.

3.2 Content of the Code: section 20

Section 20 governs the content of the Code. The following discussion covers matters that currently fall *outside* the scope of the Code as permitted by the Act, but in respect of which a number of comments have been made over the past few years.

3.2.1 Responsibilities of consumers

Section 20 provides that the Code shall contain provisions relating to the duties and obligations of providers, and the rights of consumers. It does not enable the inclusion of provisions relating to the responsibilities of consumers or the rights of providers.

As a preliminary comment to this review, the Royal Australasian College of Surgeons has suggested that the Code should include a section on patient responsibilities to make it a more balanced document. In contrast, Women’s Health Action has commented that the Code should not be diluted in favour of providers.

As Commissioner, I seek to foster an environment that both protects consumers and supports providers. Although the Code spells out only the legal rights of the consumer, rights and responsibilities are a two-way street, and issues of consumer responsibility often arise in the way that the Code is applied in resolving a complaint.

Providers will not be in breach of the Code if they have taken reasonable actions in the circumstances to give effect to it (Clause 3). Any behaviour by a consumer that prevents or hinders a provider from carrying out his or her obligations will be taken into account as part of that analysis. In my view, consumers have responsibilities to:

- act in good faith;
- treat the provider with respect;
- share all information they know to be relevant; and
- be fair and truthful in making a complaint.

There is nothing to prevent organisational providers (such as hospitals) or Colleges from publishing internal codes of consumer responsibilities. I do not believe that legislation is needed to affirm such responsibilities.

Where a complaint is frivolous or vexatious or not made in good faith, section 37(1)(c)²⁴ allows the Commissioner to take no action on the complaint. In practice, this situation rarely arises.

I consider that ample procedural protection exists under the Act for providers being investigated for an alleged breach of the Code. For example, sections 41 and 67 ensure a fair opportunity to respond to notice of an investigation and to any provisional breach findings or adverse comment.

I therefore do not recommend amendment to either the Act or the Code to reflect the rights of providers and responsibilities of consumers.

Question 8

Should the Act and/or the Code be amended to include reference to the responsibilities of consumers? If so, what amendments do you suggest and why?

3.2.2 Access to services

As a preliminary comment to this review, Women's Health Action has suggested that the Code should include a principle that addresses timely access to appropriate services.

Section 20 addresses only the quality of service delivered, and does not authorise the Code to cover issues of access to services. The Act is not concerned with which services are to be funded by public funds, but with the quality of services that are delivered. Nor does the Act address related issues of timeliness and equity of access throughout New Zealand.

To date, Parliament has taken the view that issues of access and funding are not justiciable by a Commissioner and should be addressed through political accountability.

Question 9

Should the Act and/or the Code be amended to include a right to access publicly funded services? If so, what amendments do you suggest and why?

3.3 Review of the Code: sections 21–23

Section 21 provides that the Commissioner shall complete a review of the Code and make recommendations to the Minister at intervals of not more than three years. Given the level of resources necessary to conduct such a review, and the time required for legislative reform, I recommend that the timing of reviews be amended to intervals of no more than five years. This would be consistent with the

²⁴ New section 38

timing of reviews of the Act (if there continue to be regular reviews of the Act — see question 7). In my view, although regular review of the Act (which sets the overall framework for the Commissioner's work) is not necessary, there are good reasons for regular review of the Code, which impacts so directly on consumers and providers throughout New Zealand. However, in my opinion, a review of the Code every five years would be perfectly adequate.

Question 10

Is it necessary to review the Code every three years? If not, what interval do you suggest?

4.0 Part III: Health and Disability Services Consumer Advocacy Service

4.1 Overview

Part III of the Act provides for an independent advocacy service for health and disability consumers who wish to complain about an alleged breach of the Code of Health and Disability Services Consumers' Rights.

Consumer advocacy has proved to be a very successful means of resolving complaints that appear to raise no issues of exploitation or public safety. Complaints suitable for advocacy assistance may include:

- complaints involving communication issues, including being given relevant information;
- complaints involving the attitude of the provider, for example, rudeness and lack of courtesy;
- complaints involving issues where the dignity and/or independence of a consumer have not been respected;
- situations where there is an ongoing relationship between the parties and it is important that a good relationship is maintained, for example, ongoing care situations;
- complaints involving lack of co-operation among providers;
- complaints involving misunderstandings brought about through a lack of understanding around cultural and social issues; and
- complaints involving a minor lapse in the provider's standard of care.

Consumers can access regional advocates, who help consumers to clarify the issues that have given rise to a complaint, and the options for how a complaint might be resolved. Consumers are then supported by advocates in raising the complaint with the provider in an effective manner, usually through a meeting or correspondence. This process allows consumers to assert their concerns in a way that increases their confidence and allows them to achieve low-level resolution of their complaint.

From the provider's point of view, the advocacy process allows the provider an opportunity to understand the issues behind a complaint and to respond in an environment that is less formal and stressful than having the complaint investigated by the Commissioner.

Sections 24 to 30 of the Act set out how advocacy services are to operate. In particular, they deal with the appointment and functions of the Director of Advocacy, the establishment and operation of the advocacy services, and the functions of advocates.

The HDC Amendment Act has not changed the role of advocates nor their interface with the Commissioner. The Commissioner will continue to be able to make a referral to advocacy for the purpose of resolving the complaint by agreement between the parties at any time during the course of an investigation.²⁵

4.2 The Director of Advocacy: sections 24 and 25

The Act provides for the appointment, by the Commissioner, of a Director of Health and Disability Services Consumer Advocacy. The functions of the Director of Advocacy are set out in section 25 as being:

- (a) To administer advocacy services agreements:
- (b) To promote, by education and publicity, advocacy services:
- (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 that monitoring.

Section 24 provides that the Director shall act independently of the Commissioner in performing his or her functions, but be responsible to the Commissioner for the efficient, effective and economical management of the activities of the Director.

The structural independence of the Director from the Commissioner was introduced into the legislation to protect the Commissioner's impartiality when investigating and mediating complaints. Concern had been expressed in the developmental stages of the legislation that the Commissioner's position might be compromised if advocates operated directly under the Commissioner's control. By their very nature, advocates are not impartial but take the side of the consumer. In contrast, when investigating complaints it is essential that the Commissioner remain impartial and independent of both consumers and providers. The decision was therefore made to place advocacy services under the control of an independent Director.

The budget for the purchase of consumer advocacy services is currently allocated by the Commissioner. As a preliminary comment to this review, the Director of Advocacy has suggested that there may be potential for the independence of the Director's role to be compromised in having to negotiate with the Commissioner for the allocation of funding, and that such negotiations should occur directly with the Ministry of Health. I welcome any comments or feedback on this matter.

