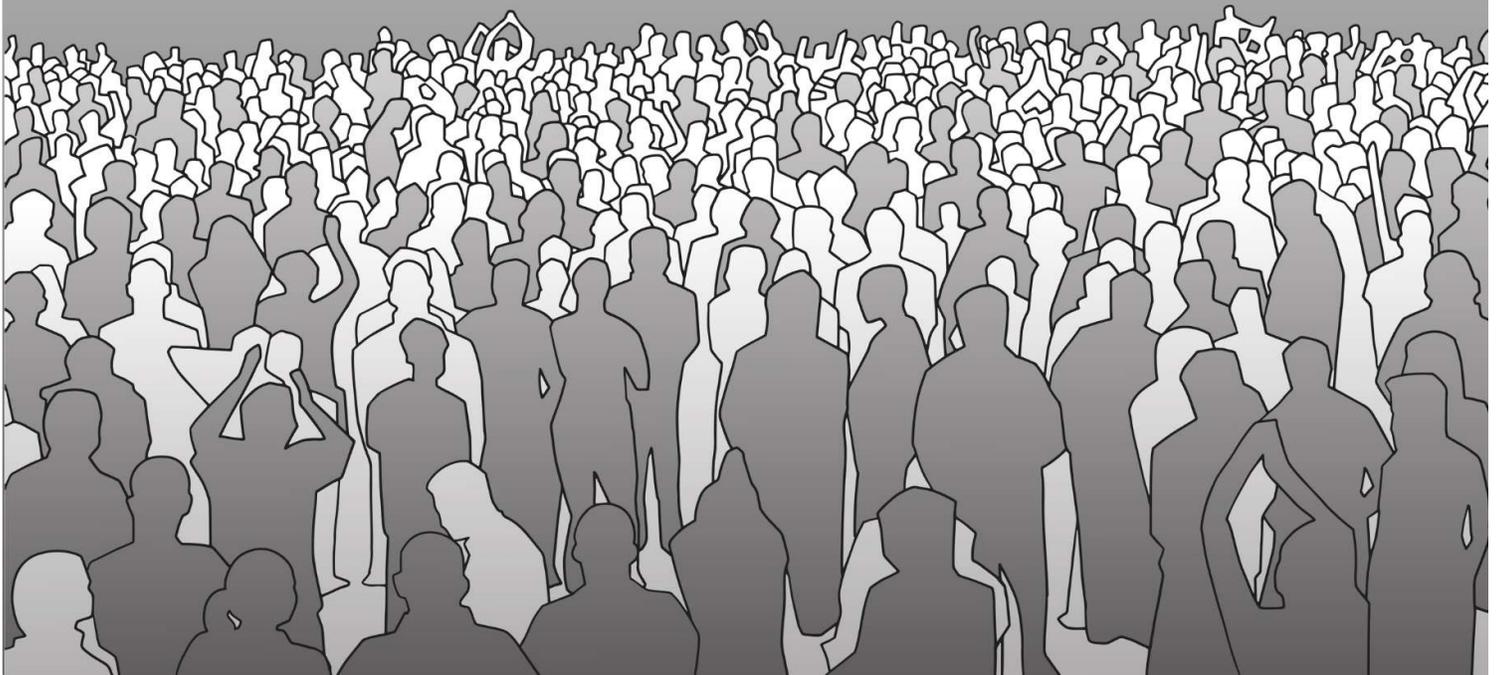


Health Consumer Advocacy Alliance Supplementary Submission H

29th October 2025

*Response to Ministry of Health | Manatū Hauora Submission to the Health
Select Committee, on 9 October 2025 on HCAA Petition to Establish an
Independent Patient Safety Commissioner*



A Patient Safety Commissioner: Restoring Trust, Driving Systemic Reform, Elevating the voices of Patients and Health Staff

The Health Consumer Advocacy Alliance (HCAA) provides this response to the Ministry of Health’s submission, which was prepared in response to the Health Select Committee’s request for further information on the proposal to establish an independent Patient Safety Commissioner (PSC). While the Ministry’s submission contends that the Health and Disability Commissioner | Te Toihau Hauora (HDC) and other existing bodies sufficiently cover patient safety functions, a closer analysis reveals significant gaps that the proposed PSC would address.

