

Appendix: comparative analysis of open disclosure frameworks

1. Data extraction and coding guide

List of tables

- Appendix Table 1: Summary of theoretical frameworks and key extraction points for open disclosure policy analysis.
- Appendix Table 2: Institutional theory.
- Appendix Table 3: Comparative health systems framework.
- Appendix Table 4: Policy diffusion theory.
- Appendix Table 5: Regulatory governance framework.
- Appendix Table 6: Ethics of care framework.
- Appendix Table 7: Implementation science framework.
- Appendix Table 8: Stakeholder theory.
- Appendix Table 9: Cultural competence and health equity framework.
- Appendix Table 10: Policy feedback theory.

This section provides a detailed guide to the data extraction and coding process used in this comparative policy analysis. The aim was to ensure transparency and auditable documentation of how information was extracted from primary policy documents and categorised according to the theoretical frameworks.

1.1. Policy documents reviewed

The following primary policy documents were systematically reviewed:

Australia:

- Australian Open Disclosure Framework (2014).¹
- *Review: Implementation of the Australian Open Disclosure Framework – Final consultation report* (February 2020).²
- Implementation of the Australian Open Disclosure Framework (2013).²
- Relevant sections of the National Safety and Quality Health Service (NSQHS) Standards. The NSQHS Standards are a set of eight standards that provide a nationally consistent statement of the level of care consumers can expect from health service organisations.³

New Zealand:

- *Guidance on open disclosure policies* (2019) by the Health & Disability Commissioner (HDC).⁴
- Relevant sections of the *Code of Health and Disability Services Consumers' Rights*. The *Code* establishes the rights of consumers, and the obligations and duties of providers to comply with the *Code*. It is a regulation under the *Health and Disability Commissioner Act 1994*.⁵

1.2. Data extraction template

For each document, information was extracted and categorised under the following headings, corresponding to the theoretical frameworks and key areas of interest identified during protocol development and expert feedback:

- Document information: file name, date, source.
- Institutional theory: legal/regulatory structures (statutory law, common law, regulatory instruments, professional codes), formal rules/informal norms, impact on organisational behaviour.⁶
- Comparative health systems framework: system structure (centralised vs decentralised, public vs private), efficiency/resource allocation, service delivery models.
- Policy diffusion theory: international models, cross-national learning, policy transfer mechanisms.⁷
- Regulatory governance framework: enforcement mechanisms, roles of regulatory bodies, clinical

leadership (role in driving/supporting policy), specific sanctions for non-compliance.^{8,9}

- Ethics of care framework: ethical considerations, relational aspects of care, patient rights/remedies, patient/staff feedback (solicitation and integration), patient/staff psychological support.¹⁰⁻¹²
- Implementation Science Framework: barriers/facilitators to implementation, workforce capacity/training (effectiveness, gaps), organisational readiness (factors contributing/hindering).^{13,14}
- Stakeholder theory: interests/influence of various stakeholders, involvement in policy development/service design.^{15,16}
- Cultural competence and health equity framework: cultural diversity, Indigenous rights, equity/access considerations (disparities, specific provisions/gaps).
- Policy feedback theory: evolution of policies, feedback mechanisms (operational integration with quality/safety systems).¹⁷
- Health economics (detailed): cost-benefit analysis (implicit/explicit, conceptual framework), efficiency/resource allocation nuances, impact on healthcare utilisation/costs (hypothesised), funding mechanisms/sustainability (comparative), economic burden of non-disclosure (broader perspective).¹⁸

1.3. Coding process

Data extraction involved a systematic reading of each document. Relevant text segments were identified and coded under the most appropriate theoretical framework and subcategory. Direct quotes or paraphrased summaries were recorded, along with page numbers or section references where applicable, to ensure traceability and auditable documentation. The coding process was iterative, with initial themes refined as more documents were reviewed and as expert feedback was incorporated into the analytical approach.

2. Summary of all theoretical frameworks and key extraction points

This table provides a concise overview of all nine theoretical frameworks used in the comprehensive data extraction, along with their primary focus and key points relevant to open disclosure policy analysis. While the main manuscript focusses on four core frameworks for in-depth discussion, this table serves as a complete reference for the broader analytical lens applied.

Appendix Table 1: Summary of theoretical frameworks and key extraction points for open disclosure policy analysis.

Framework	Primary focus	Key extraction points relevant to open disclosure
Institutional theory	How formal and informal rules shape policy design and implementation.	Legal/regulatory structures (statutory, common, regulatory, professional codes); formal rules/informal norms; impact on organisational behaviour.
Comparative health systems framework	Influence of healthcare system structures on policy design and outcomes.	System structure (centralised vs decentralised, public vs private); efficiency/resource allocation; service delivery models.
Policy diffusion theory	Influence of international models and cross-national learning on policy adoption.	International models; cross-national learning; policy transfer mechanisms.
Regulatory governance framework	Mechanisms of policy enforcement and roles of regulatory bodies.	Enforcement mechanisms; roles of regulatory bodies; clinical leadership (role in driving/supporting policy); specific sanctions for non-compliance.

