HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP (virtual)
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP
Mr JP Lister MP

Staff present:
Ms M Salisbury—Acting Committee Secretary
Ms A Groth—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE PROVISION OF PRIMARY, ALLIED AND PRIVATE HEALTH CARE, AGED CARE AND NDIS CARE SERVICES AND ITS IMPACT ON THE QUEENSLAND PUBLIC HEALTH SYSTEM

TRANSCRIPT OF PROCEEDINGS

MONDAY, 29 NOVEMBER 2021

Brisbane

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The committee met at 9.58 am.

CHAIR: Good morning. I now declare open this public briefing of the Health and Environment Committee. I am Aaron Harper, member for Thuringowa and chair of the committee. I start by respectfully acknowledging the land that we are meeting on today and pay our respects to the traditional custodians and elders past, present and emerging. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share. With me today are Mr Rob Molhoek, member for Southport and deputy chair; Mr Stephen Andrew, member for Mirani, on the phone; Ms Ali King, member for Pumicestone; and Ms Joan Pease, member for Lytton.

The purpose of today's briefing with Queensland Health, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships and the Department of Education is to assist the committee with its inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system.

This briefing is a proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Only the committee members and invited witnesses may participate in proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left for debate on the floor of the House. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the standing rules. You may be filmed or photographed during proceedings. Please turn off any mobile phones or switch to silent mode.

ALLAN, Associate Professor John, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

HARMER, Mr David, Senior Director, Social Policy and Legislation Branch, Queensland Health

McNEIL, Professor Keith, Acting Deputy Director-General, Prevention Division, and Chief Medical Officer, Queensland Health

MILLER, Ms Deborah, Acting Chief Nursing and Midwifery Officer, Queensland Health

PARTON, Ms Kathy, Acting Director-General, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

STEVENSON, Ms Hayley, Executive Director, State Schools—Operations Department of Education

WAKEFIELD, Dr John PSM, Director-General, Queensland Health

WISE, Mr Max, Assistant Director-General, Disability and Seniors Connect, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships

YBARLUCEA, Ms Carmel, Executive Director, State Schools, Disability and Inclusion, Department of Education

CHAIR: I now welcome representatives from Queensland Health, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships and the Department of Education. I recognise James Lister, who is here for the member for Oodgeroo. Welcome, James. Would you like to start with an opening statement, Director-General?

Dr Wakefield: Good morning, Chair, Deputy Chair and committee members. My name is John Wakefield, and I make this opening statement into the inquiry into the provision of primary, allied and private healthcare, aged care and NDIS care services and its impact on the Queensland public health system. I start by respectfully acknowledging the traditional custodians of the land on which we meet today, the Jagera people and Turrbal people, and pay respects to elders past, present and emerging. I thank the committee for the opportunity to provide the following opening statement. I will discuss issues relating to primary care, aged care, disability care and private health and how these impact on the Queensland public health system.

Queensland's public health system is being stretched, with increasing demand on hospitals and emergency departments including for conditions that could have been prevented or indeed more appropriately managed in the community or other sectors. Service gaps in complementary sectors inevitably impact on our public health and hospital system. I think this is really important. The geographic nature of Queensland—the distributed population—adds another layer of complexity and difficulty, and indeed inequity, when we are aiming to deliver services to populations across Queensland. Market failure—particularly thin markets where markets exist for provider services usually funded by the Commonwealth—means different approaches are needed in these locations if we are to ensure service delivery and some sense of equity. That is why a strong, integrated healthcare sector is critical. It actually supports people's health and wellbeing and it helps to keep people out of hospital. This includes being able to access general practitioners, primary care, allied health, aged care, disability services and mental health care and services through private health insurance and private hospitals where appropriate.

We welcome a review of the current state, availability and accessibility of these services and how they impact on our system. This review comes at an important time for Queensland Health. Our hospitals are seeing more patients with more chronic disease than ever before, and this is reflected in very strong and growing demand across our emergency departments, our mental health system and specialist outpatients as well as elective surgery. The growth is placing significant pressures on the state's health system to deliver against what would be regarded as unsustainable demands.

In 2021 there was a 15.4 per cent increase in public emergency department presentations compared to the previous year. That is against a background of a population growth of less than two per cent. During the same period there was an 11.2 per cent increase in patients requiring resuscitation or critical care, so the more severe end of emergency care. This coincided with the number of ambulance arrivals to EDs increasing by 5.4 per cent. We also recorded a 6.9 per cent increase in emergency surgeries compared to the previous year. All indications point to these pressures continuing this financial year. For example, between July and October 2021 our public emergency department presentations increased again by 6.6 per cent. Those requiring resuscitation or critical care jumped by nine per cent in that same four-month period compared to the previous year.

These pressures have been exacerbated by COVID-19, including the backlog of care resulting from the pandemic and the need to maintain hospital readiness as well as the impact on our workforce and models of care. As I have said to the committee previously, we have thousands of staff providing testing, sampling, support for quarantine and, of course, the enormous vaccination effort. The pandemic is also taking its toll on mental health and wellbeing.

This current and burgeoning demand is why we need to grow our skilled workforce to deliver services. You only have to travel into the regions to see our use of overseas trained doctors and significant locum use, particularly in rural and regional Queensland. There is an absolute need for to us find ways, working with the Commonwealth, to train and retain doctors and their families in rural and regional Queensland. Geographic maldistribution remains the critical workforce issue across all our clinical streams. This is further compounded by service gaps in areas that fall under the Commonwealth responsibility. That is why cooperation with stakeholders is critical.