Question 11

Should the Director of Advocacy be able to negotiate funding directly with the Ministry of Health?

4.3 Structure of advocacy services

The Act envisages the purchase of advocacy services by the Director of Advocacy through a series of advocacy service agreements entered into by the Director on behalf of the Crown. The definitions in the Act of ‘advocacy services agreement’ and ‘advocacy services’ mean that the Director is unable to employ advocates directly. Instead, the Director of Advocacy must contract with independent service providers who, in turn, are the employers of individual advocates. There are currently three regional service contracts for the delivery of advocacy services throughout New Zealand.

The “purchaser/provider split” model is mandatory under the Act. By way of preliminary comment to this review, Women’s Health Action has suggested that the current purchaser/provider model for advocacy services be reviewed, and noted that the current arrangement means there is no national system.

In the first review of the Act in 1999, it was recommended that advocates become employees of the Commissioner, but with the obligation to act independently, in order to offer a more centralised service. However, submissions in response to this recommendation raised concerns that:

- removing regional governance could take away a direct opportunity for community participation in the planning, policy and oversight of the quality of advocacy services;
- advocates could be faced with a conflict of interest by “serving two masters”; and
- the roles of advocates and the Commissioner in respect of receiving and resolving complaints could become blurred.

A comprehensive review of the structure of advocacy services was carried out by the Director of Advocacy in December 2003. The review examined the strengths and weaknesses of the purchaser/provider model and made recommendations for improving the current structure. Existing strengths were identified to include:

- the operation of the Act, which guarantees specific recognition for HDC advocates, and the Code, which requires providers to inform consumers that an advocate is available if a consumer lays a complaint;
- independence from the Commissioner, which supports open, constructive relationships between advocates and providers and enables advocates to support consumers through the Commissioner’s investigation process;
- the quality and passion of advocates and their managers; and
- the team work which supports advocates to work effectively.

The outcome of the review was a recommendation that, rather than centralising the service to gain greater consistency, the benefits of centralisation could be achieved by the following changes to the three regionally contracted advocacy services (“the service”):

- to support and enhance consistency, all parts of the service (roles, people, policies and processes) need to be aligned with a shared vision, and the relationship between the three advocacy services providers needs to be one of collaboration and accountability;
- to enhance performance management, the service needs to develop clear lines of communication between the trusts, the managers and the advocates, the Director of Advocacy needs to have a clearer mandate to require change in situations where poor performance is an issue and processes need to be set up to protect the integrity of the random sampling of participants;
- to enhance best practice, the service needs to implement common policies, processes and procedures, introduce human resource policies that result in the recruitment of high quality advocates, create an organisational culture that sustains and empowers people, and provide targeted training on the fundamentals of advocacy practice and responding to local needs;

- to support the performance of managers, the service needs to develop the role of senior advocate to support, train, supervise and ensure the safety of advocates, and operational policies to encourage clear communication and professionalism as part of a well functioning team;
- to utilise the strengths of individual advocates, the service needs to develop a system for accessing the specialist skills and knowledge of advocates from other service providers when this is required; and
- to better meet the needs of people with disabilities, the service should specifically recruit for specialist expertise in this area.

These changes will minimise the reporting layers in the purchaser/provider structure, retain service provider organisations and the direct relationships with the communities they serve, and improve consistency and performance. I consider that the proposed changes will optimise the outcomes achieved by advocacy services and do not recommend any amendments to the existing structure.

Question 12

Is the current structure for advocacy services appropriate? If not, what amendments do you suggest and why?

4.4 Functions of advocates

Advocates are not investigators and their role is not to decide whether there has been a breach of the Code. This is the role of the Commissioner. Nor are they mediators. Rather, advocates take the side of consumers and assist them in resolving complaints about a possible breach of the Code directly with the service provider. The key goal of the advocacy complaints process is to achieve resolution *for the consumer*.

The operation of advocacy services is essential to the Act's aim of resolving complaints at the lowest appropriate level. It is important that resources are used efficiently and advocacy is available to as many people who need its assistance as possible.

An independent review was carried out in November 2002 to assess the effectiveness of advocacy services. The findings confirmed that advocacy services are heading in the right direction and continue to work towards the goal of resolving an increasing number of complaints with advocacy. The review demonstrated that consumers and providers both value:

- a relationship based on understanding, respect and trust;
- the advocate's ability to clarify the issues and prepare the consumer for a focused meeting with the provider;
- the professionalism, empathy and objectivity of the advocates; and
- the advocates' ability to subtly facilitate a meeting whilst ensuring the consumer remains comfortable and the parties remain focused on achieving a resolution.

Consumers, in particular, rated the advocacy process highly, noting that they felt they had been listened to and supported by the advocacy process. These results reflect the positive effects of empowerment advocacy — giving consumers the type of support most likely to increase their ability to self advocate and to become empowered in making their own choices about solutions to their issues and concerns.

Providers responded to the review with positive comments about the advocates' approach and professionalism. However, the review identified that it is also essential for the advocate to understand the provider's systems and practice in order to support the consumer in achieving resolution. The key word is respect — respect for providers and their systems, and recognition that achieving the best outcome for the consumer requires respect for, and working with, rather than against, the people involved on the other side of the complaints process. This has ultimately led to a new approach for advocacy services — a process that actively seeks change from providers through constructively challenging systems and practices.

Women's Health Action has raised a preliminary comment that high levels of satisfaction from both consumers and providers are desirable but that the Act specifically states that advocacy services should operate for the benefit of consumers.

I do not consider that a move towards a more conciliatory approach is inconsistent with the purpose of benefiting consumers. In assisting the consumer to achieve a resolution of his or her complaint, it is essential for an advocate to understand the clinical context in which a provider operates. By understanding those processes and systems, it is more likely that the parties can work with the system to achieve a successful outcome for the consumer. In contrast, an aggressively confrontational style of advocacy is unlikely to result in a satisfying result for the consumer, and often results in the unresolved complaint being referred to the Commissioner.

I consider that advocates are currently functioning at an appropriate level to assist health and disability consumers to resolve complaints about alleged breaches of the Code at the lowest appropriate level. Accordingly, I do not recommend any changes to the functions of advocates.

Question 13

Are the functions of the advocates appropriate? If not, what amendments do you suggest and why?

5.0 Part IV: Complaints and Investigations

5.1 Overview

Part IV of the Act, sections 31 to 58, deals with the Commissioner's process for receiving and investigating complaints under the Act.

