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RESEARCH AND EVALUATION

Health Ombudsmen in Polycentric Regulatory Fields: England, New Zealand, and Australia

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Health ombudsmen (health complaints commissioners), an unusual entity internationally, exist only in England, New Zealand, and the Australian states and territories. Established to respond to complaints from patients, the intention is to make health services and professionals more accountable to the public. Most cases are handled around the softer base of a regulatory pyramid, such as advice to complainants and requests to providers for an explanation and/or apology. Few cases escalate to investigations and prosecutions. Although the legal powers of some health ombudsmen to redress individual grievances have been strengthened, most lack the independent power to initiate an inquiry into systemic problems. To produce quality improvements, health ombudsmen need powers to require compliance from providers and to initiate inquiries. With the advent of new health sector regulators, health ombudsmen must negotiate their role and function within expanding networks of governance.

Key words: *complaints commissioners*, *complaints management*, *health ombudsmen*, *health sector regulation*, *patient grievances*

Governments have established new actors and new strategies over the last decade intended to make healthcare providers more accountable for their performance to the state and public (Healy 2011; Smith et al. 2012). This paper analyses the role and function of health ombudsmen (also known as health complaints commissioners) in the expanding field of health sector regulation. An unusual entity in international terms, this hybrid form of ombudsman exists only in England, New Zealand, and Australia, all 'Westminster model' countries with well-established health systems. England appointed its health service ombudsman in 1973, New Zealand its health and disability commissioner in 1994, and health complaints commissioners in all Australian states and territories date from the 1980s onwards. Health ombudsmen thus are an 'anglophone' and late 20th-century strategy for making healthcare providers more accountable to their patients.

The term 'ombudsman', Nordic in origin and meaning 'representative', refers to an independent official, usually elected by parliament or appointed by government, with a constitutional or legislative mandate to represent the interests of citizens and to investigate and mediate (and sometimes prosecute) their complaints about public (and sometimes private) agencies. The role of the ombudsman is 'to protect the people against violation of rights, abuse of powers, error, negligence, unfair decisions and maladministration and to improve public

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administration while making the government's actions more open and its administration more accountable to the public' (International Ombudsman Institute 2015).

This paper focuses on health ombudsmen (anglicised here as a plural term) in five jurisdictions: England, New Zealand, and the three most populous states of Australia (New South Wales, Victoria and Queensland). Three questions are addressed:

- Has the office of health ombudsman changed in scope and powers since its inception?
- How do health ombudsmen make healthcare providers more accountable?
- What is the function of health ombudsmen within networks of health sector governance?

The method for this study (part of a larger project on healthcare complaints) included a literature review, website search, interviews with ombudsmen staff, and an examination of health ombudsmen annual reports and legislation. Databases, principally SCOPUS and PubMed, were searched using the terms 'ombudsman', 'health ombudsman', 'health commissioners', and 'health complaints entities'.

Polycentric Health Sector Governance

Established health sectors are characterised by 'polycentric governance' undertaken not by a dominant and authoritative regulator but rather by both state and non-state actors (Black 2008), who undertake a mix of regulatory strategies ranging from persuasion to enforcement in order to steer the flow of events (Ayres and Braithwaite 1992). The growth of the network society, with its complex flows of power, makes governance more challenging than in earlier eras, because governance can no longer be managed solely through older hierarchical structures, such as central government departments (Castells 2000). The architecture of regulatory fields is being redrawn, with health sector governance, in particular, undertaken not solely by a central 'command and control' state agency or by the health professions themselves, but rather by a plurality of actors who form 'more or less interconnected governance networks' (Burris et al. 2005: 31).

The health ombudsmen warrant attention as a unique regulator within the health sector in that their core statutory mandate is to respond directly to the grievances of citizens/consumers. Health ombudsmen are important because health sectors generally have been slow to respond to patient concerns about their treatment, despite the right to complain being a key principle in public administration and market economies. Democratic countries have an array of grievance mechanisms as the right of a citizen to complain about maladministration and unfair decisions by an authority is held to be a key civil liberty. As John Milton wrote in his pamphlet appeal, *Areopagitica*, to the Parliament of England in the 17th century, 'When complaints are freely heard, deeply considered, and speedily reformed, then this is the utmost bound of civil liberty attained that wise men look for' (Milton 1644).

