

Balancing rights and governance: comparative analysis of open disclosure frameworks in Australia and New Zealand

Dylan A Mordaunt

ABSTRACT

AIM: We aimed to conduct a comparative analysis of the open disclosure frameworks in Australia and New Zealand to identify the strengths, weaknesses and trade-offs of their respective approaches and to propose a hybrid model that integrates the best practices from both systems.

METHOD: This qualitative comparative policy analysis systematically reviewed key policy documents from Australia and New Zealand. Data extraction focussed on the principles, processes, governance, legal aspects and implementation strategies of each framework. A multi-theoretical approach was adopted, applying four core theoretical frameworks—institutional theory, regulatory governance, ethics of care and implementation science—to analyse the extracted data. The analysis involved thematic coding, a cross-country comparison through each theoretical lens and a synthesis of the findings to identify the trade-offs between the two models and to inform the development of a refined hybrid model.

RESULT: The analysis revealed that Australia's framework, which is embedded in national safety standards, emphasises system-wide governance and accreditation, offering flexibility but at the risk of implementation variability. In contrast, New Zealand's model, which is legally mandated under consumer rights legislation, prioritises individual accountability and patient rights, ensuring strong enforcement but potentially fostering a compliance-driven culture. The key differences between the two frameworks emerged in their legal specificity, enforcement mechanisms and the practicalities of their implementation. The analysis highlighted the critical role of ethical considerations, workforce capacity and organisational readiness for the effective implementation of open disclosure.

CONCLUSION: Both the Australian and New Zealand open disclosure frameworks offer valuable insights into the challenge of balancing systemic governance and consumer rights. A hybrid approach that integrates Australia's focus on systemic learning with New Zealand's robust legal mandate for patient rights and explicit ethical considerations could provide a more effective and equitable framework for open disclosure, and could enhance healthcare quality and transparency. Future research should focus on the empirical evaluation of the practical implementation and outcomes of such hybrid models.

Open disclosure—transparent and honest communication with patients and their families following an adverse healthcare event—is a cornerstone of modern patient safety systems.¹ It is fundamental to fostering transparency, accountability and trust, and is essential for cultivating a restorative, just and learning culture where lessons are learned from harm.² There is a global consensus on the ethical imperative and practical benefits of open disclosure, which include improved patient satisfaction, reduced litigation and enhanced organisational learning from errors.³ However, despite this global recognition, the implementation of open disclosure varies significantly across different national contexts, reflecting diverse legal, regulatory and cultural landscapes. This variation presents

a research gap in understanding how different national approaches to open disclosure balance the competing priorities of system-level governance and individual patient rights, and what lessons can be learned from these different models.

Australia and New Zealand, two countries with comparable healthcare systems and a shared commitment to patient safety, provide a compelling case for a comparative analysis of open disclosure frameworks. Both nations have formally adopted open disclosure, yet their approaches are fundamentally different. Australia, through its National Safety and Quality Health Service (NSQHS) Standards,⁴ has integrated open disclosure into a broader framework of accreditation and continuous quality improvement, emphasising a system-wide governance model. In contrast, New

Zealand has adopted a legally mandated, rights-based approach, with open disclosure overseen by the Health & Disability Commissioner (HDC) under the *Code of Health and Disability Services Consumers' Rights*,⁵ which prioritises individual consumer entitlements and accountability.

These divergent approaches present inherent trade-offs. Australia's system-focussed model may promote continuous improvement and a learning culture, but it also risks creating variability in implementation and potentially de-prioritising individual patient experiences. On the other hand, New Zealand's rights-based model ensures legal accountability and consistency, but could foster a compliance-driven culture that focusses on legal obligations rather than genuine, patient-centred communication. A deeper, multifaceted comparative analysis is therefore needed to understand these nuances, with a focus on the practical implications, underlying policy instruments, legal ramifications and the impact on health service delivery. This examination is needed for identifying transferable lessons and informing the development of more effective and equitable open disclosure policies internationally.

This study addresses this research gap by conducting a comprehensive comparative policy analysis of the open disclosure frameworks in Australia and New Zealand. Our objectives are to: systematically review and synthesise key policy documents; apply a focussed multi-theoretical framework to analyse these policies; identify distinct regulatory priorities, institutional structures, policy instruments and implementation strategies; critically assess the trade-offs between system governance and consumer rights; and propose a refined hybrid model that integrates the strengths of both approaches. By achieving these objectives, this research aims to provide valuable insights for enhancing healthcare quality, patient safety and transparency on a global scale.