Fostering and maintaining a strong health system is not simple. It requires a much greater focus on joint planning and funding across state and Commonwealth systems at the local level. These pressure points will impose challenges on the Queensland health system now and in the next few years, and one of the most significant is felt in primary care. This is where Australians have their first contact with the healthcare system and ongoing care. Indeed, it really should be regarded as their healthcare home. All the best healthcare systems in the world have a really strong primary and family care system at their heart. Queensland has difficulty sustaining our public health system without this effective, sustainable primary care that caters for all our regions and citizens.

Under the National Health Reform Agreement, the Commonwealth is responsible for system management and support, policy and funding for general practice and primary healthcare services. This includes holding the lead responsibility for Aboriginal and Torres Strait Islander community

controlled health services. The primary healthcare system is primarily funded through the Medicare Benefits Schedule on a fee-for-service basis; in other words, it is a market. This approach is based on a private provider market. If the private provider chooses not to set up shop in a town, there is no provider, no service and no billing to Medicare. With insufficient funding and policy settings this exacerbates inequity, impacting on our most vulnerable Queenslanders. Unfortunately, it is significantly rural, remote and regional communities that this significantly underservices. Many areas do not have access to GPs at all, and the MBS benefits per capita are much lower in rural and remote areas.

I will give an example: in 2020 there was one GP for every 766 people in metropolitan areas such as Brisbane, Gold Coast and Ipswich. Conversely, there was one GP for every 1,160 people in rural towns like Ingham and Condamine. In remote communities it is worse. In remote communities like on the cape or in Cloncurry, there is one GP for every 1,428 people. When you add that the local GP in those regional, rural and remote areas has much less access to supporting services and has to do a lot more than a traditional city GP, I think that explains itself in terms of the inequity.

Poorer access to primary care services is demonstrated by the differential in the per capita MBS spend across regions in Queensland. The Western Queensland primary health network has the lowest MBS spend per capita, at $977. If you compare this to the Gold Coast, where the MBS spend per capita was $1,467 in 2018-19, that is one-third more. Why should rural people suffer one-third less per capita expenditure from the health MBS budget?

The Queensland government is often the provider of last resort for primary care services, especially in rural and regional areas. In 2020-21, it is estimated we spent about $160.6 million on these services. The bulk-billing rate for a standard GP consultation is $39.10. As a past GP myself, I can tell you that it is very hard to keep in business when you are supposed to deliver good health care for $39. The average cost for an emergency department presentation, by comparison, is $729.

The Medicare system also does not provide sufficient incentives for GPs to service people in residential aged-care facilities or for after-hours services. It is still designed, really, for a 20th century break-fix model of episodic treatment of acute conditions rather than being set up to provide holistic, person centred care for chronic disease for a population which often requires longer consultations and a multidisciplinary team to wrap around and support the care to an individual.

Out-of-pocket fees and access to Medicare for primary care, allied health and nurse specialist services are also contributing to access barriers for consumers. I put it this way: you can go to an emergency department at any time of the day or night, seven days a week, for free. Your median wait time is 14 minutes. It is a safe place. You get comprehensive assessment, you get all your tests and you get whatever you need at discharge, and you get it all for free. Compare that—and I am very sympathetic to my GP colleagues—to trying to get a same-day GP appointment if you have a problem today.

Since 2018, the Queensland Health workforce needs assessment has identified significant workforce gaps in regional, rural and remote areas, especially in allied health. This is evident in psychology, social work, occupational therapy and speech pathology. Mental health, alcohol and other drug services, community based rehabilitation, social support and disability services were identified in the 2021 report as the most significant service gaps. I was at a regional forum recently in the Gympie region where a psychologist said that her next available appointment was in April of next year, based on the MBS items.

Preventable chronic disease continues to be a major contributor to the First Nations health gap. The expansion and uptake of chronic disease checks, continuity of care and chronic disease management needs to be incentivised through Medicare, along with enabling First Nations people choice of access, especially in rural and remote settings. The role of investment in service planning and capacity building for Aboriginal and Torres Strait Islander community controlled health organisations has largely been undertaken by the state. For example, in 2020 services for primary health on Palm Island transitioned to the Palm Island Community Company, a reform led solely by Queensland. All these significant gaps place an additional burden on our public hospital system.

In 2019-20, potentially preventable hospitalisations—PPHs—which may have been prevented by adequate and timely primary and community health care, accounted for 6.6 per cent of all Queensland hospital separations. That is 153,000 patients in our public hospitals. In 2018-19, there were 406,000 lower urgency emergency department presentations in Queensland. This means that over a quarter of all of our emergency department presentations, at least at some level, could and should be provided in a community setting—if it was available, free at the point of care and accessible

to people. Many of these occur after hours or in rural areas, and they reflect a lack of primary and GP services at these times or locations.

The impact of these failures can be demonstrated by the case of an elderly gentleman in Townsville. Following his transfer to a residential aged-care facility, his family were advised that his regular GP would no longer provide ongoing care in the facility, leaving him without a primary carer. I had conversations with the chief executive of Townsville about this, because it occurred at the time that the last GP providing services to the residential aged-care sector in Townsville was about to pull out. I cannot say that I blame him, if he is the last one! After the family made multiple calls to GP practices, they were unable to identify a GP willing or able to take on the care of him whilst living in the aged-care facility. There was no GP to document his administration or to write up his prescriptions, and without that his heart valve was at risk of thrombosing. My understanding is that, in this setting, the GP input to the residential aged-care facility is through a videoconference to a GP in Victoria in the evenings.

