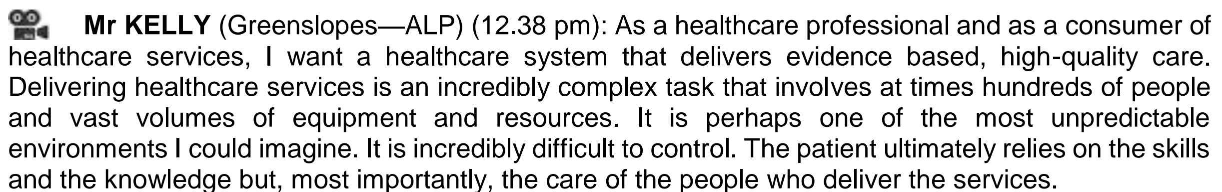
Speech By

Joseph Kelly

MEMBER FOR GREENSLOPES

Record of Proceedings, 2 March 2017

HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE: REPORT, MOTION TO TAKE NOTE



Mr KELLY (Greenslopes—ALP) (12.38 pm): As a healthcare professional and as a consumer of healthcare services, I want a healthcare system that delivers evidence based, high-quality care. Delivering healthcare services is an incredibly complex task that involves at times hundreds of people and vast volumes of equipment and resources. It is perhaps one of the most unpredictable environments I could imagine. It is incredibly difficult to control. The patient ultimately relies on the skills and the knowledge but, most importantly, the care of the people who deliver the services.

Given this situation, it is not unexpected that at times things can go wrong. When things go wrong in health care, the consequences for patients and their families can be devastating. When something does go wrong, healthcare professionals know they have an ethical obligation to be accountable for their decisions and actions. It is imperative that when something goes wrong it is investigated properly and, if necessary, practices are changed to ensure the situation does not reoccur.

There has been an ongoing evolution of the process of managing complaints and problems in health care in Queensland. The current model relies on two bodies: the Office of the Health Ombudsman and the Australian Health Practitioner Regulation Agency and its associated boards. This model was established in response to problems with previous attempts to manage complaints by healthcare consumers. It may not surprise honourable members that Queensland has chosen to go its own unique way on this issue, so it is incumbent on our parliament to monitor this new approach and attempt to improve it if necessary.

I should thank the members of the committee and particularly the chair for pursuing this issue and delivering this report at a time when the committee was considering a great deal of other matters.

There is much to like about the new model and the role of the Office of the Health Ombudsman. The single point of referral, the responsibility it assumes for unregistered health practitioners and the capacity to review systemic problems are all excellent innovations. The OHO is a new system but of course there are issues.

It is very stressful to be investigated over one's clinical practice. When this has happened to me it has been extremely distressing for me and my family. When it happened to me the investigation was quick. I have spoken to nursing colleagues and other health professionals who have been investigated under the current system. They complain of lengthy delays and note the impacts this has on themselves, their families and, most importantly, their patients. Patients who make allegations of damage as a result of healthcare services are also poorly served by delays in investigation processes, regardless of the validity of their complaints. It is imperative for the delivery of quality, evidence based health care to patients that we investigate complaints and act to correct practices and systems in as short a time as possible. The experiences of my professional colleagues are borne out by the statistics in the report. I fully support the recommendations in this report that seek to address these delays.

I have also had discussions with healthcare professionals who have raised concerns about the clinical advice relied on by the Office of the Health Ombudsman. The Queensland Nurses' Union, the Australian Medical Association, the Australian Lawyers Alliance, the Medical Insurance Group of Australia and many other submitters raised concerns in this area. They noted a lack of transparency with no information being made available about the experts being consulted, their qualifications, the advice being sought or the advice being provided. This is very, very concerning and must change.

While it is important that non-healthcare professionals are involved in assessing complaints, the reality is that it is imperative that clinical advice is sought on complaints. I certainly support the recommendation that seeks to improve the clinical input into investigations and I urge the minister and the Health Ombudsman to take this issue very seriously.

We have a co-regulatory system here in Queensland. This requires a high level of coordination between the OHO and AHPRA. In the committee's interactions with the staff from the OHO and AHPRA it was obvious that the level of cooperation and coordination was not high. This was particularly evident in relation to the management of data. Data management is crucial to investigations. I would urge both parties to make cooperation and coordination in all areas as high a priority as possible. I certainly support the recommendations in the report that will assist in this.

My personal and strong preference as a healthcare professional would be to have one national, uniform system of managing healthcare quality and safety. It is my view that the issues we face in Queensland are not unique and it would be far better for patients and practitioners if the systems were national, uniform and effective. Whilst my strong preference is for a uniform national system, I believe that the recommendations in this report will certainly do much to improve the current system of managing complaints about healthcare services. These will result in better outcomes for patients and healthcare professionals. I commend the report to the House.