Methods

Study design

This study employed a qualitative comparative policy analysis design to systematically examine and contrast the open disclosure frameworks of Australia and New Zealand. The analytical approach was structured around a focussed multi-theoretical framework to provide a robust interpretation of the policy landscape, integrating key insights relevant to clinical governance and health policy. The protocol was registered with the

Open Science Foundation (<https://osf.io/7pa65/>).

Data sources

Primary data sources included key policy documents from both countries. For Australia, these comprised the Australian Open Disclosure Framework (2014),⁶ the *Review: Implementation of the Australian Open Disclosure Framework – Final consultation report* (February 2020)⁷ and relevant sections of the NSQHS Standards.⁴ For New Zealand, documents included *Guidance on open disclosure policies* (2019)⁸ by the HDC and relevant sections of the *Code of Health and Disability Services Consumers' Rights*.⁵ Supplementary documents, such as legislative acts pertaining to open disclosure, apology laws and data privacy, were also included where identified as relevant during the review process.

Theoretical frameworks

The analysis was guided by a two-stage theoretical approach. Initially, a comprehensive review was undertaken using nine distinct theoretical frameworks to ensure a robust and wide-ranging analysis of the policy documents (see the Appendix for a full description of all nine frameworks). Following this, the four most salient frameworks were selected for an in-depth analysis, as they provided the most direct insights into the core trade-offs and practicalities of the open disclosure policies. These four frameworks were:

- Institutional theory framework: This framework was used to examine how formal and informal rules, including statutory law, common law, regulatory instruments and professional codes, shape policy design and implementation.^{9,10} It helped identify the specific types of legal structures and their interactions or potential conflicts, providing a foundational understanding of the institutional environment in which open disclosure operates.
- Regulatory governance framework: This framework focussed on the mechanisms of policy enforcement, the roles of various regulatory bodies (e.g., Australian Commission on Safety and Quality in Health Care [ACSQHC], HDC) and the specific sanctions or consequences for non-compliance.^{11,12} It helped understand how accountability is ensured and how clinical leadership drives and supports policy implementation.

- **Ethics of care framework:** This framework examined the ethical underpinnings of consumer–provider relationships, emphasising empathy, responsiveness and the relational aspects of care.^{13–15} It allowed for analysis of specific patient rights and remedies, and how patient and staff feedback, along with psychological support, is integrated into the disclosure process.
- **Implementation science framework:** This framework assessed the translation of policies into practice, identifying barriers and facilitators to effective implementation and fidelity.^{16,17} It provided insights into workforce capacity, training needs and organisational readiness for open disclosure, including the effectiveness of training programmes and factors hindering organisational change.

Analytical approach

The author conducted all data extraction and analysis. To ensure rigour and mitigate bias, extraction and analysis was repeated after a 2-week wash-out period. Any differences were resolved after a second 2-week wash-out period, comparison of the extractions and finalised interpretation. The analytical process involved the following steps:

1. **Document review and data extraction:** Each identified policy document was thoroughly read by the author. Key information related to open disclosure principles, processes, governance, legal aspects and implementation strategies was extracted. This included specific attention to the types of legal frameworks, enforcement mechanisms and sanctions, patient rights and remedies, medico-legal barriers and protections, data privacy, cost–benefit considerations, efficiency, resource allocation, funding mechanisms and the economic consequences of non-disclosure.
2. **Thematic analysis:** The extracted data underwent thematic analysis, conducted by the author, to identify recurring themes and patterns within and across the Australian and New Zealand frameworks. This focussed on the practicalities of implementation, the role of clinical leadership and interprofessional collaboration.
3. **Comparative analysis through theoretical lenses:** The identified themes and policy

elements were compared through the lens of the four selected frameworks. This involved describing how each framework manifests in both Australian and New Zealand policies. Similarities and differences in their application and outcomes were identified, including the impact on clinical outcomes and interprofessional collaboration. The strengths, weaknesses and inherent trade-offs of each approach were analysed, considering the political, economic, social and technological (PEST) factors influencing policy choices.

4. **Synthesis and hybrid model proposal:** The insights gained from the comparative analysis were synthesised to develop a refined hybrid model for open disclosure. This model aims to integrate the most effective elements from both Australian and New Zealand frameworks, addressing identified gaps and maximising benefits for patient safety, consumer rights, systemic learning, cultural competence and sustainable service delivery. This synthesis also considers actionable insights for clinical practice and effective patient/family engagement in service co-design.

Ethical considerations

As this study involved the analysis of publicly available policy documents and did not involve human subjects or data, direct ethical approval was not required. The study adhered to principles of academic integrity, transparency and responsible research conduct. All sources were cited.

Results

This section presents the key findings from the comparative analysis of open disclosure frameworks in Australia and New Zealand, structured around the insights derived from the application of the four selected theoretical frameworks. The analysis reveals significant differences in the institutional, regulatory, ethical and implementation dimensions of the two frameworks, which are summarised in Figure 1 and detailed below.