- Sections 31 to 40 cover the method by which people can make complaints, the Commissioner's options on receipt of a complaint, the decision to investigate (including the grounds for declining to investigate), notification of complaints to the relevant health professional body, and the steps for referring complaints to the Ombudsmen, Privacy Commissioner or Human Rights Commission.
- Where a complaint is to be investigated or an investigation is to be initiated by the Commissioner, sections 41 to 49 then cover the various procedural requirements the Commissioner must follow, the discretion to refer a matter to another person or body for action, the options and powers after investigation, and the functions and powers of the Director of Proceedings.

- The remaining sections of Part IV essentially deal with actions before the Human Rights Review Tribunal.

Part IV of the Act has been operational since 1 July 1996. It will be significantly amended when the HDC Amendment Act reforms come into effect in September 2004. I support the changes. In my view, further change to Part IV is not desirable until it has been operational for a reasonable period and there has been opportunity to evaluate its effectiveness.

By way of background, however, the following discussion will include a brief explanation of the Act's existing complaints procedure. An overview of the Commissioner's processes is also set out in brochures,²⁶ which can be obtained from my office or downloaded from the website (www.hdc.org.nz). Set out below are the key changes to Part IV and how it will operate once the changes come into effect.

5.2 Complaints resolution procedure

The Commissioner receives complaints directly from consumers and third party complainants. Complaints are also referred by health professional bodies and advocates.²⁷ Complaints may therefore come from a variety of sources, including consumers, family and friends of consumers, concerned providers, the Police, ACC, etc. Complaints can be made either orally or in writing.²⁸

The Commissioner's ability to receive complaints from persons other than the consumer is very important. Many consumers are particularly vulnerable and unable to complain for themselves. Some are afraid to complain because of concerns about the effect this may have on the delivery of services, for example elderly consumers and people who receive care in residential facilities.

From time to time third party complaints are not made in good faith, or are in respect of matters the consumer does not wish to take further. The Act caters for these situations by providing the Commissioner with a discretion to take no action on a complaint in certain circumstances (s 37(1)²⁹). Care is always taken in assessing whether to proceed with a third party complaint.

Once a complaint has been received, the Commissioner reviews the complaint and makes a decision as to what action is appropriate. Currently, the options available to the Commissioner are:

- referring the complaint to advocacy services under section 42;
- taking no action pursuant to section 37 or because the complaint is outside jurisdiction; or
- commencing an investigation under Part IV.

The parties involved in the complaint are then notified of the action the Commissioner intends to take.

The Commissioner's investigative function is currently set out in section 35 and covers the Commissioner's dual ability to investigate both individual complaints and matters on his or her own initiative. The investigation of complaints is a means to the wider end of promoting and protecting consumer rights. To achieve this wider end, the Commissioner must have discretion to investigate on his or her own initiative when circumstances warrant. This includes the investigation of systems issues, as well as the investigation of discrete events.

If the Commissioner decides to investigate a complaint, the provider and his or her employer is generally sent a copy of the complaint and asked to provide a response. The Commissioner also notifies the

26 "Health and Disability Commissioner's Investigation Process — Guide for Providers" and "Health and Disability Commissioner's Investigation Process — Guide for Consumers"

27 Sections 31 and 34

28 Section 32

29 New section 38(1)

health professional body and asks for any relevant information. The Commissioner then gathers information from the parties and witnesses, and the clinical records, in order to establish the facts. If the complaint concerns standards of care, the Commissioner may request independent expert advice on the reasonableness of the conduct giving rise to the complaint.

If circumstances change during the process, the Commissioner retains the option of taking no further action on a complaint (section 37(2)). The parties may also be referred to advocacy or mediation at any stage of an investigation. In practice this occurs only if the complaint does not raise issues of exploitation or public safety.

Once the investigation is complete, the Commissioner must inform the complainant, the consumer (if he or she is not the complainant) and the provider of the results of the investigation and any further action that the Commissioner proposes to take, if any.

Before the Commissioner finalises an opinion on whether the complaint gives rise to a breach of the Code, a provisional opinion is sent to the provider (in the case of a provisional breach finding or adverse comment) or the complainant (in the event of a provisional no breach finding). Once any response has been considered, the opinion is finalised and a written report is sent to the parties. An anonymised version of the report may then be sent to other organisations, for educational purposes.

If, at the end of an investigation, the Commissioner is of the opinion that there has been a breach of the Code, there are a number of options available.³⁰ An opinion finding that a provider has breached the Code will usually include recommendations ranging from an apology, review of practice, re-training, staff training, internal audit and systems review.

By way of preliminary comment, the National Council of Women of New Zealand has raised concerns about the length of time it takes for the Commissioner's recommendations to be implemented. The Commissioner may specify a time frame for implementation of a recommendation, and will usually do so. If within three weeks of sending out the final report the Commissioner has not received advice that the recommendation has been carried out, the current practice is to send a follow-up letter seeking confirmation that the required action has been taken. If the person concerned is unable to provide confirmation that the action has been taken, the Commissioner considers any comments that have been made in response and can:

- make further recommendations; and
- send a report to the Minister of Health.³¹

If a recommendation is not met, the Commissioner also has the option of taking any other action authorised by section 46. This could include publicly naming a non-compliant provider. In practice, the process for following up on recommendations generally results in timely compliance.

Where there are ongoing concerns about the provider's abilities, the Commissioner is entitled to refer the provider to a health professional body for a competence review. In serious cases of misconduct, the matter is referred to the Director of Proceedings.

The Director of Proceedings can institute proceedings in any court or tribunal.³² In practice, however, the Director of Proceedings will usually consider proceedings before the Human Rights Review Tribunal or the relevant disciplinary tribunal, or both. Human Rights Review Tribunal proceedings can also be commenced directly by the consumer in certain cases. The power to order a provider to pay damages or a fine, or to regulate the terms under which the provider can practise, are powers exercised by the Human Rights Review Tribunal and/or the disciplinary tribunal, not by the Commissioner.

30 Section 45

31 Section 46

32 Section 47

5.2.1 Right of appeal

As a preliminary comment to this review, the Australian and New Zealand College of Anaesthetists has suggested that providers should have a right of appeal from a Commissioner's decision.

If the Commissioner decides not to investigate a matter, or forms an opinion that the complaint does not give rise to a breach of the Code, a consumer is unable to instigate proceedings directly in the Human Rights Review Tribunal. There is no direct right of appeal from a Commissioner's decision. Similarly, a provider does not have any right of appeal from a Commissioner's opinion.