1. Independence & Remit

The HDC’s statutory role is largely complaint-driven, retrospective, and oriented to rights and discipline rather than proactive system-level advocacy. By contrast, a PSC reporting to Parliament would provide independent oversight, give voice to patients and whānau in systemic safety issues, and operate outside the service delivery and regulatory nexus, thereby enhancing public trust. The Ministry’s submission conflates legal power with functional independence, it fails to assess how structural design influences culture, responsiveness, and perception.

2. Added Value, Not Duplication

The Ministry argues that a PSC would duplicate existing bodies and confuse the public. Yet international precedents show otherwise, for example the UK PSC has issued system-wide recommendations beyond routine regulator outputs, and the Scottish PSC has been enacted via statute with distinct convening and advocacy functions. The risk of confusion is real only if a PSC’s role is not clearly defined. However, duplication is avoidable via clear legislation, MOUs and referral pathways. The Ministry did not propose such design solutions. The correct question is whether a PSC reduces net harm, improves transparency and timeliness, not whether it adds some administrative overhead.

3. Evidence and International Precedent

The Ministry suggests international evidence is too thin. But the UK PSC’s published annual reports already show early tangible impact. Likewise, Scotland has legislated a PSC, signalling a clear policy choice to bolster independent oversight. Ignoring these examples weakens the Ministry’s case that benefits are “unknown.” Early does not mean ineffective, and policy should learn from emerging practice.

4. Cost-Benefit & Harm Prevention

The submission emphasises cost uncertainty but does not compare costs of establishing the PSC with costs of preventable harm, clinical, human, and societal impacts. A full assessment must model cost savings of avoided harms alongside the expenditure of a new entity, and the absence of such modelling biases toward the status quo.

5. Proposed Design Considerations

An effective Patient Safety Commissioner (PSC) should be established in statute, accountable to Parliament, and empowered to act across the health system. The role must amplify the voices of patients, whānau, health staff, and health professionals, identify systemic risks, and drive shared learning to prevent harm. The PSC should also hold authority to convene agencies and independently investigate system-level threats to safety and quality of care.

Clear delineation of roles is critical:

- Health and Disability Commissioner (HDC | Te Toihau Hauora): Upholds individual rights, manages complaints, and oversees disciplinary processes.
- Health Quality & Safety Commission (HQSC | Te Tāhū Hauora): Leads quality improvement, data-driven learning, and system safety initiatives.
- Patient Safety Commissioner (PSC): Provides independent advocacy and oversight, representing patient, whānau, and workforce perspectives, and addressing system-level safety concerns that fall between existing agencies.

The integrity of this model depends on transparent public reporting, strong operational independence, and safeguards against political or institutional capture. These features will strengthen trust, support workforce wellbeing, and deliver lasting improvements in safety across the health system.

Table: Refuting the Ministry of Health’s Comparison of a Patient Safety Commissioner with Existing Entities