The Australian open disclosure framework is institutionalised as a core component of clinical governance and risk management, embedded within the NSQHS Standards.⁴ This approach positions open disclosure as a system-level intervention, with enforcement tied to the accreditation process. As the ACSQHC states, the framework is intended to

“assist health service organisations to communicate with patients when care does not go to plan.” This system-level focus is further supported by the presence of apology laws in various Australian jurisdictions,¹⁸ which are designed to protect expressions of regret from being used as admissions of liability in legal proceedings.⁶

From a regulatory governance perspective, the ACSQHC plays a central oversight role, providing guidance and monitoring the implementation of the framework. Clinical leadership is identified as a key driver of open disclosure, with a focus on fostering a “just culture” that encourages reporting and learning from errors. However, the framework has been criticised for its lack of specific sanctions for non-compliance, which are primarily limited to accreditation outcomes and potential professional disciplinary actions.

The ethical dimension of the Australian framework is centred on the principles of empathy, respect and honesty in communication with patients and their families. The framework emphasises the importance of providing support to both patients and staff involved in adverse events. However, the systematic integration of patient and staff feedback into continuous improvement loops is not explicitly detailed, and psychological support mechanisms are generally implicit within broader support services.

The implementation of the Australian framework has faced a number of challenges, including medico-legal concerns, reputational damage, limited resources and a lack of consistent training and awareness.⁷ However, the framework has also been praised for its flexibility and its focus on organisational learning.

The New Zealand open disclosure framework: a rights-based approach

In contrast to the Australian model, the New Zealand open disclosure framework is legally mandated under the *Code of Health and Disability Services Consumers' Rights*.⁵ This approach establishes open disclosure as a fundamental consumer right, with a strong emphasis on individual accountability. The HDC is the primary regulatory body responsible for enforcing the framework, and non-compliance can lead to formal complaints and investigations.⁸ As the HDC has stated, “*The Code of Rights gives every consumer the right to be fully informed.*”

The legalistic nature of the New Zealand framework provides a clear and unambiguous basis for enforcement, with specific sanctions for non-

compliance, including recommendations for apologies, changes in practice or referral to professional bodies for disciplinary action. This rights-based approach is further strengthened by the absence of separate apology laws, as the legal mandate for disclosure is the primary driver of the process.¹⁹

The ethical dimension of the New Zealand framework is centred on the principles of sincere, compassionate and thoughtful communication.²⁰ The framework focusses on consumer rights, ensuring that patients are fully informed and supported. It also acknowledges the emotional impact of adverse events on both patients and staff, and it advocates for the provision of support mechanisms.²¹

The implementation of the New Zealand framework has been facilitated by its legal mandate, which has ensured a high level of consistency across the country. However, the framework has also been criticised for its potential to foster a “tick-box” mentality, which could detract from the relational aspects of open disclosure.

Comparative analysis: key trade-offs and implications

The comparison of the Australian and New Zealand open disclosure frameworks reveals a key trade-off between system-level governance and individual patient rights. Australia's system-focussed approach promotes continuous improvement and a learning culture, but it also risks creating variability in implementation and potentially de-prioritising individual patient experiences. In contrast, New Zealand's rights-based model ensures legal accountability and consistency, but it could foster a compliance-driven culture that focusses on legal obligations rather than genuine, patient-centred communication.

These differences have implications for clinical practice. In Australia, the focus on system-level governance may encourage a more proactive approach to risk management and quality improvement, but it may also lead to a more bureaucratic and less personal approach to open disclosure. In New Zealand, the focus on individual rights may encourage a more patient-centred approach, but it may also create a more adversarial environment.

The two frameworks also differ in their approach to legal specificity and enforcement. New Zealand's framework is more legally explicit, with clear sanctions for non-compliance. This provides a strong incentive for healthcare profes-

sionals to comply with the framework, but it may also create a fear of complaints. Australia's framework is less legally prescriptive, with a greater emphasis on professional self-regulation. This may create a more supportive environment for healthcare professionals, but it may also lead to a lack of accountability.

Finally, the two frameworks differ in their approach to ethical and relational issues. New Zealand's framework places a stronger emphasis on consumer rights and cultural competence, particularly for Māori health. Australia's framework also emphasises ethical principles, but it provides less specific guidance on how to integrate patient and staff feedback and psychological support into the open disclosure process.