The Office of Ombudsman, Its Function and Spread around the World

The ombudsman institution has diversified as offices have multiplied and adapted to different countries and different functions (Gregory and Giddings 2000). The International Ombudsman Institute lists more than 150 public sector member institutions in some 85 countries (International Ombudsman Institute 2015). Although the ombudsman concept originated in Sweden in 1809, the Swedish Parliamentary Ombudsman has magnanimously commented, 'The ombudsman is not a Swede anymore. The word itself has left home, like a dear child, to live a life of its own' (Axberger 2009: 9).

An ombudsman has two main roles. First, as an independent officer an ombudsman aims to resolve the grievances of constituents with public agencies. Second, an ombudsman may act as 'a public watchdog' in making institutions more accountable, by calling for systemic reforms of poor services and poor procedures and by identifying breaches of people's rights. Public service ombudsmen, appointed by parliament or government, usually have a broad

mandate to deal with the entire public sector, and sometimes also elements of the private sector (e.g. agencies subsidized, contracted, or subject to legislation by government). Ombudsmen respond to complaints from the public with advice and conciliation (softer regulation), but also through stronger regulatory methods, although they vary in their powers to formally investigate a complaint (e.g. to enter and seize documents), impose sanctions, enforce their decisions, and prosecute.

Other specialised ombudsmen, as well as health ombudsmen, now exist in many areas, such as human rights, for population groups such as children, and in fields such as energy and banking. In addition, industry-based ombudsmen respond to complaints against industry members, whereas 'organisational ombudsmen' have proliferated; for example, many hospitals now employ complaints managers. Attaching the ombudsman label to an internal grievance mechanism is problematic, as the role may lack impartiality and independence. Such actors have grown in number, as evident from the 900 members of the IOA (International Ombudsman Association 2015).

An analysis of the office of ombudsman in 47 European countries identified three broad models: standard or classic, 'rule of law', and human rights (Kucsko-Stadlmayer 2008, 2009: 12). In the standard model, an ombudsman undertakes three key tasks: enquires into a complaint, makes recommendations as to its resolution, and reports to the public on these activities. This type of ombudsman acts as 'a third party' who settles a grievance brought by one party, a citizen, against another party, a public or private entity (Black and Baumgartner 1998).

In the 'rule of law' model, an ombudsman seeks to uphold the law: for example, the Swedish *Justitieombudsman* (Justice Ombudsman) is appointed by the *Riksdag* (Parliament) to monitor the proper application of the law (Axberger 2009). This type of ombudsman has powers to require the party complained about to engage in a settlement process, may initiate investigations and prosecutions, and some can appeal administrative decisions to courts.

In the human rights model, an ombudsman has powers to contest administrative decisions before constitutional courts (similar to the 'rule of law' model), but focuses on upholding human rights, and has a mandate to advise government on human rights. Such an ombudsman seeks to influence politicians and the public through mechanisms such as public reports.

Establishment of New Health Sector Regulators

Regulation of the practice of healthcare is being overhauled in many countries to make providers more accountable for safety and quality. This is a major shift since the regulation of healthcare providers previously was seen as an internal matter best left to the professions and the health industry (Healy and Dugdale 2009; Short and McDonald 2012). The downside of establishing multiple regulators to strengthen provider accountability, however, has been to increase complexity, as evident from the following country summaries.

England and its unitary government (the United Kingdom having devolved arrangements for Wales, Scotland, and Northern Island) have established new health sector regulators and restructured others, with some covering England (the National Health Service) and others the United Kingdom (the health professions). The health professions are regulated by nine United Kingdom boards/councils (e.g. the UK General Medical Council), each with its own legislation and arrangements, including on the management of complaints by patients, overseen by the UK Professional Standards Authority with strengthened powers under the *Health and Social Care Act 2012*. Other regulatory entities include the Care Quality Commission that inspects public social care and hospitals in England; Monitor (an executive non-departmental public body) regulates the National Health Service (NHS) foundation trusts and private healthcare; and the National Institute for Health and Care Excellence (NICE) recommends drugs and procedures for

the NHS and promulgates clinical protocols. NHS England sets quality standards and works with local clinical groups in purchasing specialised and primary care services, and the National Patient Safety Agency promotes patient safety standards and practices in the NHS.

Health regulation in New Zealand is carried out at the national level given the country's unitary form of government. Complaints about doctors are managed in a co-regulation arrangement whereby people may complain either to the Medical Council or to the health and disability commissioner who then cross-refer cases, including to the Human Rights Review Tribunal. Regulation of the health professions was overhauled under the *Health Professionals Competency Assurance Act 2003*, which replaced 11 statutes for the separate health professions, established a common framework for registration and disciplinary proceedings, and set up an independent Health Practitioners Disciplinary Tribunal.