Again, the public health system had to fill this gap. The frailty intervention team—it is run out of our emergency department at Townsville and mirrors many services across our hospitals and health services—does the outreach or in-reach primary care that is necessary, and the state government is picking up the tab for that. It is the right thing to do. I do not know how we as a community can justify our residential aged-care facility residents not having access to basic general practice and primary care. I must say: I do not blame general practice. I am a GP by background. It is simply not viable within the current economics of general practice.

I would like to turn to private health coverage. Our population is growing, it is ageing and it is experiencing increased complex chronic conditions and morbidities. We know about the increased demand on our system; approximately a third of that demand is coming from greater use per person. We have higher expectations of care yet are relying less on private health insurance. Across Queensland, the level of private health insurance coverage is near the lowest levels seen in the past 20 years. There are now more Queenslanders without some form of hospital insurance than at any other period, with 3.1 million Queenslanders uninsured.

The key fact is that over the past five years insurance coverage has dropped from 45 per cent to 40 per cent or thereabouts. That is 250,000 Queenslanders who no longer have private health insurance. Moreover, less than 40 per cent of all the insured persons now have a policy which some would call junk policies. That policy requires multiple co-payments, up-front payments and has exclusions. I have spoken to patients and clinicians in this regard. Patients come into the hospital and say, ‘I don’t want to use my private insurance because it’s going to cost me.’ I note the *Courier-Mail* article on obstetrics on the weekend, which mentioned a lady who had spent $20,000 out of pocket on obstetric care. The mind boggles. That is someone with private insurance.

One of the key rationales for the federal government’s support for private health insurance is that it reduces pressure on our public hospital system, but the changes we have seen in private health insurance are actually contributing to service demand increase across most regions and medical specialties. If we turn to obstetrics, which has traditionally been a strong area of private care, the share of work in the public sector has increased from 72 per cent to 78 per cent. Conversely, the private sector has fallen from 28 per cent to 22 per cent of the market. We are not seeking to get more market share here.

Private sector volumes over this period have fallen from a peak of 17,156 births in 2013-14 to 13,005 births to 2020-21. There is a significant shift of pregnant mums into the public sector for birthing and antenatal care. The falls in volume are likely to challenge the viability—and they are challenging the viability—of some of the private providers, as we saw with closure at the Gladstone private hospital, which further exacerbates the pressure on the public system and reduces choice for regional communities. If you have private health insurance there now, your ability to access it and choose a doctor is gone. Similar pressures exist for lots of the smaller towns’ private hospitals.

Finally, I turn to aged care and disability. Pressure on the public hospital system is exacerbated by issues in the aged-care and disability sectors including the financial sustainability of these sectors, the workforce challenges and the delays waiting for adequate accommodation and community supports. Delays in discharging long-stay hospital patients have serious significant resource implications.

On 25 August 2021, there were 238 long-stay patients occupying Queensland Health beds awaiting disability supports. This costs about $478,000 a day, based on the daily bed cost of $2,011. In reality, the costs are higher, because most of these patients have complex needs. This is an area where the market is struggling to meet their needs. On that same day, there were 325 older patients

remaining in public health settings despite being medically ready for discharge. The cohort could leave hospital if they had access to appropriate aged-care supports and suitable accommodation. They should not be in hospital; they need a home. Hospital is not a home. In addition, the discharge delays divert resources away from patients who need acute care. Unnecessary prolonged hospitalisations are also associated with poor outcomes. People get deconditioned, institutionalised, confused, fall, get infections and so on.

My final example is Tommy. Tommy was admitted to hospital in December 2020, when he was 18 years old. I spent quite a bit of time back and forth with the provider HHS, with the departmental people, trying to resolve the situation for Tommy and with Tommy. Tommy had a breakdown in his disability residential accommodation and support arrangements. As is often the case, because the hospital is the provider of last resort, he ended up in hospital. He did not need hospital and a hospital was not the right place for him, but there was nowhere else to go. Due to the risks that he posed to himself, other patients and staff during this admission, he needed 24/7 security and one-on-one nursing support. Tommy had significant behavioural challenges which were exacerbated by being in hospital.

A lack of NDIS policy flexibility, a poor provider market and poorly structured disability accommodation pricing all contributed to the discharge delays that Tommy experienced. There were many meetings and many attempts to try to get an appropriate place for Tommy. Tommy was discharged successfully in July 2021. I am pleased to say that, according to his mum, he is now thriving in his new home environment—after seven months of unnecessary admission and with his hospital stay costing over $2 million to the healthcare system. Fundamentally, though, we failed Tommy as a society. Sometimes administrative matters can have a huge impact on people's experience and outcomes.

In conclusion, Queensland's health system is simply being stretched. As you have heard today, the reasons for this are many and complex; however, these pressures are exacerbated by the need to treat patients whose conditions could have been prevented or better managed in the community or other sectors. It is critical that we address these issues, both to enable better patient care and to take unnecessary pressure off the public hospital system. I would be happy to answer the committee's questions. Thank you, Chair.