Discussion

This comparative analysis of open disclosure frameworks in Australia and New Zealand reveals two distinct approaches to balancing system-level governance with individual patient rights. These differences, shaped by unique regulatory philosophies and healthcare system structures, offer valuable lessons for international healthcare systems grappling with the same challenges. The findings highlight the complex interplay of institutional, legal, ethical and implementation factors in shaping policy design and delivery, and they underscore the need for a nuanced approach that leverages the strengths of both models.²²

Australia's emphasis on system governance, driven by the NSQHS Standards⁴ and the accreditation process, is effective in fostering a culture of continuous quality improvement and organisational learning. This approach aligns with the principles of a just culture, which encourages reporting and learning from error without immediate blame.² However, as the implementation science framework reveals, this flexibility can lead to significant variability in the application of open disclosure, as well as in resource allocation and the integration of patient feedback. While clinical leadership is identified as a critical success factor, the framework lacks explicit mechanisms to ensure that this leadership is consistently translated into effective practice at the clinical level.

In contrast, New Zealand's rights-based model, which is legally mandated under the *Code of Health and Disability Services Consumers' Rights*,⁵ provides a clear and unambiguous framework for individual clinician accountability and prioritises individual patient entitlements. The strong

emphasis on cultural competence, particularly for Māori health, is a notable strength of this model. However, the legalistic nature of the New Zealand approach, while ensuring compliance, may inadvertently foster a tick-box mentality, which could detract from the relational aspects of open disclosure. The focus on individual rights may also create a significant administrative burden and may not be as effective in driving broader systemic improvements as a governance-focussed model.

The central trade-off between system governance (Australia) and patient rights (New Zealand) is a key finding of this study. Australia's approach, which promotes systemic learning, may at times deprioritise the experiences of individual patients. Conversely, New Zealand's strong legal mandate, while ensuring accountability, may not be as effective in fostering proactive systemic change or leadership accountability.

The proposed hybrid model: integrating strengths for a more robust framework

A hybrid model of open disclosure, integrating the strengths of both the Australian and New Zealand frameworks, could offer a more robust and effective solution. Such a model would combine the system-wide learning and quality improvement focus of the Australian approach with the legally mandated patient rights and strong ethical considerations of the New Zealand model. This would create a framework that is not only responsive to the needs of individual patients but also committed to continuous improvement at a systemic level.

The key components of this proposed hybrid model would include:

- A dual focus on system-level governance and individual patient rights: This would involve integrating open disclosure into a broader quality improvement framework, while also ensuring that individual patient rights are legally protected and enforceable.
- Clear and consistent standards for implementation: The model would include clear and consistent standards for the implementation of open disclosure, with a focus on ensuring that all patients, regardless of their location or circumstances, have access to the same high-quality process.
- Strong clinical leadership and a supportive organisational culture: The model would emphasise the importance of strong clinical

leadership and a supportive organisational culture in promoting a just and learning culture.

- Comprehensive training and support for healthcare professionals: The model would include comprehensive training and support for healthcare professionals, with a focus on developing their communication skills and their ability to respond to the emotional needs of patients and their families.
- A commitment to cultural competence and health equity: The model would be designed to be culturally competent and to promote health equity, with a particular focus on the needs of Indigenous populations and other vulnerable groups.

International implications and transferability

The findings of this study have implications for other countries seeking to develop or refine their own open disclosure frameworks. The proposed hybrid model, with its dual focus on system-level governance and individual patient rights, offers a potential solution for countries that are grappling with the same challenges as Australia and New Zealand. The model is designed to be adaptable to different national contexts, and it provides a framework for developing a more effective and equitable approach to open disclosure.

The successful implementation of such a model would require a strong commitment from policymakers, healthcare leaders and clinicians, as well as a willingness to invest in the necessary resources and infrastructure.²³ However, the potential benefits of a more robust and effective open disclosure framework, including improved patient safety, enhanced patient trust and a more just and learning culture, are significant.

Australia's emphasis on system governance, primarily through the NSQHS Standards⁴ and accreditation, fosters a culture of continuous quality improvement and organisational learning. This aligns with a just culture, encouraging reporting without immediate blame.² However, as highlighted by the implementation science framework, this flexibility can lead to variability in application, resource allocation and feedback integration. Clinical leadership, while critical, requires more explicit mechanisms to translate commitment into consistent practice.²²

New Zealand's rights-based model, legally mandated under the *Code of Health and Disability Services Consumers' Rights*,⁵ supports individual

clinician accountability and prioritises individual patient entitlements. This provides a clear framework, reducing ambiguity. Its strong emphasis on cultural competence, particularly for Māori health, is a notable strength. However, this legalistic approach, while ensuring compliance, may inadvertently foster a tick-box mentality, potentially detracting from relational aspects. The focus on individual rights may also place greater administrative burden and not inherently drive broader systemic improvements as effectively as a governance-focussed model.