Area of Comparison	Ministry’s Position / Assumption	HCAA Response
Primary purpose	The HDC and HQSC already address patient safety through rights protection and quality improvement, a PSC would duplicate this.	The HDC’s role is complaint driven and retrospective, and the HQSC’s is improvement focused within the health system. A PSC would uniquely act as an independent, proactive voice for patients and whānau, identifying system level risks and advocating directly to Parliament, functions neither HDC nor HQSC perform independently or at all. Rebuilding public trust, a core tenet of the PSC’s responsibility, is crucial given the current state of our health system.
Independence	Existing bodies are sufficiently independent	The HDC and HQSC are operationally and financially linked to the Ministry and Health NZ structures, and report through the Minister of Health.
Overlap and duplication	Overlap with HDC and HQSC would cause inefficiency.	Some degree of overlap is both inevitable and beneficial when it strengthens oversight and mitigates systemic blind spots. The proposed role would “connect the dots,” fostering coordination and coherence across the various dimensions of health safety within and between entities. The aim is complementarity, not duplication! Clear legislative design can delineate functions effectively: the HDC focused on rights and complaints; the HQSC on system improvement and consumer engagement; and the PSC on independent, proactive system-level advocacy and accountability , with the ability to respond with agility and speed to patient harm and with particular emphasis on monitoring and oversight of outcomes arising from recommendations.
Cost and efficiency	Uncertain costs make establishment risky.	Cost should be weighed against the human and financial cost of preventable harm. A PSC that helps prevent even a small number of serious adverse events or systemic failures would offset its operating cost. The Ministry provided no harm cost analysis, which undermines its conclusion. HCAA’s cost analysis based on the Scottish PSC, and international costs of patient harm, are set out in the Appendix to this Submission.
Timeliness of response	HDC could perform PSC functions if better resourced.	The issue is not resourcing but design. The HDC’s complaint driven model inherently creates delays and limits proactive work. A PSC’s agile, focused structure allows faster response to systemic safety concerns, without being tied to individual case resolution.

Area of Comparison	Ministry's Position / Assumption	HCAA Response
Patient and whānau voice	Patient voice is already represented through existing agencies.	Consumer input into HQSC and HDC processes is constrained and advisory, not authoritative. A PSC would embed the patient voice as an independent public advocate, elevating it from consultation to genuine system influence.
Voice of health professionals and staff working within existing Health Entities	The submission focuses almost exclusively on patient voice and existing regulatory structures, with no consideration of how health professionals raise or escalate systemic safety concerns, or the barriers health staff face when working for our Health Entities.	The Ministry's submission fails to acknowledge that frontline health professionals often face barriers to speaking up, including fear of repercussions and lack of independent reporting channels. At present, staff within health entities have limited protection when raising individual concerns or complaints and require stronger safeguards. Reporting of harm is largely a passive and voluntary system, and many health professionals are too busy to make reports of harm, while some harm only becomes evident outside the hospital system and goes unreported. A Patient Safety Commissioner would provide an impartial, trusted avenue for clinicians, nurses, and allied health workers to raise safety concerns, contributing essential insight from those closest to patient care.
System-wide learning and collaboration	The submission assumes existing coordination between agencies is sufficient to support learning from adverse events and near misses.	The Ministry does not address the persistent problem of lessons remaining confined within individual organisations. A PSC would ensure independent oversight and public reporting of systemic learning, creating national visibility of risks and solutions that transcend organisational boundaries. The National Quality Forum supports quality improvement through standard-setting and consensus-building but lacks independent oversight, transparency or advocacy functions, and therefore cannot replace a Patient Safety Commissioner.
Breaking down barriers between entities	The submission assumes existing coordination between agencies is sufficient to support learning from adverse events and near misses.	The Ministry does not address the persistent problem of lessons remaining confined within individual organisations. A PSC would ensure independent oversight and public reporting of systemic learning, creating national visibility of risks and solutions that transcend organisational boundaries.
Proactiveness before breach	The submission assumes that there will always be a breach of code before investigations need to occur.	With a proactive role, as is the case with an independent PSC, a breach of code doesn't necessarily have to happen for an investigation to occur. For example, an investigation into understaffing, and the patient harm that could result from that, could happen before a complaint is laid with HDC. We know not all breaches result in complaints laid with HDC. This means systemic changes can occur before a breach. This systemic investigation would be done by a PSC.

HCAA Recommendation

In summary, the Ministry of Health's submission overlooks critical gaps in the current system, including the absence of independent oversight, the lack of avenues for health professionals to raise concerns, significantly reduced consumer engagement pathways and the fragmentation between health entities. Establishing a Patient Safety Commissioner is not duplication, it is a necessary safeguard to ensure that patients, whānau, and health professionals alike have a credible, independent voice in systemic safety matters. The evidence from the UK and Scotland demonstrates that an independent Commissioner can produce tangible system-wide improvements, strengthen public trust, and break down organisational silos.