However, any consumer or provider who is concerned that the process the Commissioner adopted in assessing a complaint or during the course of an investigation was unfair, or that the result is substantively unreasonable, may seek a review (free of charge) by the Office of the Ombudsmen. Each year approximately 10 cases are reviewed by the Ombudsmen, but most are resolved by clarifying procedural matters, without the need for any formal recommendation. On rare occasions, the exercise of the Commissioner's power is challenged by judicial review proceedings in the High Court (to date without success).

The Commissioner's complaint resolution processes are required to be "fair, simple, speedy, and efficient". That requirement, together with the Ombudsmen and judicial review remedies already available, suggest that no formal right of appeal is necessary.

5.3 Key changes to Part IV

From 18 September 2004, the Commissioner will have more options for dealing with complaints upon receipt, including the option of referring the complaint back to the provider for resolution or calling a mediation conference, without commencing an investigation. The Commissioner will be empowered to refer complaints to appropriate agencies or persons involved in the health and disability sectors, who will be required to report back on the outcome of the complaint. The Commissioner's current practice of sharing information with other key agencies (ACC, registration bodies, and the Director-General of Health) will be formalised.

In cases where the Commissioner plans to refer the matter to the Director of Proceedings, the Commissioner will be required to give the provider an opportunity to comment on the proposed referral before it is finalised. Finally, an aggrieved consumer will be entitled to commence proceedings in the Human Rights Review Tribunal if the Commissioner's opinion finds that the provider breached the Code but the matter is not referred to the Director of Proceedings.

5.3.1 Options for resolving complaints

The Commissioner is currently required to investigate most complaints alleging substandard health care or disability services. The complaint process is undoubtedly slow, and has resulted in too many investigations. It has become increasingly necessary to prioritise complaints so that more serious matters, often involving public safety, are dealt with in a timely manner.

Section 33 provides the Commissioner with options to facilitate resolution of complaints at the lowest appropriate level. The Commissioner will be required to make a preliminary assessment of the complaint to decide what course of action, if any, is appropriate. The types of actions the Commissioner may take on receipt of the complaint include:

- referring the matter to the provider for resolution;
- referring the matter to an advocate for resolution;³³

33 See discussion at paragraph 4.4 above

- calling a mediation conference;³⁴
- investigating the complaint; or
- taking no action, if action is “unnecessary or inappropriate”.

Resolution need not always occur through a formal investigation under the Act. If public safety and provider competence are not an issue, resolution between the parties may be the most appropriate response, either directly or by way of advocacy or mediation. In some cases complainants may prefer that no formal action be taken and that providers receive a simple reminder, in general terms, of their obligations under the Code. However, in other cases, given the seriousness and nature of the complaint, an investigation is necessary. Sometimes appropriate resolution can occur only when the provider is held accountable for his or her actions, and formal action is taken to prevent the same events from recurring. When deciding what action to take under the new section 33, the need to ensure public safety and proper accountability to protect consumers will be primary considerations.

It is nonetheless anticipated that fewer cases will proceed to investigation, and that more will be referred back to the parties or to advocacy or mediation. All referrals to an advocate or a provider will be accompanied by reporting requirements back to the Commissioner.³⁵ This will enable the Commissioner to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues addressed, and independent oversight maintained. The Commissioner will not be precluded from taking further action if not satisfied with the reported outcome.³⁶

While some may be concerned that this removes their right to an independent investigation, the changes are consistent with the statutory framework of the Act, which supports low-level resolution, where appropriate. It was never intended that the Commissioner would resolve all complaints through investigation. It is noteworthy that the Commissioner currently investigates a much greater proportion of complaints than equivalent agencies in the Australian states.

Decision to refer to the provider

The Commissioner does not currently have any authority to refer a complaint back to a provider. In some situations, a provider may be advised of the complaint and invited to take any action he or she deems appropriate, but only where the Commissioner has decided to take no action on the complaint. The provider is not required to report back on the action taken, if any.

New sections 33 and 34(1)(d) will enable the Commissioner to refer a complaint back to the provider for resolution, if it does not raise public safety questions and can be appropriately resolved by the provider.

Preliminary enquiries may reveal that a provider is well motivated to resolve a complaint that may never before have been brought to the provider’s attention, for example because the consumer was unaware of his or her right under the Code to complain directly to the provider. Additionally, consumers sometimes do not want the assistance of an advocate, and mediation may be an unnecessary formality. A referral to the provider will enable him or her to attempt to resolve complaints directly. If such a complaint is resolved adequately, it will be unnecessary for the Commissioner to take any further action on the matter.

34 See discussion at paragraph 6.3 below

35 New sections 35 (provider) and 37 (advocacy)

36 New sections 33(3) and 34(5)

A decision to take no action

The Commissioner's discretion to take no action upon receipt of a complaint is currently limited.³⁷ In the future, the Commissioner will have a discretion to take no action on a complaint if the Commissioner considers that, having regard to all the circumstances of the case, any action is unnecessary or inappropriate.³⁸ This provision is similar to the existing section 37(2), but the discretion may now be exercised upon receipt of the complaint, as well as at any time during the course of an investigation.

By way of example, it may be appropriate to take no action if the matter has already been fully investigated by an independent agency (a District Inspector or Coroner) and the recommendations of the independent review have been implemented. Investigation by the Commissioner in such cases is unlikely to shed further light on the matter.

It may also be appropriate to take no action where the matter has been fully investigated by the provider and there is good reason to believe that the review, although not independent, has been thorough and has uncovered the relevant causes/problems and that appropriate recommendations have been implemented. However, each case will need to be considered on its own merits.

5.3.2 Sharing information

Referral of complaints to agencies, persons and statutory officers

The Act currently anticipates co-operation between the Commissioner and a number of agencies.³⁹ Depending on the circumstances, the interface may involve consultation on the best way of dealing with a complaint, a referral of the complaint to the other agency, or the sharing of risk information.

The Act currently provides both for referral of complaints to statutory officers (the Chief Ombudsman, the Privacy Commissioner, the Chief Commissioner under the Human Rights Act),⁴⁰ and more generally to other appropriate (but unspecified) persons (where this is called for in the public interest).⁴¹

Section 59(4) gives the Commissioner wide discretion to refer a matter to an appropriate person or authority at any time, where the Commissioner considers this necessary or desirable in the public interest. Examples include referral to the relevant health professional body (where there are professional conduct concerns), Medsafe (where concerns exist about dangerous or inappropriate prescribing) or a District Inspector (where concerns exist about a person's assessment or compulsory treatment). There is no formal oversight retained by the Commissioner in relation to such referrals.