CHAIR: Thank you, Director-General. Your statement has put a focus on the, as you said, unsustainable demand on our public healthcare system. On behalf of the committee, I acknowledge the hard work of everyone involved in Queensland Health in dealing with such huge pressure points, particularly given COVID. I know that we have the director-general from Disability and Seniors present. We might come back to you, Max, at some point in time. I am keen to explore the 238 beds and how that issue might be better outcome. I invite you to make an opening statement. The committee is in your hands.

Mr Wise: Slight correction: I am the assistant director-general. The acting director-general is Kathy Parton.

CHAIR: I apologise, Kathy.

Mr Wise: I am not sure if I am relieved about that or not!

CHAIR: Sorry, Kathy. My apologies. We are in your hands.

Ms Parton: I have an opening statement. It might elaborate on some of the issues around disability services and the NDIS.

CHAIR: Thank you.

Ms Parton: Thank you for the opportunity to provide some information to this inquiry today. First, I acknowledge the traditional owners of the land where the briefing is taking place today and pay my respects to elders past and present and to future leaders.

I am going to provide a quick overview of some of the key issues relating to supports provided to people with disability by the National Disability Insurance Scheme, NDIS, which interface with and potentially impact on the Queensland health system. Queensland invests more than $2 billion per year in the NDIS. This is to enable participants to obtain reasonable and necessary supports to help them achieve their goals, objectives and aspirations. The NDIA, the National Disability Insurance Agency, is responsible for administering and operating the NDIS. They are responsible for ensuring participants are able to access support they need from service providers across Queensland.

The NDIS is making a positive impact and a positive difference to the health and wellbeing of participants. At 30 September, there were 97,475 active NDIS participants in Queensland, with plans valued annually at more than $7 billion. The NDIS has released some longitudinal data about participants who have been in the scheme for three years. This data indicates that NDIS participants on the whole are becoming less likely to have visited the hospital in the past 12 months. That is 7.6 per cent less likely for females and 7.1 per cent for males.

However, there are complex and ongoing issues with the interface between the NDIS and health services that impact on the Queensland public health system. These issues include increased pressure on the public health system, as this can result in unnecessary hospital admissions, as my colleague Dr John has said, and prevent patients with disability from leaving hospital, despite being medically fit for discharge, or they impede access to the scheme for particular cohorts such as those with psychosocial disability.

Broadly, the key issues in relation to the health interface include thin markets in Queensland. Thin markets, where there are gaps in the supply of services and supports, are a particular concern, as my colleague has previously said, in regional, remote and rural areas. There are some acknowledged supply gaps in allied health professionals skilled at working with people with high and complex disability needs. There are also examples of people with high and complex support needs remaining in hospital for long periods after being medically fit for discharge due to the lack of appropriate accommodation, including robust accommodation. Thin markets lead to an under-utilisation of funds allocated in participants' plans, as well as increasing reliance on health services as the provider of last resort.

The NDIS workforce is another issue. The size of the disability support workforce has grown with the introduction of the NDIS, but labour supply shortages remain for several key occupations and in many locations. While these shortages are not unique to the NDIS, stakeholders have highlighted challenges including attracting and retaining health professionals to rural and remote areas. This obviously impacts on the availability of specialist disability services which can, in turn, provide pressure on the health systems. While the NDIS national workforce plan has been endorsed by disability ministers and aims to attract and keep workers in the sector, more work is required to monitor the progress and effectiveness of these initiatives.

Specialist disability accommodation is a third issue. Queensland has the highest proportion of NDIS participants in Australia with specialist disability accommodation funding who are actively seeking a new specialist disability accommodation dwelling. This indicates that supply is not currently matching demand, which can again place pressure on the health system to accommodate people with disability because they have nowhere else to go.

In terms of service capacity for clients with complex needs, Queensland Health has reported some concerns about discharging clients from hospital with complex disability support needs, including complex behaviours, due to a lack of suitable disability support provider or insufficient NDIS plan funding. The NDIA is also ultimately responsible for implementing strategies to ensure critical functions are maintained for participants in the event of market failure, provider exits or sudden withdrawals of service; however, this role often falls to state health services as people present to emergency departments following the breakdown or unavailability of NDIS supports and services.

The fifth issue is the insufficient outreach and assistance to access the NDIS. Our department is currently delivering a Commonwealth funded project to support access to the NDIS by disadvantaged or otherwise hard-to-reach clients. People with psychosocial disability are less likely to have access requests approved; that is, 71 per cent of approvals compared to 84 per cent of other requests. The department's assessment and referral team works closely with Queensland Health to provide support to health consumers who require NDIS access, including to facilitate their discharge from hospital, and to help people with psychosocial disability gain access to the NDIS in particular circumstances.

The assessment and referral team has supported more than 2,000 people with disability, 331 of whom have a psychosocial disability, to access the NDIS and has secured more than $140 million in plan supports for those people. Approximately half of the people supported to access the NDIS through this project have been turned away or have dropped out of the application process previously. The health system is the biggest referrer of people to our assessment and referral team for assistance. The support secured for these individuals can be life-changing and help drive local economies as well. Importantly, they also reduce the demand for mainstream services that would otherwise be required to address these gaps.

The Queensland government is working with the Commonwealth, the NDIA and other states and territories to address these issues through the national governance arrangements for the NDIS, including the disability reform ministers meetings. Given the impact of market issues under the NDIS, the Queensland government asked the Queensland Productivity Commission to do an inquiry into the NDIS market in Queensland, and this highlights many of the issues I have spoken about today. The commission's final report and the Queensland government's response were released at the end of October. I would be happy to provide the committee with a copy of that and the details through the secretariat. Thank you very much. We welcome the inquiry and are available to answer any questions.