Appendix Table 1 (continued):

Ethics of care framework	Ethical considerations and relational aspects of consumer-provider relationships.	Ethical considerations; relational aspects of care; patient rights/remedies; patient/staff feedback (solicitation and integration); patient/staff psychological support.
Implementation science framework	Translation of policies into practice; barriers and facilitators.	Barriers/facilitators to implementation; workforce capacity/training (effectiveness, gaps); organisational readiness (factors contributing/hindering); implementation fidelity and adaptation.
Stakeholder theory	Interests, power, and influence of various stakeholders on policy.	Interests/influence of various stakeholders; involvement in policy development/service design.
Cultural competence and health equity framework	How policies address cultural diversity, Indigenous rights and health equity.	Cultural diversity; Indigenous rights; equity/access considerations (disparities, specific provisions/gaps); patient journey and touchpoints.
Policy feedback theory	How policies evolve over time based on feedback and shape future behaviour.	Evolution of policies; feedback mechanisms; organizational learning and improvement cycles; operational integration with quality/safety systems.

3. Detailed comparative analysis tables

Appendix Table 2: Institutional theory.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Regulatory body	The ACSQHC oversees the policy within the NSQHS Standards framework.	The HDC is the main regulatory body, enforcing the <i>Code of Rights</i> .	Different institutional structures: Australia focusses on system governance; New Zealand is rights-based and legally mandated.
Implementation method	Accreditation-based, with flexibility for local adaptation across states and territories.	Legally mandated under the <i>Code of Rights</i> , ensuring consistency across the country.	Australia allows for regional flexibility; New Zealand has uniform legal enforcement.
Focus of governance	System-wide quality improvement, with an emphasis on organisational learning.	Patient-centred legal accountability, ensuring transparency and patient rights.	New Zealand's framework is more rigid and legally enforceable; Australia's is more adaptable but potentially variable.

ACSQHC = Australian Commission on Safety and Quality in Health Care; HDC = Health & Disability Commissioner; NSQHS = National Safety and Quality Health Service.

Appendix Table 3: Comparative health systems framework.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Healthcare system structure	State-based systems with healthcare services and policy implementation vary by state and territory.	A centralised healthcare system with uniform governance across the country.	New Zealand's centralised system ensures consistency, while Australia's federal structure can lead to variability.
Governance model	The ACSQHC oversees national standards, but local implementation varies due to state autonomy.	The Ministry of Health oversees the entire health system, with the HDC ensuring compliance across all regions.	New Zealand's centralised model enables more uniform policy application compared with Australia's decentralised model.
Impact on policy implementation	Varies across regions, particularly in rural and resource-limited settings.	More uniform implementation across both urban and rural settings due to centralised governance.	Australia's model allows for flexibility but may be less consistent across regions.

Appendix Table 4: Policy diffusion theory.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
International influence	Influenced by the NHS Being Open Policy and international best practices in patient safety.	Adapted from international models (including Australia), but with stronger legal obligations added.	Both countries are influenced by international best practices, but New Zealand has strengthened legal accountability.
Policy evolution	Updated periodically based on organisational feedback and global best practices in clinical governance.	Adapted lessons from Australia and other international frameworks to create a rights-based legal model.	New Zealand's legal framework reflects a more rigid adaptation of international best practices.
Adaptation to national context	Adapted to fit Australia's federal structure, allowing for local flexibility within the accreditation system.	Adapted to New Zealand's centralised governance and legal obligations under the <i>Code of Rights</i> .	Australia's system allows for local adaptation, while New Zealand's is uniform and legally enforceable.

NHS = National Health Service.

Appendix Table 5: Regulatory governance framework.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Compliance mechanism	Compliance is enforced through the accreditation process under the NSQHS Standards.	Compliance is enforced through legal mandates under the <i>Code of Rights</i> , with the HDC having investigative powers.	Australia's compliance is tied to accreditation, while New Zealand uses legal enforcement.
Consequences of non-compliance	Loss of accreditation and potential reputational damage.	Legal consequences include potential disciplinary actions and public accountability.	New Zealand's consequences are more severe due to legal enforcement, while Australia's are less punitive.
Focus on organisational learning	Focuses on self-regulation and continuous quality improvement rather than punitive measures.	Emphasises legal compliance and patient rights, with less emphasis on organisational learning.	Australia emphasises organisational improvement, while New Zealand emphasises strict legal compliance.