The core trade-off between system governance (Australia) and patient rights (New Zealand) is central. Australia's approach, promoting systemic learning, may sometimes de-prioritise individual patient experiences. Conversely, New Zealand's strong legal mandate, while ensuring accountability, might not inherently foster proactive systemic change or leadership accountability. A hybrid model would ideally integrate Australia's robust quality improvement and systemic learning with New Zealand's commitment to patient rights and explicit ethical considerations, providing actionable insights for clinical practice and addressing interprofessional team dynamics.

Limitations

This study's limitations include its reliance solely on publicly available policy documents. While these documents provide a foundational understanding of the frameworks, they may not fully capture the nuances of real-world implementation, including informal practices, unwritten norms or day-to-day challenges faced by healthcare providers. In particular, the differences in tort law have not been explored in depth and may be an important factor in how differences in policy are realised. The dynamic nature of health policy means some aspects of the analysed documents may have evolved since their publication; efforts were made to acknowledge the most current available information. The interpretation of policy documents is inherently subjective, a limitation mitigated by the systematic application of theoretical frameworks and a multi-faceted analytical approach.

Future research

Future research should build upon this analysis by incorporating empirical data on actual implementation and outcomes. This could involve qualitative studies (e.g., interviews with patients, providers, policymakers) and quantitative studies

(e.g., impact on patient safety indicators, litigation rates, healthcare costs). This is important in both countries.

In New Zealand, the Accident Compensation Corporation's (ACC) no-fault scheme, which was introduced in the 1970s, effectively limits organisational liability for adverse events through its "treatment injury" programme. While legislation has been introduced to mitigate moral hazard (lack of incentive to guard against risk where one is protected from its consequences) related to this for worker safety, no equivalent legislation exists for patient safety. Professional regulation and the HDC's open disclosure framework focus on clinician compliance; however, no equivalent to worker health and safety legislation exists for boards and executives of healthcare organisations to ensure accountability for patient safety.²⁴ Around 2002, Australia experienced a major medical indemnity insurance crisis resulting in the Ipp report, which prompted tort law reforms across all jurisdictions.²⁵ This means that while litigation for healthcare-acquired adverse events and negligence occurs, there are limits to liability for both organisations and practitioners. While there is some understanding of the role of litigation in healthcare quality, further work is warranted in both Australia and New Zealand.²⁶⁻²⁸

Further investigation into the economic implications, including detailed cost-benefit analyses and the broader economic burden of non-disclosure, is warranted—particularly given New Zealand's no-fault approach to treatment injury. Research exploring the effectiveness of specific training programmes, leadership interventions and patient engagement strategies in diverse healthcare settings would also be valuable. Studies focussing on the long-term impact on trust, transparency and a just culture,²⁹ and the operational integration of open disclosure with broader quality and safety systems, would provide important insights.

Conclusion

This comparative policy analysis of open disclosure frameworks in Australia and New Zealand highlights the distinct yet complementary nature of their respective approaches. Australia's framework, which is grounded in system-level governance and continuous improvement, fosters a strong learning culture. In contrast, New Zealand's legally mandated, rights-based model

emphasises individual consumer entitlements and clinician accountability. This study has identified the key trade-offs between these two models: Australia's flexible, system-oriented approach encourages broad leadership-enabled quality enhancement but can lead to inconsistencies in implementation, while New Zealand's prescriptive, rights-focussed model guarantees individual practitioner legal accountability but risks fostering a compliance-driven culture and moral hazard from health system and services leadership.

The findings of this study suggest that a hybrid approach, which integrates the strengths of both models, could provide a more robust and effective framework for open disclosure. Such a model would combine the system-wide learning and quality improvement focus of the Australian approach with the legally mandated patient rights and strong ethical considerations of the New Zealand model. This integrated framework would aim to achieve widespread systemic safety enhancements, while also promoting individual patient advocacy, transparency and redress.

For policymakers and healthcare administrators, the key recommendation is to move beyond a singular focus on either system-level governance or individual rights, and to instead embrace a dual approach that integrates both. This would involve developing a clear and consistent national framework for open disclosure that is flexible enough to be adapted to local contexts, while also ensuring that individual patient rights are legally protected and enforceable.

For clinicians, the key recommendation is to embrace a culture of open disclosure that is grounded in empathy, respect and a commitment to learning from error. This would involve developing strong communication skills, as well as a willingness to engage in open and honest conversations with patients and their families following an adverse event.³⁰

By fostering a culture that is learning-orientated, legally accountable, culturally sensitive and economically conscious, healthcare systems globally can move closer to realising the full potential of open disclosure as a transformative practice for patient safety and trust. Future research should focus on the empirical evaluation of hybrid models of open disclosure, with a particular focus on their impact on patient safety, patient satisfaction and healthcare costs.