CHAIR: Thank you very much, Ms Parton. I might start by going back to one of the last topics the director-general talked about with regard to aged care. To put this in context, Director-General, how many beds would Townsville Hospital or the PA have?

Dr Wakefield: I would have to check, but Townsville would have 400 to 450.

CHAIR: That is the figure I am familiar with. The reason I ask is: you have given us figures of close to 600 people who are either long-stay disability support, as we have just heard, because they cannot get accommodation, or older patients. That is an entire hospital taken up with these beds in this state.

Dr Wakefield: It is one big hospital or two regional hospitals—absolutely.

CHAIR: In the previous term this committee did some work around aged care. We made a number of recommendations, but it is clear from your opening statement that if people were ageing in place—particularly, from memory, the 469 private residential aged-care facilities—there would be less impact on our public hospital system. It is very clear that in Townsville, as you have identified, the lack of bulk-billing and the lack of GPs willing to go to a residential care facility are impacting on that. It would be helpful if we can get some data—it might be a special project or something for Queensland ambulance—on how many transfers are going out of the 469 residential aged-care facilities—those privately-run facilities—and impacting on our EDs. If we can look at the data per HHS over the past couple of years, that would be helpful. I am cognisant of the fact that we have 16 state-run facilities but, on the back of getting increased nurse-to-patient ratios, I think that would be a comparison.

Dr Wakefield: I would be happy, Chair, to source that. We gave evidence to the royal commission and a lot of that work was done to prepare for the royal commission, so I am certainly happy to take that on notice to provide a briefing, if that is what you are asking for.

CHAIR: Yes, that would be very good. Some of these things are simple catheter changes. That require an ambulance to go to an ED. If systems were in place in these aged-care facilities in terms of the right level of care, could those presentations be avoided?

Dr Wakefield: The short answer to that is yes. Over the past five years or so, Queensland Health has had a number of pilot projects. There are two types. First there is hospital in the nursing home, if we can put it that way. Predominantly that is primary care. The example from Metro South is CAREPACT. There are other examples where something is run out of the emergency department which actually helps to make sure that really quick assessments are done and a lot of careful work is done to try to avoid admission. We know that admissions are often not the best way forward once an elderly patient gets in hospital, unless they need something specific, because they are deconditioned, get confused and so on.

CAREPACT is probably the best worked up. The CAREPACT service—it inreaches to the residential aged-care assessments, does responses and so on before an older person is put in an ambulance and sent to the ED—has decreased by around one-third the need for transfer to emergency departments. It is better for the resident and better for the system. Furthermore, that same study found—it was external and has been published, I understand—that, for those who do come to the emergency department, there is a further 30 per cent reduction in the length of stay of those older residents when they come into a hospital. They get managed more swiftly and more appropriately so they can return to their home. We are 30 per cent less in terms of bed days.

We know that it works. The issue at the moment is that it is the Commonwealth's responsibility to provide those primary care services and again that falls to the state. We pay twice, effectively. We pay to do that and we pay because there is a loss of revenue, because our funding comes from having a patient in the hospital and what we are doing is preventing it.

CHAIR: You mentioned a figure of $39 for Medicare rebate for a GP. When was the last time GP rebates were looked at? What is the incentive for GPs to go to residential care? If it is a rebate issue, does anyone know when it was last looked at?

Dr Wakefield: I cannot answer offhand. I do not want to speak for general practice. I think it is important that they speak for themselves, even though I have been a general practitioner. It is fair to say, though, that GPs want to do a great job. They want to provide the best care possible. In terms of providing highly professional care, at $39, with all the overheads, it is pretty obvious that to at least break even a lot of corners have to be cut. I would prefer to let general practice speak for itself. The fact remains: if we are to get the sort of primary care system that we need for Queenslanders, particularly for Queenslanders in rural and regional areas, there will have to be some sort of consideration around the economics of general practice if it is to be free at the point of care.

Mr MOLHOEK: We have had a few figures thrown out this morning. I must admit that I struggled to follow them a little bit at one point. Perhaps this question will need to be taken on notice, but do we have any trend data on the number of beds that have been occupied by disability patients and aged-care patients over, say, the last decade and how much that has increased or decreased? The two figures I wrote down—and correct me if I am wrong—are that there are 274 people occupying beds awaiting disability support and about 320 people across the state awaiting aged-care places. I would be interested to see the trend data for that over the past 10 years—how many admissions, how many have gone in and out of the system and perhaps the average length of stay. That would be handy for context.

Dr Wakefield: My expert colleague David might be able to answer that better than I can.

Mr Harmer: The department collects long-stay data through a census process. It has done that approximately annually for the past decade. It has collected it more recently in the last couple of years. We will be able to provide the trend data you are seeking on notice, but I would observe that the numbers have remained fairly stable across the decade. We typically expect to see around 300 disability patients and around 300 aged-care patients. Those numbers vary from time to time on the census dates. What we have been able to achieve recently, through direct intervention, is a reduction in the length of time people spend on average in hospital, particularly disability patients. If we can take that question on notice, we can reply with the trend data. The important point is that we have been able to demonstrate through our long-stay rapid response initiative that we can reduce the length of time people stay in hospital with proactive interventions that respond to the needs of individual patients, particularly those with a disability.