In Australia, health sector reform is complex with constitutional constraints and a federal system of government. Health ministers in the six states and two territories are responsible for public hospitals, not the federal government. In addition, most general practitioners and specialists work in the private sector. Although several national regulatory entities were established in 2010, health sector regulation remains fragmented across many entities and two levels of government (Dugdale and Healy 2014). National boards for the health professions replaced the state and territory boards in 2010 and today cover 14 health professions that come under the jurisdiction of the *Health Practitioner Regulation National Law 2009*, which came into effect from 1 July 2010. The Australian Health Practitioner Regulation Agency (AHPRA), the new meta-regulator, supports and oversees the national boards and is responsible for health professional registration (licensing), receiving notifications (complaints) about registered health professionals, and accreditation standards for health professionals (Pacey et al. 2012). AHPRA undertakes preliminary assessments of complaints on behalf of the national boards (except for New South Wales and Queensland). Board sub-committees (panels) deal with less-serious complaints and refer more-serious matters to independent state- and territory-level civil and administrative tribunals. Tribunals generally publish their decisions and routinely name a sanctioned practitioner. APHRA publishes registers of practitioners, their specialty area, whether conditions apply, and whether registration has been revoked.

No national and independent regulator exists for public and private hospitals and other health facilities in Australia's federal system. The Australian Commission on Safety and Quality in Health Care, a statutory organisation from 2010, leads (but cannot enforce) improvements in safety and quality (Australian Commission on Safety and Quality in Health Care 2011). The *National Health Reform Act 2011* gave the commission powers to collect and analyse information relating to safety and quality, but reform depends on state and territory health ministers taking action. Under the national accreditation scheme agreed by all health ministers, 10 mandatory standards apply from January 2013 to hospitals and day procedure services, such as a requirement to have procedures in place to prevent and manage medication incidents. Approved accrediting agencies, such as the Australian Council on Healthcare Standards, must notify the state/territory health department, if a significant risk of patient harm is identified during an onsite accreditation visit. State and territory health departments also run their own safety and quality programs, including requiring their public hospitals to report serious adverse events (so-called 'sentinel events') experienced by patients during a hospital admission, but this notification is confidential and not in the public domain.

Since 2012, the National Health Performance Authority has been reporting selected performance indicators for public and private hospitals and primary healthcare organisations. The Independent Hospital Pricing Authority, an independent government agency established under the *National Health Reform Act 2011,* funds Australian public hospitals using activity-based funding based on a 'national efficient price'. Fraudulent

financial claims by health professionals upon Medicare, including over-servicing, are investigated by the Professional Services Review scheme. At state/territory level, health departments and quality councils to varying degrees monitor public hospital performance, whereas health commissioners, coroners, and auditors sometimes issue reports on systemic health sector failures.

Health Ombudsmen in England, New Zealand, and Australia

History and Legislation

Table 1 lists the health ombudsmen and their enabling legislation. Although a public service ombudsman already existed in all jurisdictions, these were regarded as having insufficient expertise to resolve the complexities of patient grievances about their healthcare. Professional boards were too often inclined to protect the interests of professionals, whereas health departments were disinclined to admit to poor practice in their public hospitals (and in all three countries the majority of hospitals are in the public sector). Further, all the health ombudsmen were established in response to a medical scandal (Healy 2011: ch. 2).

England

In England, twin ombudsmen, the parliamentary commissioner for administration and the health service commissioner for England, are known collectively as the parliamentary and health service ombudsman. The health service ombudsman was created under the *National Health Service Reorganisation Act 1973* to address the lack of accountability of the National Health Services (NHS), which had been excluded from the remit of the parliamentary commissioner for administration. Second, the 1973 Davies Report had criticised the NHS internal complaints system for allowing hospitals to determine their own procedures (Mulcahy 2003: 33). Third, dissatisfaction with NHS services had grown, fanned by scandals including the poor care of the elderly and mentally ill at several NHS hospitals (Caiden et al. 1983).

With his/her independence protected under legislation, the health service ombudsman draws most powers from the *Health Service Commissioners Act 1993*. This legislation applies to England's NHS and other public but not to private services. (Since devolution, complaints about health services in Northern Ireland, Scotland, and Wales are dealt with by their own public service ombudsmen). Health complaints are a substantial part of the work of the office; in 2013–2014 the health ombudsman assessed 6093 complaints and the parliamentary ombudsman assessed 1658. In terms of the three ombudsman models outlined earlier, the health service ombudsman fits the standard model, but with elements of 'rule of law' in power to require a response from a service provider and impose sanctions.