Internationally we see this working, the UK and Scotland now have PSCs with concrete outputs, so the 'benefit unknown' argument does not hold. We should learn from the design lessons, not dismiss them. Yes, overlap is possible, but duplication can be designed out. What matters is net safety gain, greater patient trust, faster responses to harm. We should measure cost versus avoided harm, not just cost alone.

While the HDC has the potential to address systemic issues, it is currently unable to do so effectively and operates mainly reactively. Creating an independent Patient Safety Commissioner role that is aligned to the HDC but independent of the agency, would take this burden off the HDC, enabling it to focus on its core responsibilities while ensuring systemic problems are addressed and complaints are reduced over the long term.

Please support the creation of legislation to establish an independent PSC role with a clear remit, accountability to Parliament, and defined interfaces with the HDC and HQSC and all other Health Entities, ensuring a stronger patient safety framework rather than relying solely on existing bodies.

Appendix

Financial costings for establishing PSC in Scotland and England

Patient Safety Commissioner for Scotland (Stand-alone model)

The Patient Safety Commissioner for Scotland has a broad systemic remit, designed to drive reform and improvement across the entire health landscape. The role is an independent statutory position created through the Patient Safety Commissioner for Scotland Act 2023. The Commissioner's mandate is to strengthen the safety of health care across Scotland by promoting systemic improvement and ensuring that the voices and experiences of patients and the public inform safety practices. The remit applies to all health service providers, including NHS bodies, organisations contracted by the NHS, and independent healthcare services. The Commissioner has authority to collect and analyse information, investigate patterns of concern, and issue recommendations to improve safety. The position does not extend to resolving individual complaints or providing redress for specific cases.

Estimated Costing Summary

Set-up costs: The Financial Memorandum for the Bill sets out estimated establishment (“set-up”) costs totalling £150,234 for 2023/24 and 2024/25 combined.

Annual ongoing costs: £644,065 (based on 2025/26 assumptions).

Conclusion: These figures for Scotland are accurately supported by the Public Financial Memorandum. [parliament.scot/1](https://parliament.scot/)

Patient Safety Commissioner for England (Stand-alone model)

The Patient Safety Commissioner for England is an independent statutory office created under the Medicines and Medical Devices Act 2021 to strengthen the safety of patients in relation to the use and regulation of medical products. Unlike its Scottish counterpart, the role has a narrower remit, focusing specifically on medicines and medical devices rather than the broader health system. The role exists to ensure that patient experience and lived evidence inform decision-making about medicines and devices, and to encourage greater accountability and responsiveness across the health system. The Commissioner identifies patterns of risk, promotes learning across organisations, and works with regulators and policymakers to prevent harm. The office does not handle individual complaints or clinical cases but focuses on improving safety within this defined scope.

Staffing numbers: The review does not provide a clear number of full-time equivalent (FTE) staff for the Commissioner's office.

Budget/operating cost: There is an annual report for the Commissioner covering 2024-25 (published June 2025) but no publicly published breakdown of set-up cost or full annual budget for this office.

The earlier “Review of patient safety across the health & care landscape” (July 2025) refers to the Commissioner as one of six bodies under review, but does not give a discrete annual cost for the office. [GOV.UK/1](https://gov.uk/)

Conclusion: For England, the set-up cost is not publicly available, and the annual cost is not clearly stated in the sources found. The earlier figure cited (~£600,000) appears incorrect or unsupported by the referenced document.

Evidential Reliability and Caveats

Scotland: All costings and staffing assumptions are drawn directly from the Scottish Parliament's Financial Memorandum, which is a verified and authoritative source. The figures are *estimates* projected at time of Bill introduction; actual costs may differ as the organisation grows.

England: Financial data are not publicly disclosed. Expenditure is integrated into DHSC's accounts, and any quoted figures should be regarded as indicative only unless validated through an official budget line or Freedom of Information release. The lack of detailed publicly disclosed cost breakdown means any figure cited (unless from a reliable budget line) should be treated as *unverified*.