New section 34 of the Act will specifically allow for complaints to be referred to specified agencies or persons involved in the health and disability sectors, as appropriate. The agencies include ACC (if it appears that the consumer may be entitled to compensation), relevant registration authorities (if it appears from the complaint that the competence of the health practitioner, or the appropriateness of his or her conduct, may be in doubt), the Director-General of Health (if it appears that there are systems failures or the practices of the provider may harm the health and safety of the public) and/or the provider (if the complaint does not raise public health and safety questions). Such referrals are accompanied by reporting requirements back to the Commissioner⁴² on what action, if any, it has taken in relation to the matter.

37 Section 37

38 New section 38(1)

39 Sections 38–40

40 Section 40

41 Section 59(4)

42 New section 35

While each complaint will be assessed on its own merits, the referral of a complaint about an apparent breach of the Code to such agencies (other than the provider) will usually be concurrent with, rather than instead of, any action by the Commissioner on the matter because of the respective roles and purposes of the various agencies. Different agencies will continue to have important and distinct roles that should not be performed by the Commissioner. For example:

ACC

ACC's role is compensation, not complaint resolution, and it is appropriate that this role remains distinct from the work of the Commissioner. The purpose and philosophy underpinning ACC investigations is substantially different from Commissioner investigations. ACC provides “no fault” compensation for people who suffer personal injury. As a matter of practice, when an investigation is commenced into whether the treatment of a registered health professional is of an appropriate standard, the ACC Medical Misadventure Unit is notified and a request is made for any information ACC holds that is relevant to the investigation.

Registration authorities

Similarly, registration authorities have a distinct and important role — public protection. They are the appropriate agencies to consider referrals from the Commissioner about the competence and fitness of practitioners, and to follow up those concerns with a confidential review.

While no longer having responsibility for pre-1996 patient care complaints, the registration authorities will retain a limited complaints resolution role through the Professional Conduct Committees (PCCs).⁴³ This is quite different from the Commissioner's role. The Select Committee changed the name of Complaint Investigation Committees to Professional Conduct Committees in the Health Practitioners Competence Assurance Act to more accurately reflect their role. The PCCs will deal with criminal activity and professional conduct matters — issues that typically do not involve patient care (such as theft of hospital equipment,⁴⁴ assault on another health practitioner,⁴⁵ self-prescribing,⁴⁶ misleading advertising,⁴⁷ or ACC fraud). The referral of such a complaint to the registration authority would usually be instead of any action by the Commissioner on the matter.

Reporting public safety risks

The Act currently envisages that the Commissioner is alert to the possibility of wider public safety issues — he or she may refer such issues to the relevant authority where appropriate.⁴⁸ Section 48⁴⁹ makes referral to an appropriate person or authority mandatory where the Commissioner considers there is evidence of any significant breach of duty or misconduct by the provider.

New section 39(1) will impose a broad obligation on the Commissioner to notify risks to the appropriate authority. The Commissioner will be required to notify the appropriate authority if he or she has “reason to believe that *the practice of* a health practitioner may pose a risk of harm to the public”. This is a requirement to notify concerns with the practice of a health practitioner generally, which could, for

43 Section 65 HPCA Act

44 03/07271: nurse stole doppler machine and replaced with older model

45 03/09273: GP assaulted by another GP (colleague)

46 03/10136: psychiatrist self-prescribing Aropax

47 03/06012: misleading advertising by two chiropractors with claims to cure SARS and diabetes

48 Section 59(4)

49 New section 39(3)

example, include reasons related to a practitioner’s fitness or unethical conduct. This reporting obligation focuses on the potential risk of harm to the public, and is not limited to the issue of competence.⁵⁰

Section 39(2) requires the Commissioner to notify the Director-General of Health if he or she has “reason to believe that failures or inadequacies in the systems or practices of a health care provider or a disability provider are harming or likely to harm the health or safety of members of the public”.

Section 39(3)⁵¹ makes referral to an appropriate person or authority mandatory where the Commissioner considers “there is evidence of a significant breach of duty or misconduct” by the provider. The referral could occur either during or after an investigation — for example, referral to the Police where a crime is suspected.

Notifications to registration authorities

Under the current provisions, where a complaint about a registered health professional is made to the Commissioner, the Commissioner has a discretion to notify the relevant professional body of the complaint.⁵² As a matter of practice, whenever an investigation of a health practitioner is commenced, the relevant health professional body is always notified of the complaint and investigation. At the same time, a request is usually made for any information the health professional body holds that is relevant to the subject matter of the investigation. Once notified, disciplinary action by the relevant professional body is suspended until the Commissioner, or the Director of Proceedings, notifies the professional body that no further action is to be taken under the Health and Disability Commissioner Act.

In the future, the Commissioner will be required to notify the responsible authority of any investigation under the Act.⁵³ New section 42(1) of the Act will specifically require the Commissioner to notify the responsible authority of any investigation under that Act that directly concerns a health practitioner. The Commissioner is not required to notify the authority of other actions taken in relation to a complaint unless he or she considers there may be a risk of harm to the public (discussed on page 34).

The Act currently gives the Commissioner a discretion to notify the relevant health professional body if the Commissioner decides to take no further action on the matter.⁵⁴ However, the health registration body must be notified of the result of an investigation involving a registered health professional if the Commissioner proposes to take further action. As a matter of practice — and in the future pursuant to new section 43(1) and 43(2)(d) of the HDC Act — the registration authorities are informed of the result of investigations involving members, whether or not a breach is found and action taken.

5.4 Referral of providers to the Director of Proceedings: sections 47–49

One of the options available to the Commissioner at the end of an investigation is to refer the complaint to the Director of Proceedings.

The Director of Proceedings is responsible for making a decision on what proceedings, if any, should be taken in relation to the complaint or subject matter of investigation. Proceedings may be commenced in any court or tribunal. In practice, proceedings are usually commenced in the Human Rights Review Tribunal or the relevant disciplinary tribunal (authority), and on rare occasions in both.

50 Unlike section 34(2) of the HPCA Act, which requires the Commissioner and the Director of Proceedings to notify the appropriate registration authority if they have “reason to believe that a health practitioner may pose a risk of harm to the public by practising below the required standard of competence”

51 Equivalent of current section 48

52 Section 38

53 New section 42(1) of the Act and section 66 HPCA Act

54 Section 44(2)(b)

In making this decision, the Director reviews the information gathered during the investigation. Section 49(2) and (3) require the Director to give the affected provider an opportunity to be heard and, in determining what, if any, action to take, to have regard to:

- the wishes of the complainant and consumer (if not the complainant); and
- the need to ensure that appropriate disciplinary action is instituted where the public interest so requires.