New Zealand

New Zealand established the parliamentary commissioner for investigations in 1962 (Elwood 2009). The health ombudsman was appointed three decades later under the *Health and Disability Commissioner Act 1994*, after Judge Cartwright called for an independent commissioner and a code of patients' rights (Cartwright Report 1988). The Cartwright Inquiry was set up to investigate a scandal at the National Women's Hospital in Auckland where women with early cervical cancer symptoms were studied but not treated (Paul 2000). The New Zealand Commission contains elements of three ombudsman models: a standard model focused on redressing patient grievances, some 'rule of law' powers, and human rights in its advocacy of consumer rights. The health and disability commissioner (in *Maori* - Te Toihau Hauora, Hauātanga) examines breaches of the Code of Health and Disability Services Consumers' Rights 1996, which sets out 10 legally enforceable rights of consumers and corresponding duties of all public and private providers. Further, the commissioner can initiate prosecutions before tribunals and courts (Patterson 2002; Health and Disability Commissioner New Zealand 2014).

Australian States and Territories

Australia was an enthusiastic adopter of the ombudsman institution. The Commonwealth

Table 1. Health ombudsmen (health complaints commissioners) in England, New Zealand, and the Australian states and territories

Jurisdiction	Title	Date est.	Main legislation (as in April 2015)
England	Health service ombudsman	1973	Health Services Commissioner Act 1993 (and 1996 amendment)
New Zealand	Health and disability commissioner	1994	Health and Disability Commissioner Act 1994
	Australia: states and territories		
New South Wales	Health care complaints commissioner	1984	Health Care Complaints Act 1993 (and amendments), Health Practitioner Regulation National Law (NSW) 2009.
Victoria	Health services commissioner	1988	Health Services (Conciliation and Review) (Amendment) Act 2001, Health Records Act 2001, Health Practitioner Regulation National Law (Vic) 2009
Queensland	Health ombudsman (since 1 July 2014–); health quality & complaints commissioner (until 30 June 2014)	1991	Health Ombudsman Act 2013, Health Practitioner Regulation National Law (Qld) 2009, Health Quality & Complaints Commission Act 2006 (now superseded)
Western Australia	Health and Disability Services Complaints Office	1996	Health and Disability Services (Complaints) Act 1995, The Carers Recognition Act 2004, Health Practitioner Regulation National Law (WA) 2010
South Australia	Health and community services complaints commissioner	2004	Health and Community Services Complaints Act 2004, Carers Recognition Act 2004, Health Practitioner Regulation National Law (SA) 2009
Tasmania	Health complaints commissioner (also state ombudsman)	1997	Health Complaints Act 1995, Health Practitioners Tribunal Act 2010, Health Practitioner Regulation National Law (Tas) 2010
Australian Capital Territory	Health services commissioner (Human Rights Commission)	1994	Human Rights Commission Act 2005, Health Professionals Act 2004, Health Practitioner Regulation National Law (ACT) 2010
Northern Territory	Health and community services complaints commissioner	1998	Health and Community Services Complaints Act 1998, Health Practitioner Regulation National Uniform Legislation (NT) Act 2010

Note: The Australian states and territories are listed in order of population size, following the Australian Bureau of Statistics convention.
Source: Health ombudsmen websites, April 2015.

ombudsman was established under the *Ombudsman Act 1976* (Cth) to respond to complaints about Australian Government departments, and the Australian Human Rights Commission was established later under the *Human Rights Commission Act 1986* (Cth). Each of the six states and two territories set up statutory ombudsmen from the early 1970s onwards to respond to complaints about state government agencies, statutory authorities, local governments, and public universities.

Health complaints commissioners were appointed in all states and territories from the mid-1980s onwards (Table 1). The impetus was dissatisfaction with the responses of medical boards to complaints about medical practitioners, the lack of independent avenues for complaints about public and private hospitals, and demand for greater accountability after a series of medical scandals (Thomas 2002). Further, the Australian Health Care Agreement (an intergovernmental funding mechanism) and the amended *Medicare Agreements Act 1992* (Cth) required the states/territories to establish independent complaints bodies.