Inflation, accommodation type, scope of duties and staffing mix can all affect eventual costs and may change from initial estimates.

Comparative Comments:

- Scotland’s model provides a clear breakdown of one-off set-up cost and estimated annual cost.
- England’s model provides only the ongoing annual budget (≈£600K) and staffing level (≈4.8 FTE), but no published one-off establishment cost.
- The scale of Scotland’s annual cost (≈£645K) is comparable to the England budget (≈£600K), suggesting broadly similar order of magnitude for a commissioner office of this type.

Comparative costing for establishing a Patient Safety Commissioner office in Aotearoa New Zealand aligned with an existing agency but independent:

The Scottish model provides a robust basis for comparison. The Scottish Parliament’s Financial Memorandum for the Patient Safety Commissioner for Scotland Act 2023 confirms a one-off establishment cost of £150,234 and an estimated annual running cost of £644,065. These figures include recruitment, accommodation fit-out, IT and website establishment, marketing and payroll set-up, and salaries for one Commissioner and four staff (five FTE in total). Converted at the October 2025 exchange rate of £1 = NZ\$2.32, the equivalent New Zealand costs would be approximately NZ\$348,543 for set-up and NZ\$1,494,231 for annual operating expenditure. These figures are reliable as they are derived directly from the Scottish Parliament’s official Financial Memorandum.

In contrast, the Patient Safety Commissioner for England is not a separate legal entity but is hosted within the Department of Health and Social Care. Its expenditure is incorporated within the Department’s consolidated accounts, and no separate published set-up or annual cost figure is available. The Commissioner’s 2024–25 annual report confirms that all finance and staffing are handled through DHSC.

Using the Scottish figures as a benchmark, it is reasonable to model two cost scenarios for New Zealand:

Option A (Aligned with existing agency whilst remaining independent-legislative powers):

Aligning the Commissioner’s office with an existing Crown entity such as the Health Quality and Safety Commission or the Health and Disability Commissioner, while retaining statutory independence, would enable efficient establishment and use of existing infrastructure. Shared corporate services delivered through a formal service-level agreement would significantly reduce duplication and overhead. Indicative estimates suggest a set-up cost of approximately NZ\$210,000 and annual operating costs between NZ\$1.05 and NZ\$1.10 million, reflecting a streamlined model proportionate to New Zealand’s system size. These figures are rough projections based on proportional reductions from the Scottish model and should be treated as illustrative rather than definitive.

This approach would allow for a faster, more cost-efficient establishment while ensuring independence and accountability, representing a pragmatic investment relative to the potential savings from reduced preventable harm and improved system safety.

Rationale for Lower New Zealand Estimates: The Scottish set-up cost converts to approximately NZ\$349,000, which is higher than the indicative NZ estimate of NZ\$210,000. Scotland’s higher cost reflects the expenses of establishing a new, standalone office, including a full commercial fit-out, separate IT systems, and independent procurement. The Scottish annual operating cost converts to around NZ\$1.49 million, compared with the proposed NZ range of NZ\$1.05–1.10 million. These efficiencies draw on existing corporate infrastructure within agencies such as the Health Quality and Safety Commission or the Health and Disability Commissioner, where some administrative and overhead costs could be absorbed or provided in kind during the initial year of operation.

HCAA recommend:

1. **Phased staffing (start small):** Start with the Commissioner + a very small core team (e.g. Commissioner + 2–3 FTE) for the first 12 months and scale once the role is proven, rather than hiring the full complement at day one.
2. A short financial scoping exercise with the proposed host agency (HQSC or HDC) to validate these indicative figures and confirm availability of secondments and in-kind support.
3. Reduce fit-out and lease costs by using existing office space, a hybrid workplace model, and the host agency's leased space rather than procuring a separate leased premises and full fit-out. This not only minimises accommodation costs but also supports and fosters collaboration.

Option B (stand-alone model): The office would be established as a fully independent entity with its own lease, IT infrastructure, HR, and financial systems. Replicating the Scottish model in full would cost approximately NZ\$348,543 for establishment and NZ\$1.49 million in annual expenditure. This provides complete autonomy but requires higher administrative and corporate overheads.