Mr MOLHOEK: If I understand you correctly, you are actually saying that the situation has improved over the past 10 years, not deteriorated?

Mr Harmer: No, what I am saying is that the problems remain—

Mr MOLHOEK: You are managing it?

Mr Harmer: Thank you for the question. To clarify, the problem has remained approximately the same in terms of total numbers. The department has intervened directly to try and facilitate discharge. The department has invested money directly. Through that intervention we have been able to achieve a reduction in the average length of stay, particularly for people with disability. To your first question, we will provide the data showing the trend over time and we can talk to the changes we have seen in the average length of stay.

Ms KING: Do you think when you provide that data we could also get some brief notes on the specific interventions the department and Queensland Health have undertaken to achieve that stable outcome? It sounds like a lot of effort has gone into maintaining those levels at a stable point.

Mr Harmer: Yes, we are happy to do that.

Dr Wakefield: I think it is fair to say that a lot of work has been and is being done by the state to work with the Commonwealth and other providers to get around some of these things. I would not like you to think that we are not trying to address it, as per Tommy's case, for example. We do know some things work. For residential disability, for example, for a period of time my colleague David and others worked with the Commonwealth. They had some short-term or medium-term accommodation options that they opened up. That certainly helped the discharge of some long-stay disability residents, but they stopped that—David, you will have to remind me when—and they are not willing to continue it. So it worked.

Mr MOLHOEK: It was remiss of me not to add to the chair's thanks for the efforts of all Queensland Health employees and allied health workers. Over the last two years I understand it has been a pretty stressful time for all of you. I am very grateful for your appearance here today and for the time that you have made available for us.

Dr Wakefield—I am trying not to be political because the chair will shut me down if I am—you have raised some significant concerns and you have highlighted, I think, some issues that you see as shortcomings within federal government responsibilities. In the Department of Health Strategic

Plan 2019-2023, there is no reference to federal health services or the provision of health services in fulfilling the objectives of Queensland Health. I wonder why there is no reference in that overview that talks about primary health network support and allied health services.

Dr Wakefield: I would have to see the document that you are referring to, if I could.

Mr MOLHOEK: It is the Department of Health Strategic Plan 2019-2023 that is published on the Queensland Health website. It states—

Our purpose

To provide leadership and direction, and to work collaboratively to enable the health system to deliver quality services that are safe and responsive for Queenslanders.

Under all the key headings within that document there is not even a mention of allied health services or federal government primary health services.

CHAIR: Before you answer that, Director-General, we will get it printed so you are aware of the reference that he is talking to. I did pick up in your opening statement collaboration between levels of government to effectively address some of the issues we are facing now.

Dr Wakefield: Maybe I will just make a comment. That is the Department of Health's strategic plan—in other words, the department as an entity. The public health system at large is obviously the department and all the health services, which has a broader system strategic plan Advancing Health 2026. If we are talking about the health system, the reference that I would be suggesting is the strategic plan for the public health system at large rather than for the department. I am happy to have a look at that document and respond.

Mr MOLHOEK: I raise it as a broader concern because there have been previous reports from the Audit Office around the need for greater strategic planning and workforce planning. I would assume that much of your work has to be done in collaboration with the primary health networks and the federal government. I thought it was unusual that in that strategic planning document under the seven key headings nowhere does it talk about the primary health network or external service provision. I am curious about the amount of collaboration that goes on between Queensland Health and primary health networks to ensure better delivery of services.

Dr Wakefield: I will take that, if I may, as a comment—and I accept that. You are absolutely right in terms of joint planning. Our health approach has to be about partnership. The public health system has a remit. The Commonwealth has a remit. Indeed, other areas of government have a remit. There is a lot of interface, as we have heard, with other sectors—mental health, aged care, education, disabilities et cetera.

First of all, as part of the National Health Reform Agreement, one of those strategic priorities is joint planning and funding. Queensland has really taken a lead role in that. Our first project is in Far North Queensland because we felt that was probably the area most right for this—so joint planning and funding around the cape and the Torres Strait. The south-west is now another priority area of jointly planning and funding. Those are the areas often where there is significant market failure of Commonwealth services because there are no providers.

I think you would have to ask the primary healthcare networks about the level of engagement from their perspective. We are indeed proud of the work that we do in partnership with primary healthcare networks. To the extent that it does not appear in that department's plan is one thing, but on the ground I would certainly argue that we do a lot of work with primary healthcare networks.

Fundamentally, as I have already pointed out, general practice is founded on fee for service and a market. The primary healthcare networks do not run general practice. I think the argument that we have—and certainly I talk to GPs who say this to me as well—is that it is time to look at how the remuneration of general practice and the model works to serve a community and a population.

Mr MOLHOEK: Further to that, I understand there is a scoring system that is used—I am not sure what it is called, but it loosely describes the efficiency of a health system. In Victoria, because it is a small state and they have communities that are closer to each other, the system operates at a higher level, whereas the Queensland health system, because it is so scattered, actually gets a lower score. Is it possible to have an explanation as to how that works?

I would like to explore as a principle how far Queensland Health's responsibilities extend in terms of servicing those unserviceable communities that are quite small. You have a base minimum of staff to keep the hospital open, but there might only be one or two patients. How does that impact on our ability to deliver services?