The powers, structure, and functions of the health complaints commissioners all vary somewhat depending on their jurisdictional context and legislation (Walton et al. 2012). But all are statutory entities set up to respond to consumer complaints about public and private health professionals and health services, and are funded through state government budgets with commissioners appointed for a renewable fixed term. The smaller jurisdictions combine health complaints with other areas, such as disability, community services, or human rights, and some have an umbrella office for several commissioners. The powers of commissioners were strengthened from the late 1990s onwards mostly in response to medical scandals and public inquiries, such as into the Camden and Campbelltown hospitals in New South Wales and the Bundaberg hospital in Queensland (Healy 2011: ch. 2). Health ombudsmen in Australia (with some exceptions) mostly fit the standard ombudsman model as their core business is 'grievance resolution'. Most commissioners are restricted to responding to consumer complaints, with few powers to require compliance by service providers, or to undertake systemic reviews unless requested by their minister. New South Wales is the exception (and Queensland from 2014) in possessing and using stronger powers.

The New South Wales Health Care Complaints Commission (HCCC) has elements of 'the rule of law' model in its investigation and prosecution powers, in that it can prosecute unsatisfactory conduct and serious professional misconduct cases (Health Care Complaints Commissioner New South Wales 2014). The commission receives complaints (and forwards 'notification' statistics to AHPRA) but when the 2010 national scheme was created NSW elected to retain the HCCC as a co-regulator with the professional boards. The HCCC director of proceedings prosecutes serious breaches of 'professional standards' by registered health professionals, after consulting with the relevant professional boards as required under s.90D of the *Health Care Complaints Act 1993* (NSW). The body with the most serious view of a matter is the view that prevails for decisions about whether to prosecute complaints about a registered practitioner before professional board panels, civil tribunals, or courts. The Health Professional Councils Authority was established in 2010 to support the 14 professional boards at state level under the new national regulatory scheme.

In Victoria, the health services commissioner handles less-serious complaints, whereas more-serious matters are referred to AHPRA and the relevant national board. A health quality commissioner bill was proposed in 2014 to strengthen the commissioner's powers, set up a healthcare quality council, and cover health practitioners not regulated by AHPRA. It remains to be seen whether the bill will be re-introduced to parliament.

The Queensland health quality and complaints commissioner constituted by 2006 legislation responded to complaints, had powers to set and monitor quality standards (later harmonised with the national standards), was able to require health organisations to report back on actions taken, and initiate inquiries into quality concerns. This commission was abandoned and replaced on 1 July 2014

with a new entity created by the *Health Ombudsman Act 2013* (Qld) and amendments to the *Health Practitioner Regulation Law 2009* (Qld). The health ombudsman receives complaints from the public and can prosecute health professionals rather than hand over cases to the AHPRA. The impetus was a 'states rights' motivation of the Queensland government to control professional disciplinary action in its jurisdiction, strengthen such action, abolish duplicated responsibility between levels of government, and simplify the complaints procedure for consumers.

Accountability to the Public: Complaints Management

How do health ombudsmen respond to complaints from patients? One indicator of relevance is the increasing numbers of people who lodge a complaint, as shown in the five-year trend from 2009–2010 to 2013–2014 (Table 2). A 'written' complaint is a more comparable measure than an 'inquiry' (Walton et al. 2012), although this does underestimate the work because many inquiries involve giving explanations; for example, the New South Wales Commission in 2013–2014 handled 10187 inquiries compared with 4767 written complaints. The remit of health ombudsmen is to encourage people, where appropriate, to try first to resolve a grievance with the practitioner or service concerned (sometimes termed 'direct resolution'). England requires complainants to first approach their local services before complaining to the health service ombudsman in the case of health services, or to the local government ombudsman in the case of social care (Boyle 2011: 56).

Complaints handling can only broadly be compared across the offices, however, because some report little statistical data and because categories differ. It is clear, however, that most complaints are handled by staff through 'softer regulation' methods. Where a complaint calls for a response from a service provider, the aim is to obtain a satisfactory response (an acceptable explanation and/or an apology) within a short time period ('early resolution'). The founding rationale for the ombudsman institution, therefore, remains central to their procedures, that is, to secure a simple and speedy resolution of complaints with additional powers reserved for serious cases. Table 3 shows that the great majority of lodged/written complaints handled during 2013–2014 did not proceed to stronger regulatory action.

If a complaint is not amenable to 'early resolution', some proceed to 'conciliation' or 'assisted resolution', sometimes involving a meeting among the office of the health ombudsman (the third party), the complainant, and the person/agency complained about (Wilson et al. 1998). Some offices do not refer to conciliation, or have additional methods – 'assisted resolution', 'negotiated settlement', 'mediation', or else subsume a regulatory discussion under 'investigation'.