Table 1: Summary of framework and key extraction points.

Framework	Key focus in open disclosure	Australian framework (key themes)	New Zealand framework (key themes)
Institutional theory	Legal and regulatory structures shaping policy.	Embedded in NSQHS Standards; ⁴ apology laws across jurisdictions; complex interplay of legal sources.	Legally mandated by <i>Code of Rights</i> ; ⁵ direct legal duty; clear hierarchy of legal instruments.
Regulatory governance framework	Policy enforcement, regulatory roles and accountability.	Enforcement via NSQHS accreditation; ACSQHC oversight; clinical leadership crucial; sanctions through accreditation/professional action.	HDC as primary enforcer; non-compliance leads to complaints/investigations; senior management support vital; specific sanctions (apologies, practice changes).
Ethics of care framework	Ethical and relational aspects of consumer-provider interactions.	Ethical imperative, empathy, honesty; support for patients/staff; feedback via surveys (less systematic integration); implicit psychological support.	Strong ethical imperative, sincere communication; explicit consumer rights; ⁵ emotional impact acknowledged; feedback via complaints; implied psychological support.
Implementation science framework	Translation of policies into practice; barriers and facilitators.	Barriers: medico-legal fears, resources, inconsistent training; facilitators: supportive culture, governance; challenges in workforce capacity/training effectiveness.	Emphasis on ongoing training/communication skills; recognition of systemic issues; less detail on specific barriers/facilitators or training effectiveness.

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

Figure 1: Graphical abstract.

