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MEDIA STATEMENT

For Immediate Release

HCAA Responds to Petition Report Health Select Committee's Plan: Cross Fingers and Hope!

HCAA's petition to Parliament focused squarely on patient safety. The Health Committee's final report, now released, fails on multiple fronts to address the accountability gaps that place patients, whānau, and health staff at ongoing risk. It accepts unsubstantiated assurances at face value, sidesteps structural failures, and avoids confronting clear evidence that the system remains reactive, opaque, and incapable of preventing repeat harm.

While acknowledging ongoing systemic issues, the report treats existing inter-agency arrangements as sufficient, leaving those failures largely unchallenged. There is no mechanism for consumers to raise concerns about the conduct, performance, or failures of New Zealand's oversight bodies and Health Entities themselves. The Committee ultimately concludes by saying it merely "hopes" existing agencies will address these issues, while making no recommendations whatsoever. This exposes a failure far deeper than patient safety alone: the absence of any credible, independent oversight of the system itself.

The Committee states: ***"We hope that the work of the Health and Disability Commissioner and [other health sector entities]... will help address systemic issues in the health sector."*** Hope, however, is not accountability. Promises of future regulatory reform are accepted without challenge, despite repeated and well-documented failures. Workforce safety is largely ignored, and the system's persistent inability to learn from past harm continues to allow preventable failures to recur.

Although the Committee acknowledges serious problems, it proposes no action to address them. This approach amounts to little more than crossing fingers and hoping for improvement, a response that risks further eroding public confidence in the parliamentary process.

Oversight remains embedded within the very system it is meant to scrutinise, undermining transparency, learning, and sustained improvement. The consequences extend beyond patient safety, affecting equity, access to care, workforce wellbeing, and overall quality of care. Submitted evidence is dismissed, contradictions over independence between the Ministry of Health and the Health and Disability Commissioner go unexamined, and the report offers no explanation for how meaningful system improvement could be sustained across political cycles without independent parliamentary oversight.

Ending the report by stating that the Committee "hopes" existing agencies will address systemic issues is an abdication of parliamentary responsibility. Transparency, independence, and visibility are not optional; they are foundational to a safe health system. This failure is precisely why HCAA launched its petition: to demand independent oversight and real accountability. Patients, whānau, and health staff deserve a system that intervenes before harm occurs, learns from failure, and can be held to account when it does not.

The Health Select Committee has acknowledged systemic issues. How will “hope” address system failures?

[Read HCAA’s submissions plus supporting evidence](#) from other health organisations and individuals



10 Key Issues Overlooked in the Health Committee Report

The [Health Committee’s report](#) accepts assurances at face value, overlooks structural accountability gaps, and fails to confront evidence that the health system remains reactive, opaque, and unable to prevent repeat harm at scale.

The Committee literally concludes its report by saying it “*hopes*” existing agencies will address systemic issues and strengthen advocacy, while making no recommendations whatsoever. In a system marked by ongoing, preventable harm, reliance on hope is not just inadequate, it represents an abdication of accountability. This failure to act is exactly why the petition was launched, to call for independent oversight and real accountability where the system has repeatedly failed those it is meant to protect.

1. The report fails to address the absence of any mechanism for consumers to raise concerns about the health bodies that are currently positioned as having oversight of the system, which leaves our Health Entities effectively unaccountable.
2. While the report acknowledges that unintentional and preventable harm continues to occur, it fails to respond meaningfully to overwhelming evidence that patients and health staff face ongoing, preventable harm.
3. The report treats existing agencies as operating proactively, despite evidence that significant interventions typically occur only after serious harm, sustained public pressure, or media exposure.
4. Contradictory statements from the Ministry of Health and the HDC about their independence are not examined, undermining confidence in current accountability claims.
5. Without independent oversight, health system improvements remain vulnerable to shifting political priorities, organisational restructures, and changes in ministerial focus.
6. Assertions that feedback and restorative practices are improving are accepted without evidence, despite the absence of a national restorative framework.
7. The claims in the report of ‘system strengthening’ completely overlooks the significant voids in consumer engagement across the health system, especially localised engagement that is genuinely consumer-led, the learning capability of the health system as a whole, and the massive cuts in experience of our existing workforce.
8. Reliance on the National Quality Forum is untested in practice, with no scrutiny of its transparency, effectiveness, auditing, or independence.
9. The report accepts future regulatory reform promises as sufficient, despite repeated failures and reversals, including over reliance on outdated medicines and unregulated devices still causing harm.
10. Workforce safety concerns are still not being properly addressed, despite evidence that clinicians and health staff fear speaking up and lack effective, independent escalation pathways.

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