In the future, the Director of Proceedings will no longer be required to offer the provider an opportunity to be heard before determining what action to take, if any. Sections 49(2) and (3) will be repealed.⁵⁵ However, section 44 will impose a similar requirement on the Commissioner. The Commissioner will not be able to refer a matter to the Director of Proceedings unless he or she has given the provider an opportunity to comment on the proposed referral.⁵⁶ (In practice, this already occurs.) The Commissioner will be required to have regard to any comments from the provider, as well as the wishes of the complainant/consumer and the public interest, in deciding whether to refer the matter to the Director of Proceedings.⁵⁷ The Commissioner must also advise the Director of Proceedings of these factors.⁵⁸

5.5 Direct action in the Human Rights Review Tribunal: section 51

Under the current complaints scheme, the Commissioner plays an important gatekeeper role. A complaint must be referred to the Director of Proceedings as a trigger for an individual consumer's claim before the Human Rights Review Tribunal.

When the amendments come into effect, section 51 will give consumers greater access to the Human Rights Review Tribunal.⁵⁹ The new provision will allow an aggrieved person to bring proceedings before the Tribunal where the Commissioner, having found a breach of the Code, has not referred the matter to the Director of Proceedings, or where the Director has decided not to take proceedings.

This proposal was strongly opposed by many health practitioner groups in submissions and through the media.⁶⁰ Some legal commentators feared it would result in a surge of litigation. In my view, there is no good reason why access to the Human Rights Review Tribunal is currently more restrictive for health and disability consumers than for privacy or human rights matters.

It seems to be an accident of statutory drafting that the Health and Disability Commissioner Act currently requires referral to the Director of Proceedings as a trigger for an individual consumer's claim before the Human Rights Review Tribunal. The accident compensation bar already poses a significant disincentive to aggrieved health and disability consumers; it seems inappropriate to impose another barrier in a statute intended to promote consumers' rights. It is unlikely to open the "floodgates". To date, few matters have been taken to the Human Rights Review Tribunal by the Director of Proceedings;⁶¹ none have been brought by complainants where the Director has declined to take proceedings.

55 Section 13 HDC Amendment Act

56 New section 44(1)

57 New sections 44(2) and (3)

58 New section 45(3)

59 Section 15

60 NZMA

61 HRRT claims involving doctors include *A* (1998) and *Harrild* (2001)

Question 14

Do you agree that further changes to Part IV (Complaints and investigations) are not necessary or desirable at this stage? If not, what amendments do you suggest and why?

6.0 Part V: Miscellaneous Provisions

6.1 Overview

Sections 59 to 82 of the Act cover various miscellaneous matters relating to complaints and procedure, the calling of mediation conferences, protections and privileges, delegations, vicarious liability, offences, etc. Although placed in a part of the Act entitled “Miscellaneous”, these provisions are essential to the Act’s effective operation.

6.2 Procedure: section 59

Section 59 contains a number of important provisions enabling the Commissioner to regulate procedures as he or she thinks fit. This flexibility is essential if the Commissioner is to achieve the Act’s stated purpose of “fair, simple, speedy, and efficient resolution of complaints”. In outline, section 59 provides as follows:

- investigations may be in public or in private (s 59(1))
- the Commissioner may hear or obtain information from such persons as he thinks fit (s 59(2)(a))
- the Commissioner may make such enquiries as he thinks fit (s 59(2)(b))
- it shall not be necessary for the Commissioner to hold any hearing (s 59(2)(c))
- subject to the right to respond to a complaint and to adverse comment, no person shall be entitled as of right to be heard by the Commissioner (s 59(3))
- if it is in the public interest to do so, the Commissioner may refer matters to the appropriate person or authority
- subject to the provisions of the Act, the Commissioner and every advocate may regulate his or her procedure as he or she thinks fit (s 59(5)).

6.3 Mediation conference: section 61

Some disputes lend themselves more to mediation than advocacy. Mediation involves attempting to resolve the matter through the formal intervention of an impartial mediator. If the complaint is referred to advocacy, the parties attempt to resolve the matter with the assistance of an advocate, who takes the side of the consumer.

Currently a mediation conference can be called only once an investigation has begun. Section 61 enables the Commissioner to call a mediation conference in respect of any matter that is the subject of an investigation, for the purpose of endeavouring to resolve the matter by agreement between the parties.

However, in many situations it is clear from the outset that the dispute would be best resolved through mediation. Examples include situations where:

- the ongoing relationship between the parties requires a formalised agreement as to the future delivery of services;

- the parties have unsuccessfully attempted to resolve the complaint; or
- advocacy has been unsuccessful in achieving resolution.

When the HDC Amendment Act comes into effect, new section 33(1) will enable the Commissioner to call a mediation conference at any time after a complaint has been received. This will introduce a beneficial element of flexibility into the Act and reduce the current formality of having to commence an investigation before mediation is available.⁶²

6.4 Adverse comment: section 67

Section 67 ensures that any person who is the subject of adverse comment in any report or recommendation:

- has a reasonable opportunity to be heard (s 67(a)(i));
- has a reasonable opportunity to make a written statement in response to that adverse comment (s 67(a)(ii)); and
- may, if he or she requires, have his or her response or a summary of it (whichever the Commissioner considers appropriate) included in or appended to the report or recommendation (s 67(b)).

The right to respond to adverse comment is a fundamental right in administrative law. Its purpose is to ensure a fair process and outcome for the parties.

During an investigation into a complaint, a provider has a number of opportunities for input before the Commissioner forms a final opinion that a breach of the Code has occurred. As a minimum, this includes the opportunity at the start of the investigation to respond to the complaint (as required by section 41), as well as the opportunity to respond to any adverse comment in the provisional opinion.

There has been some debate about the meaning of section 67. For a provider under investigation, I consider that the right to be heard is fulfilled during the investigation by the opportunity to respond to the complaint, and the right to make a written statement in answer to proposed adverse comment is fulfilled by the opportunity to respond to the provisional opinion. The provision does not require formal hearings, which would inevitably slow the investigative process.

6.5 Is amendment to the Act necessary?

As noted earlier, I consider that the Act is currently operating appropriately and will be significantly improved by the reforms under the HDC Amendment Act. I therefore consider that there is not currently a need for further amendment. I welcome discussion and comment on this matter.