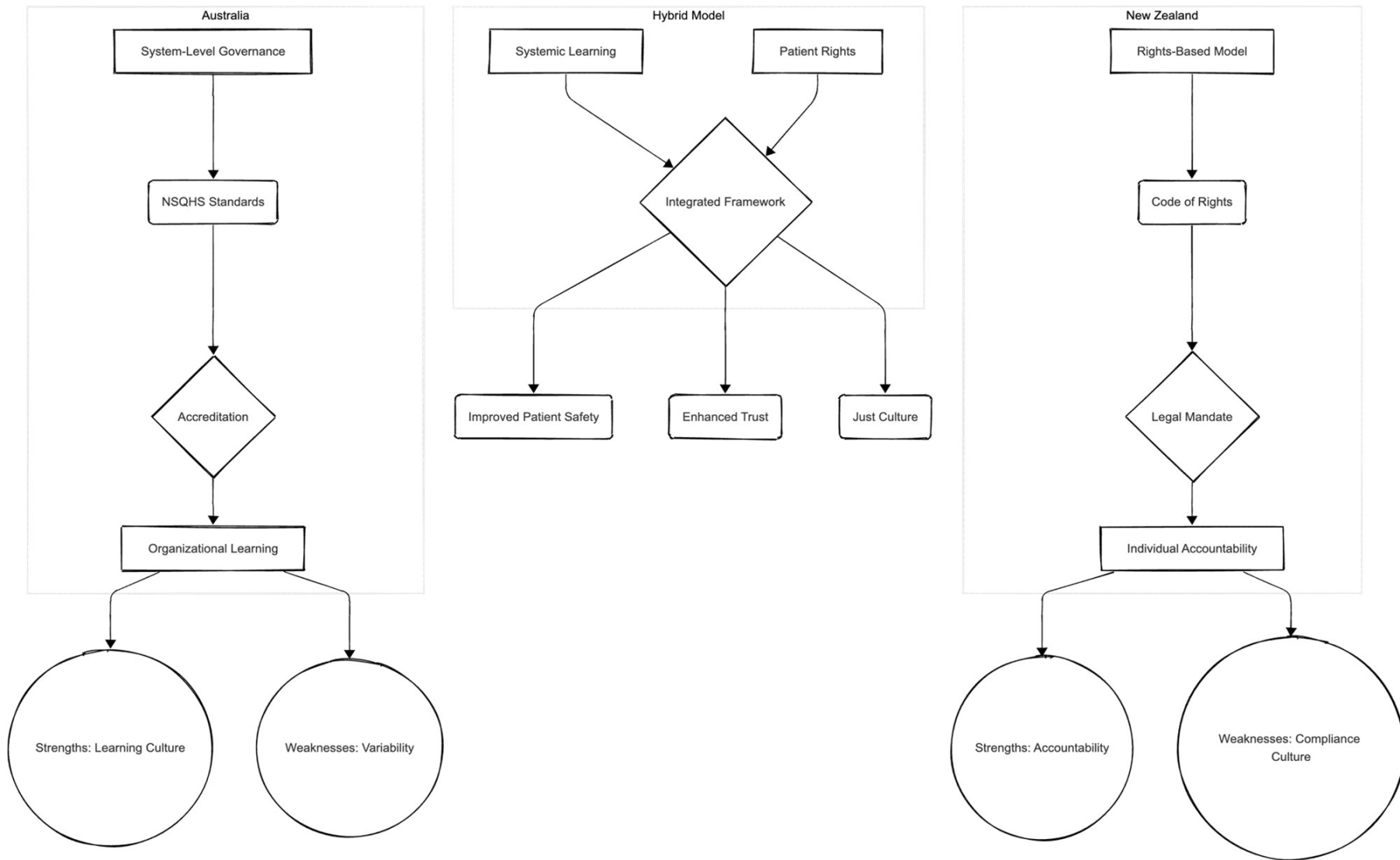


Figure 2: The Australian open disclosure framework: a system-level approach (conceptual diagram of the hybrid model).