CHAIR: We should also ask that question of the PHNs, I think, in terms of delivery of primary care. We look forward to getting the PHNs in front of us as well.

Dr Wakefield: The document that you are referring to is outdated, according to my information. Objective 2 of the Department of Health Strategic Plan 2021-2025 is ‘Effective partnerships with primary care and Queensland Ambulance Service to drive co-designed models of care’.

Mr MOLHOEK: If we could get that, that would be great.

Dr Wakefield: I am quite happy to table that document. That is the Department of Health strategic plan.

CHAIR: Once we get the copies we will deal with that.

Mr MOLHOEK: That is fine. What is that scoring system called?

Dr Wakefield: I am not sure what scoring system you are referring to.

Mr MOLHOEK: It is an efficiency measure or a scale that is used to compare health systems. I understand it is like a global standard.

Dr Wakefield: The Commonwealth Fund is a US based organisation, if that is what you are referring to. That refers to Australia as No. 2. It has a ranking of healthcare systems around key OECD countries. Australia ranks second, I think to the UK, in terms of how good it is, if that is what you are referring to.

Mr MOLHOEK: I understand that there is also a state-by-state score that is given.

Dr Wakefield: Not by the Commonwealth Fund.

Mr MOLHOEK: I am happy for you to take it on notice and we can come back to it on another occasion.

Dr Wakefield: If you could point us to that. The Commonwealth Fund is national. It does not do state by state.

CHAIR: You can explore that and maybe articulate it when we get them back in front of us.

Ms KING: Thank you all for being here today. Director-General, I was, I think like all of us, very struck by your comments. I want to go to something that was not specifically addressed by your opening statement, though, which is specifically the impact of the fee-for-service model in general practice on elderly people who are not in residential aged care but are waiting for a home care package. Do we have any information about the length of those waits and the number of people waiting at the present time and what the impact on our public health system might be as those people await support?

Dr Wakefield: I am advised that it is best that we take that on notice. We can answer it but we would need to provide an answer on notice.

CHAIR: Absolutely.

Ms KING: I represent the area of Pumicestone, which includes the community of Bribie Island—probably the single oldest community in Queensland geographically concentrated. Since before I was elected, our ability to access after-hours GP services has completely disappeared in terms of the home care GPs. Can you provide any comments on that service? What mechanism led to the removal of that service for many communities like mine? Do you have any information about that? I have been unable to obtain information about why that service is no longer available in my community.

Dr Wakefield: Can I clarify that that is the after-hours deputising service rather than regular general practice responding?

Ms KING: Yes, the after-hours deputising service where people could call a number and have a GP visit their home. I understand that there were some policy changes that led to that no longer being effectively available.

Dr Wakefield: I am looking at my colleagues for detail. I know that there were changes to the Medicare reimbursements for that system which I understand basically led to the business model not being able to be economically viable. In other words, it is a car with a driver and a doctor and I understand they tightened up some of the requirements for genuine after-hours care rather than just its convenience because that determines how much money they get. I am not the best person—unless anyone has the detail on that—but there were certainly Commonwealth policy changes at the MBS level. Can you provide any detail? I will ask David Harmer to comment.

Mr Harmer: I cannot answer the question directly but I do wonder whether it is worth sharing with the committee observations that the royal commission into aged care made in this space. They noted that the additional cost of delivering high-quality, decent care to Australians in residential aged

care would be between $2 billion and $20 billion over the next four years and that the cost of providing high-quality, safe, decent care for older Australians could be achieved if the Medicare levy was lifted from its current level of two per cent to 2.5 per cent. We can probably provide additional detail.

Ms KING: That would be welcome. As a follow-up, I would love some reflections on what the impacts on, say, a hospital like Caboolture Hospital might be where those after-hours services are effectively not available.

Dr Wakefield: Perhaps we can take that on notice. I am not sure we have done the work to specifically link that to that change of policy, unless I get advice to the contrary. We are happy to have a look at it.

Ms KING: I am looking at this region as an example of a geographically isolated region that is not actually very far from the central business district of a capital city. There are different types of geographic isolation that Queensland communities experience. Outer metro is one area that does not specifically get flagged very often, but I recognise the GP crisis that people in my community raise with me day after day and I think that has been replicated in communities right across Queensland. I would welcome any information the department is able to provide on the impact of thin markets and market failure in the GP space on outer metro hospital and health services, and specifically hospital performance.

Ms PEASE: I too would like to acknowledge the great work of all of our health workers and GPs. My husband's family are local GP providers. They very kindly still visit our residential aged-care facilities. I spoke to Dr Petrie just yesterday at Coles. She is busy visiting all of our residential aged-care facilities. Dr Wakefield, thank you very much for your really amazing opening statement. I was busily trying to take notes but decided to just listen and read the transcript afterwards. You said that a lot of people are not contributing to private health care, that it has significantly dropped and that there are a lot of junk products available. Is there any data around the impact and the costs as a result of people removing themselves from private health care, particularly the impact that is having on our public health system?

Dr Wakefield: There has been, I understand, some significant work done by the Productivity Commission. A number of reports were done about out-of-pocket costs for providers. I would have to do a bit of a sweep about what is available in terms of work that has already been done. There are some statistics on the changes in market share. I think I raised some of those in my opening statement. Can we specify the question? I think it might be best to take it on notice and we can properly research that.