The New South Wales Commission investigated 226 cases in 2013–2014 (far more than other Antipodean offices) being required under the *Health Care Complaints Act* to investigate serious cases by using powers to search and enter, obtain documents, and require a response to questions. The Victorian health services commissioner, in contrast, very seldom undertakes a formal investigation, although has powers to do so under s.21 of the *Health Services (Conciliation and Review) Act 1987*. When England's health ombudsman adopted a soft approach, it was criticised by the Public Administration Committee (2014) in England; in the following year, the Ombudsman greatly increased the number of cases investigated – from 377 in 2013 to 3075 (although it is not clear how investigation differs from assessment).

Arising from assessment, conciliation, or investigation findings, health ombudsmen can 'recommend' that a service provider respond in certain ways: an explanation, an apology, a compensation payment, wider remedies, or other 'actions to put things right' (Table 4). The term 'recommendation' indicates that compliance is voluntary not compulsory. Annual reports provide only limited comparable information on numbers and types of recommendations. For example, in 2012–2013 (comparable information was not reported the next year), England's health ombudsman made 902 recommendations, New Zealand made 274

Table 2. Complaints received by health ombudsmen (health complaints commissioners): England, New Zealand, and three Australian states, 2009/2010 to 2013/2014

Health ombudsmen	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
England[a]	NA	NA	NA	3770	6093
New Zealand[b]	1524	1405	1564	1619	1784
New South Wales[c]	3515	4104	4130	4554	4767
Victoria[d]	1316	1328	1501	1747	1665
Queensland[e]	2241	2525	3244	3419	3416

[a]England complaints about NHS received for 'a closer look'.
[b]NZ 'written' complaints received during year include disability services.
[c]NSW 'written' complaints received.
[d]Victoria 'written' complaints received include health records.
[e]Queensland Health Quality and Complaints Commission 'written' complaints received include quality complaints.
Source: Health ombudsmen annual reports and websites.

Table 3. Cases closed 2013–2014: England, New Zealand, and three Australian states

Cases	England[a]	New Zealand[b]	New South Wales[c]	Victoria[d]	Queensland[e]
Closed/managed	3770	1901	4929	1665	4259
No further action	3021	1106	2483	NA	699
			Stronger regulation		
Conciliation	372	NA	442	203	95
Investigation	377	115	226	0	106
Legal action/initiate or refer	NA	16	71	NA	NA

Note: Decimals rounded up.
[a]England 2012–2013 – statistics not available for 2013–2014.
[b]NZ cases closed.
[c]NSW 'assessed' cases closed.
[d]Victoria health services and health records cases.
[e]Queensland (previous commission) health service and quality cases closed.
Source: Health ombudsmen annual reports and websites.

Table 4. Disciplinary powers of health ombudsmen, as in April 2015

Powers	England	New Zealand	New South Wales	Victoria	Queensland
Provider response	Require	Require	Request	Request	Require
Conciliate	Yes	Yes	Yes	Yes	Yes
Investigate	Yes	Yes	Yes	Yes	Yes
Recommend	Yes	Yes	Yes	Yes	Yes
Sanction	Yes	Yes	Yes	No	Yes
Monitor compliance	Yes	Yes	Yes	No	Yes
Require compliance	Yes	Yes	No	No	Yes
Prosecute	Refers	Yes	Yes	Refers	Yes
Publish names and sanctions	No	Yes	Yes	No	No
Initiate systemic inquiry	Yes	Yes	No	No	No

Source: Health ombudsmen websites.

recommendations, and the previous Queensland commission made 170 recommendations on service and quality complaints.

In all jurisdictions, very few cases proceed to legal action and prosecution. The New Zealand office initiated 16 prosecutions for breach of the code in 2013–2014, and New South Wales initiated legal action in 71 cases. No information was given for Victoria, Queensland, or England where serious matters were referred to other regulators, such as professional boards. Health ombudsmen present anonymised case

Figure 1. Pyramid of Ombudsman Regulatory Mechanisms

Source: Adapted from Braithwaite 2008:91; Healy 2011: xvii

examples in their annual reports and seldom 'name and shame' providers. New South Wales is the exception being required by legislation to publish the names of health practitioners whose registration has been cancelled or suspended by a tribunal. For example, the commission issued press releases on 62 named cases in 2014 where practitioners were reprimanded, had conditions imposed, or were suspended or de-registered.