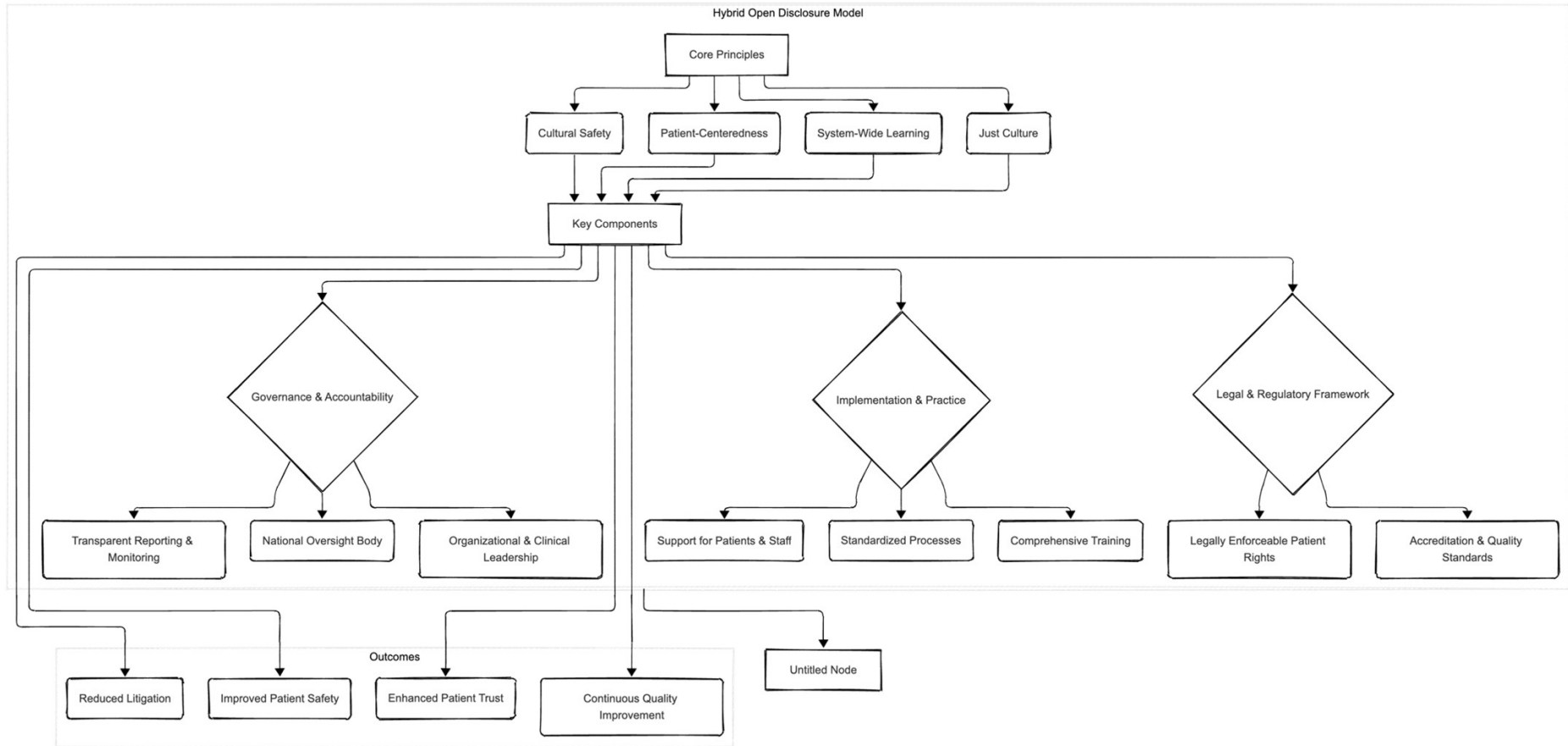
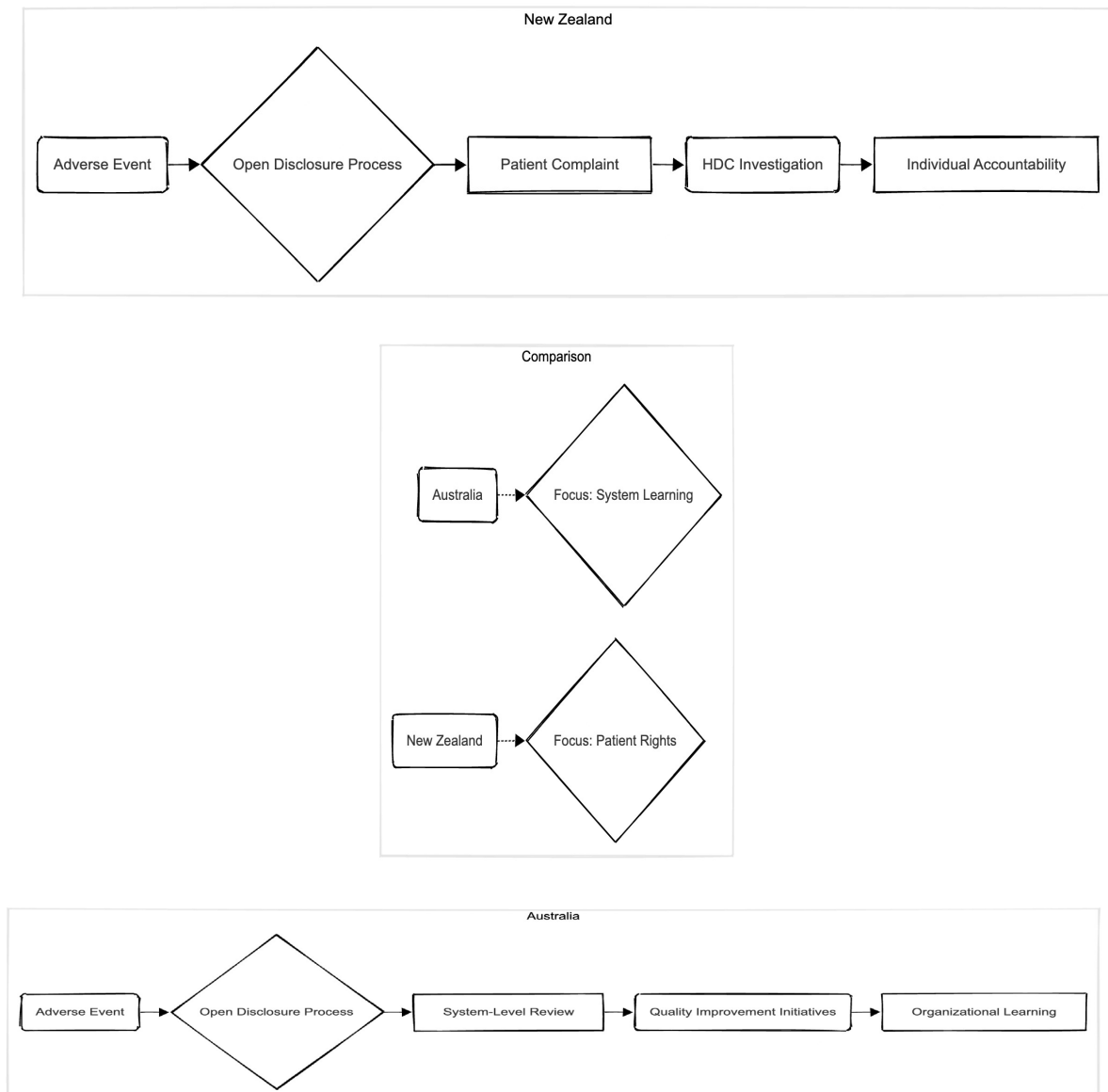


Figure 3: Conceptual workflow diagram.



COMPETING INTERESTS

The author has worked in clinical and clinical governance roles in both Australia and New Zealand.

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DATA

The final codebook, extractions and original documents are available as supplementary documents.

CORRESPONDING AUTHOR INFORMATION

Dylan A Mordaunt: Faculty of Education, Health, and Psychological Sciences, Victoria University of Wellington, New Zealand; College of Medicine and Public Health, Flinders University, Bedford Park, South Australia; Faculty of Medical and Health Sciences, Adelaide University, Adelaide, South Australia; Centre for Health Policy, University of Melbourne, Parkville, Victoria; Wellington Free Ambulance, New Zealand.
E: dylan.mordaunt@vuw.ac.nz

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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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