Appendix Table 6: Ethics of care framework.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key Insights
Patient-centred care	Focuses on empathy, apologies and patient communication, but also integrates risk management and system improvements.	Focuses on full disclosure, acknowledgment of harm and sincere apologies as core elements of care.	Both frameworks promote patient-centred care, but Australia also balances system-level improvement.
Balancing ethics with governance	Emphasises balancing patient needs with broader system learning and governance to improve future outcomes.	Focuses primarily on individual patient rights, with less emphasis on system-wide governance.	New Zealand's framework emphasises patient care and healing, while Australia balances this with system governance.
Relational vs procedural care	Relies on organisational learning to improve patient care but may prioritise procedural governance in some cases.	Strong emphasis on relational care and patient rights, but the legal nature can create a compliance-driven culture.	Australia prioritises system improvement, while New Zealand's focus on rights may lead to procedural care.

Appendix Table 7: Implementation science framework.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Primary implementation mechanism	Relies on training, organisational preparedness and accreditation processes to implement open disclosure policies.	Implementation is enforced through legal mandates, ensuring uniform compliance across healthcare providers.	Australia relies on training and accreditation, while New Zealand uses legal mandates for uniform implementation.
Variability in implementation	Varies across regions and organisations, depending on institutional resources and commitment to compliance.	Implementation is consistent across the country due to the legal framework and the HDC's enforcement powers.	Australia's implementation is more variable, while New Zealand's legal framework ensures consistency.
Support for staff	Emphasises organisational support and training programmes to ensure staff understand and comply with disclosure policies.	Legal requirements place greater emphasis on compliance, potentially reducing focus on ongoing staff training for relational care.	New Zealand's legal framework ensures compliance but may place less emphasis on continuous staff training.

Appendix Table 8: Stakeholder theory.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Primary stakeholders	Balances the interests of patients, healthcare providers and organisations, with a focus on system improvement.	Patients are the primary stakeholders, with healthcare providers legally obligated to meet their rights.	Australia balances the interests of multiple stakeholders, while New Zealand prioritises patient rights.
Organisational vs patient focus	Focusses on organisational learning and quality improvement to benefit future patients.	Emphasises individual patient rights, ensuring patients receive full disclosure and legal protections.	New Zealand's framework emphasises individual patient needs, while Australia focusses on organisational improvements.
Potential for adversarial relationships	Less likely to create adversarial dynamics due to the focus on accreditation rather than legal compliance.	More likely to create adversarial dynamics due to the legal framework and potential for patient complaints.	New Zealand's legal framework may foster adversarial relationships, while Australia's is more collaborative.

Appendix Table 9: Cultural competence and health equity framework.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key insights
Focus on Indigenous populations	Acknowledges cultural competence, particularly for Aboriginal and Torres Strait Islander populations, but provides general guidelines.	Strong focus on Māori health and cultural safety, integrating Te Tiriti o Waitangi into the framework.	New Zealand's framework is more robust in addressing Indigenous health and cultural competence.
Specific cultural guidance	Provides general guidance on cultural sensitivity but lacks specific directives for addressing the needs of diverse populations.	Ensures culturally appropriate care through the legal mandate and specific guidance on Māori health.	New Zealand provides more specific guidance on cultural safety, ensuring equitable care for Māori populations.
Health equity focus	Promotes cultural competence but lacks an explicit focus on health equity for diverse populations.	Ensures cultural safety and health equity, particularly for Indigenous and marginalised groups.	New Zealand's framework places a greater emphasis on health equity and culturally appropriate care.

Appendix Table 10: Policy feedback theory.

Subcategory	Australia (ACSQHC)	New Zealand (HDC)	Key Insights
Source of feedback	Primarily driven by feedback from healthcare organisations and accreditation bodies.	Primarily driven by consumer complaints submitted to the HDC by patients and their families.	Australia's feedback is system-oriented, while New Zealand's is more patient centred.
Policy evolution mechanism	Feedback is used to update the NSQHS Standards based on lessons learned from organisational practices.	Feedback from patients is used to inform policy changes and ensure patient rights are upheld.	Australia's policy evolution focusses on organisational learning, while New Zealand's is more reactive to patient concerns.
Type of feedback loop	Focusses on proactive improvements based on system-wide feedback, encouraging organisational learning.	Focusses on reactive changes based on legal complaints and patient grievances.	Australia's feedback loop is proactive, while New Zealand's is more reactive, driven by consumer complaints.

4. Concluding summary

This supplementary document provides a detailed overview of the methodological approach and the comprehensive data analysis that underpins the main manuscript. By presenting the full data extraction and coding guide, along with the complete set of comparative tables for all nine theoretical frameworks, this document aims to enhance the transparency, rigor and depth of the research. The detailed comparative analysis presented in the tables offers a granular view of the similarities and differences between the Australian and New Zealand open disclosure frameworks, providing a rich evidence base for the arguments and recommendations made in the main manuscript.

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