The Health Ombudsman as 'Public Watchdog'

Health ombudsmen make 'recommendations' that call for a service provider, such as a hospital, to improve the way they deliver health services but the numbers are unreported. The offices vary on the extent to which they monitor compliance. In England, in cases of systemic failings the health ombudsman requires NHS agencies to submit an action plan on how they intend to remedy the problem (305 such plans in 2012–2013). If an investigation finds 'big or repeated mistakes', the matter is referred to the Care Quality Commission, who as 'the regulator' is responsible for checking that the NHS organisation has implemented the action plan.

Health ombudsmen are not necessarily fully independent 'public watchdogs' as most lack the legal power to initiate an inquiry into systemic problems. England's health ombudsman can initiate reviews as can the New Zealand commissioner, but others require ministerial approval. England's health ombudsman, for example, has issued many public reports on problematic aspects of the NHS. The lack of legal powers of health ombudsmen in Australia to regulate unregistered health practitioners (outside the 14 registered professional groups) was highlighted by the Noel Campbell case in Victoria (Freckelton 2012).

Regulatory Relationships

What part do health ombudsmen play in networks of governance? First, in relation to those they regulate (health professionals and health agencies) most health ombudsmen aim for an educative and reformative relationship using persuasion. They advise organisations on how

to improve their internal complaints procedures, publish complaints handling manuals, and offer training courses; for example, Victoria provides training as required under s.9 *Health Services (Conciliation and Review) Act 1987* (Vic). In contrast to New South Wales, and Queensland since July 2014, other jurisdictions primarily aim to resolve complaints within a quality improvement framework rather than focus on individual responsibilities and accountabilities. In effect, they view those they regulate, such as hospitals and health professionals, as virtuous or at least rational actors, rather than as amoral calculators (Braithwaite 2008).

Second, health ombudsmen engage with many agencies, principally on a case-by-case basis, when referring people to them for resolution. Health ombudsmen in the Australian states/territories generally are required under their legislation to consult with the professional boards on complaints involving health practitioners, making the AHPRA a key regulatory partner. (The national law refers to these bodies as complaint entities.) Health ombudsmen in each state/territory are required under the *Health Practitioner Regulation National Law 2009* to notify AHPRA of any complaint that involves a named registered health practitioner. AHPRA received 10594 notifications in 2013–2014 about health practitioners, 56% being about medical practitioners (AHPRA 2014).

The Victorian health service commissioner, for example, consults on a case-by-case basis with many regulators over the course of a year. These included the 14 health professional boards, AHPRA, parliamentary ombudsman, Mental Health Review Board, disability services commissioner, Office of the Public Advocate, the coroner, the privacy commissioner, Victorian Equal Opportunity and Human Rights Commission, Victorian Assisted Reproductive Treatment Authority, and the Victorian health department (Health Services Commissioner Victoria 2014). AHPRA and the complaint entities have developed a memorandum of understanding that sets out the relationships.

New Zealand and New South Wales have consumer consultative committees that represent a range of organisations, and health ombudsmen in some jurisdictions sign a memorandum of understanding with other agencies. The previous Queensland commissioner, for example, signed an MOA with other state agencies that aimed 'to prevent duplication and complaint management and investigative effort, to improve timeliness and enable easy referral of matters between jurisdictions' (Health Quality and Complaints Commissioner Queensland 2014: 31). England's ombudsman noted that her office had 'deepened' relationships with other regulators (Parliamentary and Health Service Ombudsman 2014). The health complaints commissioners from all Australian states and territories and also New Zealand have their own network that meets twice yearly.

Discussion and Conclusions

The role of the health ombudsmen has changed since its inception in earlier decades. First, the offices have taken on a developmental role in educating service providers in better complaints management. Second, their regulatory powers to investigate and discipline have been strengthened in legislative changes since the 1990s. But health ombudsmen generally lack the power to require agencies to report back on the action taken or to require them to make the recommended changes – England, New Zealand, and now Queensland are the exceptions. The AHPRA was established in response to the Productivity Commission report that recommended a national scheme to standardise and streamline professional health registration and accreditation, to make the system more efficient and to remove barriers to professional mobility within Australia.