Question 15

Should the Act be amended or, taken as a whole, are the existing provisions and the changes that will come into effect under the HDC Amendment Act 2003 satisfactory?

⁶² Section 61 will be amended accordingly

C. The Code of Health and Disability Services Consumers' Rights

7.0 Review of the Code

7.1 Overview

Prior to 1996, the ethical and professional responsibilities of health care providers in New Zealand were scattered among a variety of sources, poorly defined and often unwritten. In July 1996, the Code of Health and Disability Services Consumers' Rights came into force.

The Code does not create any new or revolutionary professional responsibilities, but rather “codifies” or “affirms” pre-existing consumer rights and corresponding provider responsibilities. The Code sets out these rights and responsibilities within a clear and accessible framework, supported by a spectrum of sanctions that can be imposed on those who breach the Code. One of the Code’s real strengths is that it allows the Commissioner to refer to external sources for guidance on appropriate standards within different professions, and for different modalities of treatment. This ensures that the Code remains dynamic and responsive to change within the health and disability sectors.

The Code consists of six clauses:

Clause 1 confers the rights contained in the Code on consumers and establishes the duties and obligations of providers to comply with the Code. It also requires providers to inform consumers of their rights and enable them to exercise those rights.

Clause 2 details the rights that are available to all health and disability services consumers, including those involved in teaching and research. Each right imposes a corresponding legal duty on all health and disability service providers. The ten Rights are as follows:

- Right 1: the right to be treated with respect
- Right 2: the right to freedom from discrimination, coercion, harassment, and exploitation
- Right 3: the right to dignity and independence
- Right 4: the right to services of an appropriate standard
- Right 5: the right to effective communication
- Right 6: the right to be fully informed
- Right 7: the right to make an informed choice and give informed consent
- Right 8: the right to support
- Right 9: rights in respect of teaching or research
- Right 10: the right to complain

Under Clause 3 of the Code, a provider will not be in breach of the Code if he or she has taken “reasonable actions in the circumstances” to give effect to a consumer’s rights. This takes into account factors such as the consumer’s clinical circumstances and the provider’s resource constraints. Proof of

actual harm to the consumer is not necessary for the Commissioner to find a provider in breach of one of the Rights.

Clause 4 sets out the definitions of certain words used in the Code.

Clause 5 notes that, in meeting the requirements of the Code, no provider is required to breach any other New Zealand law, nor does the Code prevent a provider from doing an act authorised by such a law.

Clause 6 ensures that all existing rights outside of the Code are not affected.

Overall, the provisions in the Code have worked very satisfactorily and there is little need for amendment. As understanding of the Code has increased, so too has its general acceptance. However, there are a few matters that continue to raise issues for both consumers and providers, as discussed below.

Question 16

Should the Code be amended or are the existing rights satisfactory?

7.2 Effective communication: Right 5

Right 5(1) provides that *“every consumer has the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.”*

From time to time, providers have asked about the extent to which Right 5(1) requires them to provide an interpreter to assist consumers. As a preliminary comment to this review, Women’s Health Action has suggested that a national interpreting and translating service should be made available through the Commissioner’s office.

There is currently no provision in the Act for the Commissioner to provide a national interpreting and translating service. Very few complaints are received that raise issues of language difficulties between providers and consumers.

Right 5(1) explicitly states that the right to a competent interpreter applies “where necessary and reasonably practicable”. Right 5(1) is also subject to clause 3, which states that the provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to comply with the duties in this Code. In day-to-day situations, many providers avoid language difficulties by asking consumers to bring a friend or family member to assist with communication. This may not, however, be appropriate, depending on the nature of the consultation.

Question 17

Should the right to an interpreter under the Code be enhanced in any way, or is the current provision in Right 5(1) satisfactory?

7.3 Providing services when the consumer is not competent to give informed consent: Right 7(4)

As a preliminary comment to this review, the Auckland District Health Board has suggested that:

- the Code should give more guidance on the treatment of incompetent consumers, particularly the extent to which coercion may be used to provide treatment and prevent harm;
- Right 7(4)(a) should be amended to state that services should not be “contrary to the best interests of the patient” because sometimes it is not yet known whether research is in the best interests of the consumer.

Right 7(4) is an important protection for a particularly vulnerable class of consumers — those who are not competent to give consent and there is no other person available to give consent on their behalf. Right 7(4) has been very carefully worded to ensure that certain steps are taken before services can be provided in these circumstances.

The first requirement of Right 7(4) is for the provider to attempt to obtain informed consent from someone entitled to give consent on the consumer’s behalf. Examples of those entitled to consent on the consumer’s behalf include a parent giving consent on behalf of a child, or a welfare guardian appointed by the court with authority to make health decisions on behalf of the consumer.⁶³ Assuming that no such person is available, the remaining steps in Right 7(4) must be followed before any service is provided.

7.3.1 Right 7(4)(a)

The fundamental requirement is for the proposed service to be in the best interests of the consumer. This includes a clinical assessment by the provider of the need for treatment. It also involves looking at the consumer’s needs, interests and quality of life from a wider holistic view point, as required by Right 4(4) of the Code.⁶⁴ If it is not known whether the proposed research or any other service is in the best interests of the consumer, it cannot lawfully be carried out (although it may be justified by the common law of necessity). Changing the test to “not contrary to the best interests of the consumer” would weaken a safeguard put in place by right 7(4)(a) to protect this vulnerable class of consumers. However, the current requirement of affirmatively showing that the proposed research or other service is in the best interests of the consumer, inevitably deprives consumers of the benefit of research or services that *may* prove to be beneficial and are known not to be harmful.

7.3.2 Rights 7(4)(b) and (c)

To satisfy Rights 7(4)(b) and (c), the provider must also take reasonable steps to ascertain what the consumer would have wanted if he or she were competent. Services may be provided only where they are consistent with the informed choice the consumer would have made if competent. Where it is not possible to ascertain this information, the views of other “suitable persons” able to advise the provider must be taken into account. ‘Suitable persons’ may include family, partners, friends or caregivers who have an interest in, and a relationship with, the consumer such that it makes them suitable advisors on the type of care they believe is in the consumer’s best interests. It is important to emphasise that it is not

63 The definition of “consumer” in clause 4 includes, for the purposes of Rights 5, 6, 7(1), 7(7), 7(10), and 10, a person entitled to give consent on behalf of that consumer

64 Right 4(4) provides: “Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer”. The phrase “optimises the quality of life” is defined in Clause 4 of the Code to mean “to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances”

a matter of obtaining informed consent from a “suitable person”, as the procedure set out in Right 7(4) is based on the premise that no one who is legally entitled to consent is available. Rather, it is a matter of the provider taking into account the views of “suitable persons” in deciding whether treatment is in the consumer’s best interests.