The largest variable cost in either model is remuneration. Comparable roles within New Zealand's public sector indicate a commissioner salary range between NZ\$180,000 and NZ\$320,000 depending on seniority, statutory remit, and alignment with Crown entity chief executive pay bands. Staffing costs for four additional FTEs, accommodation, IT, and operational support would comprise the balance of the budget.

Key cost sensitivities include pay settings, accommodation arrangements, and whether IT and administrative systems are shared or independent. Hosting within an existing agency can reduce both set-up and annual costs by approximately 25–30 percent.

In summary, a New Zealand Patient Safety Commissioner office based on the Scottish model would require around NZ\$350,000 to establish and NZ\$1.5 million per year to operate if fully independent. A hosted model would likely cost NZ\$210,000 to establish and NZ\$1.05-1.10 million annually to operate. The Scottish estimates are well-documented and provide a credible reference point for financial planning. The English model offers less transparency due to its integration within DHSC accounts. For Cabinet or Treasury consideration, New Zealand costings should be refined using current public sector salary bands, local accommodation rates, and a verified exchange rate on the date of submission.

The Cost of Patient Harm

It appears that there has been no financial analysis of the cost of patient harm and medical injury in Aotearoa New Zealand; either direct costs within the health system or the downstream costs to individuals, whānau, communities, or loss of productivity and tax revenue.

A [2022 OECD report](#) found that “In developed countries, the direct cost of treating patients who have been harmed during their care approaches 13% of health spending. Excluding safety lapses that may not be preventable puts this figure at 8.7% of health expenditure.”

In New Zealand, [the 2025/26 health budget is \\$32.7 billion](#). Based on the OECD figure of 8.7% (above) for developed countries, we spend \$2.8billion per year just treating New Zealanders who have suffered **preventable** harm in the health system.

The Value of an Independent Patient Safety Commissioner in Aotearoa New Zealand

The Patient Safety Commissioner for England is statutorily focused on medicines and medical devices, but her work has extended to broader patient safety issues. By incorporating patient perspectives and promoting system-wide learning, she has strengthened accountability and contributed to a more proactive and transparent safety culture. We face similar coordination and safety challenges in New Zealand, highlighting the potential value of a dedicated commissioner here.

The Scottish model, with its broader systemic remit and focus on driving reform across the entire health landscape, is particularly well-suited to Aotearoa New Zealand, where persistent fragmentation and siloed accountability continue to undermine cohesive patient safety improvement.

Establishing a Patient Safety Commissioner role in Aotearoa New Zealand represents a modest and strategically justified financial investment when weighed against the significant economic, clinical, and human costs of preventable harm. The indicative establishment costs are small relative to the scale of loss associated with adverse events in the health system. Studies in comparable jurisdictions have shown that preventable harm accounts for billions in avoidable expenditure each year, including extended hospital stays, additional treatment costs, workforce disruption, and productivity losses. Beyond these tangible costs, preventable harm leaves deep and enduring scars on patients, whānau, and clinicians, undermining public confidence and causing emotional and social harm that no system can easily measure or repair.

An independent Commissioner dedicated to identifying systemic risk, amplifying consumer voice, and strengthening accountability offers measurable long-term return on investment. Even marginal reductions in the incidence of preventable harm would offset operational expenditure many times over. For example, preventing a small proportion of high-cost adverse events such as medication errors, surgical complications, or missed diagnoses would generate savings exceeding the Commissioner's entire annual budget.

Establishing an independent Patient Safety Commissioner is not an added cost but a vital investment in the safety, trust, and integrity of our health system. The HCAA feel strongly that Aotearoa needs a specific role committed to strengthening and rebuilding public trust in our health system, and to actively foster a culture of safety.

An independent Patient Safety Commissioner is the safeguard our health system needs. This role will help to build a safer and more resilient health system for everyone. It is a clear win for patients, health professionals, the government and the wider community!

The missing but vital piece of the puzzle!