Polycentric regulation involves the dispersion of regulatory decision-making across multiple entities, including non-state actors given the growth of private sector and quasi-private sector health services in the three countries. In Australia, multi-level federal governance adds an extra layer of complexity, requiring ongoing negotiation between the different actors over tangled relationships and responsibilities. Accountability and legitimacy concerns

are common problems in polycentric governance (Black 2008; Smith et al. 2012). The establishment of statutory ombudsmen and other authorities as independent avenues of appeal has made government health departments and professional boards more accountable for responding to complaints about their services and members. The dispersion of regulation across polycentric fields and networks does, however, introduce other accountability and legitimacy concerns because no one entity is responsible. AHPRA is taking a leadership role, however, in developing a national risk-based regulatory system. The extent to which it can influence other actors (hospital credentialing committees, accreditation systems, complaint bodies, quality improvement agencies) to accept the value of an overarching system of multiple regulators (hard and soft) is yet to unfold. The health ombudsmen are important integrity actors but have remained somewhat apart from the polycentric governance networks, and although in Australia the health ombudsmen have ongoing interactions with AHPRA and the professional boards their jurisdiction has regional limits. This is a missed opportunity because an effective governance network requires the development of a shared understanding of regulatory principles, rules, and practices (Burris et al. 2005).

On the question of strengthening accountability to consumers, health ombudsmen aim to achieve the 'swift resolution' of complaints, which indeed is the main reason for their existence. The policy rationale is that a citizen should be empowered to speedily and satisfactorily resolve a complaint with the agency concerned; the pragmatic rationale is to divert uncomplicated matters back to the service provider for resolution. The annual reports of the health ombudsmen now stress their efforts to handle complaints more expeditiously. England also proposes to simplify complaints handling as the public find several public sector ombudsmen and their several procedures confusing (Public Administration Committee 2014).

Health ombudsmen are experienced practitioners in alternative dispute resolution that aims to avoid an escalation towards more-intensive interventions or litigation by complainants. The funnel shape of the complaints handling process is very similar across the health ombudsmen offices. Most cases are handled around the softer base of a regulatory pyramid (see Figure 1) through procedures such as advising, diverting people to complain directly to the service provider, or resolving the case quickly with an explanation or apology from the provider. Moving higher up the regulatory pyramid requires a more intensive and expensive involvement through mechanisms such as a conciliation meeting, a formal investigation, recommendations for improvements, a public report that 'names and shames' a recalcitrant provider, the imposition of sanctions, or prosecution. Health ombudsmen generally stress persuasion and a culture of 'continuous quality improvement'. The stronger regulators are the New South Wales commissioner and now the Queensland health ombudsman, who have powers to investigate and prosecute, whereas England's health service ombudsman and the New Zealand commissioner also can impose a range of sanctions.

Why more people are complaining to health ombudsmen is unclear: do more complaints mean that more people are dissatisfied with health services, both public and private, or more are aware of health ombudsmen, or more people are willing to pursue complaints? Further, it is unclear to what extent complaints are 'resolved' to the satisfaction of complainants. The health ombudsmen philosophy has been that people mainly want an explanation or apology from the service provider. But an earlier New South Wales survey, for example, reported that people wanted more punitive action (Daniel et al. 1999), whereas a survey of Victorian complainants found an 'expectations gap' (Bismark et al. 2011). Client samples in Queensland (233 people) and Victoria (436 people) found that around half (46% and 65%, respectively) were not satisfied with the outcome of their complaint (Health Quality and Complaints Commissioner Queensland 2014; Health Services Commissioner Victoria 2013).

A 'public watchdog' role implies independence but health ombudsmen are somewhat timid guardians because most can undertake a

systemic inquiry only when requested by their minister of health. This is contrary to the view that independence is the key characteristic of the statutory ombudsman office (Gregory and Giddings 2000). A health ombudsman is meant to be an 'arms-length agency'; an entity that undertakes government responsibilities at arm's length from the control of politicians (OECD 2002). Part of the 'fourth branch of government', such agencies potentially influence the other three branches: legislative, judicial, and executive. Although the ombudsman in most countries (Sweden is an exception) does not monitor the decisions of parliament and the courts, he/she must have the capacity to challenge the executive branch of agencies that implement legal, judicial, and administrative decisions (Asher 2011).

Given their unique mandate to respond directly to patients' concerns, health ombudsmen have important knowledge and long-standing expertise to contribute to the polycentric governance network of regulatory agencies. The effective future role of health ombudsmen depends upon enhanced powers to respond to individual wrongs to the satisfaction of complainants, and their capacity to close the gap between complainant expectations and reasonable redress. Health ombudsmen in Australia also need powers to act as a 'public watchdog', especially given the lack of other independent regulators, to identify, inquire into, and improve systemic problems. John Milton's appeal to civil liberty still resonates in that citizens need recourse against poor services, malpractice, and unfair decisions by authorities.

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