Question 18

Should the right to provide services to incompetent consumers under Right 7(4) of the Code be modified in any way? If so, what amendments do you suggest and why?

7.4 Consent to the storage, preservation or use of body parts or bodily substances: Right 7(10)

Right 7(10) provides:

Any body parts or bodily substances removed or obtained in the course of a health care procedure may be stored, preserved, or utilised only with the informed consent of the consumer.

In practice, the absolute nature of the informed consent requirements in Right 7(10) has created difficulties as it is not always reasonably practicable to obtain informed consent for all possible future uses of body parts or bodily substances that are obtained in the course of a health care procedure.

7.4.1 Difficulties in undertaking public health research

The requirement for informed consent has, in some cases, hindered valuable public health research. For example, at a time of a rising rate of HIV infection in New Zealand, there is uncertainty about the prevalence of HIV infection among pregnant women. The best way to determine prevalence is to test, anonymously, blood from newborn babies collected on Guthrie cards. This type of unlinked anonymous monitoring is used in many countries because it provides scientifically unbiased information. However, in New Zealand, such research has not been possible because of the informed consent requirements in Right 7(10).

Where research involves the use of specimens collected many years earlier, it may not be practicable to find the original donors and obtain consent to use the specimens. This may prevent valuable studies on disease pathology. This type of research may allow progression of disease to be better understood and aid public health prevention efforts.

7.4.2 Difficulties with audit and evaluation activities

There is a growing use of audit and evaluation activities in quality assurance and formal accreditation programmes for the purpose of improving the quality of health and disability services. It is not always practicable to obtain informed consent in accordance with Right 7(10) to use stored bodily substances and body parts for audit activities, yet it may be a requirement of a professional accreditation or quality assurance programme. Indeed, it is arguable that in giving consent to the provision of health care or disability services, consumers impliedly consent to audit and evaluation to assess and improve the quality of services they receive.

7.4.3 Amendment to Right 7(10)

Cabinet has recently agreed to the amendment of Right 7(10)⁶⁵ so that any bodily substances or body parts removed or obtained in the course of a health care procedure may not be stored, preserved or used otherwise than:

- (a) with the informed consent of the consumer; or
- (b) for the purpose of research that has received the approval of an ethics committee; or
- (c) for the purpose of a professionally recognised quality assurance programme or an external audit or evaluation of services that is undertaken to assure or improve the quality of services.

Right 7(10) is currently being re-drafted by Parliamentary Counsel to give effect to the minor amendments (exceptions (b) and (c) above) approved by Cabinet.

7.4.4 Safeguards

In practice, the exemptions from the informed consent requirements under Right 7(10) only apply in very limited circumstances. Ethics committees considering a research proposal are required to weigh the public interest in allowing an exception from the requirement for informed consent against the very strong ethical principle of protecting individual autonomy.

Consumers will continue to benefit from the protection of the other rights in the Code. For example, Right 7(9) provides every consumer with the right to make a decision about the return or disposal of any body parts of bodily substances removed in the course of a health care procedure. Providers will still be obliged to comply with Right 1(3) and to take into account the needs, values, and beliefs of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Māori.

Anyone involved in research, audit or evaluation activities is bound by the requirements of the Health Information Privacy Code 1994. The Code states that any information obtained in carrying out these activities must not be published in a form that could reasonably be expected to identify an individual.⁶⁶

⁶⁵ CAB Min (03) 40/8, 8 December 2003

⁶⁶ Rule 11(2)(c)(ii)

Appendix A: List of key questions

- Question 1: Are the definitions in the Act adequate and appropriate? If not, what changes do you suggest?
- Question 2: Is the purpose of the Act appropriate? If not, what changes do you suggest?
- Question 3: Should the Act be amended to include an obligation that all persons exercising functions and powers under it have regard to the principles of the Treaty of Waitangi?
- Question 4: Are the functions of the Commissioner appropriate? If not, what amendments do you suggest and why?
- Question 5: Should the Director of Proceedings be able to negotiate funding directly with the Ministry of Health?
- Question 6: Should the Director of Proceedings be able to delegate powers, duties and functions under the Act?
- Question 7: Is it necessary to retain a provision to review the Act every five years? If not, what interval do you suggest?
- Question 8: Should the Act and/or the Code be amended to include reference to the responsibilities of consumers? If so, what amendments do you suggest and why?
- Question 9: Should the Act and the Code be amended to include a right to access publicly funded services? If so, what amendments do you suggest and why?
- Question 10: Is it necessary to review the Code every three years? If not, what interval do you suggest?
- Question 11: Should the Director of Advocacy be able to negotiate funding directly with the Ministry of Health?
- Question 12: Is the current structure for advocacy services appropriate? If not, what amendments do you suggest and why?
- Question 13: Are the functions of the advocates appropriate? If not, what amendments do you suggest and why?
- Question 14: Do you agree that further changes to Part IV (Complaints and investigations) are not necessary or desirable at this stage? If not, what amendments do you suggest and why?
- Question 15: Should the Act be amended, or, taken as a whole, are the existing provisions and the changes that will come into effect under the HDC Amendment Act 2003 satisfactory?
- Question 16: Should the Code be amended or are the existing rights satisfactory?
- Question 17: Should the right to an interpreter under the Code be enhanced in any way, or is the current provision in Right 5(1) satisfactory?
- Question 18: Should the right to provide services to incompetent consumers under Right 7(4) of the Code be modified in any way? If so, what amendments do you suggest and why?

Appendix B: Schedule of Consultation Meetings

CITY	DATE	TIME	VENUE
Rotorua	Monday, 15 March	10.30am–12pm	Redwood One Room, Kingsgate Hotel, Fenton Street
Hamilton	Monday, 15 March	4.30pm–6pm	Alexanders Room, Le Grand Hotel, 237 Victoria Street
Wellington	Thursday, 18 March	10.30am–12pm	Ground Floor, Archives NZ 10 Mulgrave Street
Auckland	Tuesday, 30 March	2pm–3.30pm	Wesley Community Centre, 740 Sandringham Road Extension, Mt Roskill
Christchurch	Thursday, 1 April	6pm–7.30pm	Bealey 1 Room, Holiday Inn, Cnr Barbados Street and Oxford Terrace
Dunedin	Friday, 2 April	12pm–1.30pm	Chesters Lounge, The Dunedin Centre, 1 Harrop Street