Ms PEASE: Certainly. That would be really interesting. In your opening statement you also mentioned the fact that some people who have private health care are still presenting to public hospitals because they are not covered or there is not a service available in their area. Where do you get that information from? Is it anecdotal from conversations or is there actual data that you can indicate?

Dr Wakefield: There is certainly data. In the last seven years the public hospital market share has increased from 58.5 per cent to 63.4 per cent. It is a five per cent increase in public hospital market share which, surprisingly or not, exactly aligns with the five per cent drop in insurance. We know both from data and also from anecdote that for every person who comes into hospital there is an election process. They have to elect to be public or to be private. There is a point of conversation and a point of decision-making from the patient's perspective about that. We have data on that. They can decide whether or not they elect to use their private insurance.

It is probably better if we take a step back and ask: what are the reasons someone would not use their private insurance? We know this. Firstly, it is availability and access. If you are in Gladstone, for example, and there is no longer a private hospital, unless you leave town it is pretty hard for you to make a decision to go to a private hospital. Access is a significant issue, particularly for rural and regional Queenslanders. In rural centres, if the only hospital is public then you end up public.

The second one is the issue of junk policies. That is not my term; it is a term that was coined I think in the media mostly. Basically, people end up getting a policy to get the tax write-off but, at the end of the day, if they can get service for free—and we provide great services—versus paying $1,000 up-front to their insurer and then maybe all the out-of-pockets with doctors, they make that choice to go public.

The third thing is the confusion about what private health insurance means. Many people do not understand that private health insurance does not cover anything in relation to outpatient services. It does not cover a trip to the private emergency department. It does not cover a trip to the private specialist, for example. I think also people do not necessarily understand what they are getting. There is general confusion.

I am very happy to get whatever data we can that reflects the public hospital share of private insurance—that is, people who enter public hospital but are privately insured.

Ms PEASE: Thank you for that. You talked about the increasing presentations at public hospitals. I think you mentioned a figure—correct me if I am wrong—that 6.6 per cent of those presentations were preventable through preventive visits to GPs prior to the condition becoming chronic. How have you obtained that data, what sorts of conditions are they and what can you correlate it to? Is it because there are no GPs available, that they cannot get an appointment or that it is too expensive for them to go? Can you provide some data on that?

Dr Wakefield: I will see if I can get some detail from behind me. It is a national definition. It is defined as part of the Australian Commission on Safety and Quality in Health Care. It is nationally measured. It is based on an analysis of the inpatient data. It is a bit theoretical. It takes certain conditions and basically applies a preventive lens. That is, if someone had the currently available preventive treatment, would they be there? We can get you the definitions, how it is calculated and the national rates, which are published in the logs report.

The point is that we know that there is a revolving door of admissions into hospital of patients for whom, if they had the right sort of chronic disease care in the community, their rate of hospital admissions would decrease. There is plenty of evidence to support that. Again, if we go back to the current system, I am strongly supportive of general practice here. GPs themselves want to do the best job they can. I am talking about the economics and the way the funding works.

Right now, if you are a patient of limited means with chronic disease then you have to find a doctor who will bulk-bill you. Then to get the sort of care that you need in the community—preventive care, secondary prevention of chronic disease such as heart or lung problems, chronic liver failure and so on—you need the allied health wraparound. It is not the doctor themselves who will give you the diabetes ongoing advice, the renal ongoing advice or the cardiac advice. Those are usually nurses, expanded role nurses, allied health experts, dieticians, physios et cetera. None of that is funded. You are out of pocket for all of that. There is no way that you can access that without paying privately for it because it is not funded as part of the Medicare system. Basically, people of means can afford it; people of limited means really have nowhere to go but the hospital.

What we are saying is that proper primary care involves the home. It is the place where all of that can happen and all of it can be provided in a model that works financially for the people who are operating it. It is fundamental policy things that we are talking about here. If we go back 20 years, we did not live as long and we did not have as much chronic disease. It was much more a break-fix model. You did not need that wraparound. Now we do, but our system still has a fee for service.

Ms PEASE: That would also potentially be impacted by the Commonwealth home care package system as well. Particularly in the aged sector, if people had access to those packages in a more efficient manner they could access those allied health services because that could potentially be part of their package.

Dr Wakefield: I will hand over to David to answer that, but certainly after the royal commission we welcomed the additional investment of the Commonwealth. It did fall; I think it was 20 per cent or so of what was recommended. To that end, it will improve access to home packages. David, do you want to comment on that question?

Mr Harmer: Only to confirm what you are saying and agree with the premise that, obviously, if people had earlier access to those packages and supports then they would be able to live better at home. While new investment was made, it went some way to addressing the gap but—

CHAIR: But not all the way.

Mr Harmer: Many will remember from the inquiry that there was a significant wait that has not been fully addressed so there is definitely—

CHAIR: I believe we made recommendations, 77 of them, and a lot of them were towards the Commonwealth. The member for Lytton will remember that the waitlist was 120,000 people, waiting for a home care package. I remember that poor lady at Hervey Bay who talked about her husband. You quoted some cases, Director-General. There was a particular case where the lady's husband had passed away two years prior and she had only just got the home care package for him.

Dr Wakefield: In respect to the question of the member for Lytton and a previous question about the Medicare rebates, there are two things associated with that. There was a freeze of Medicare rebates between July 2013 and July 2017. It was a complete freeze on any CPI. I think it was commenced again in 2018. There has also been a five-year review of Medicare and MBS items to

modernise MBS. That was not about general practice, per se; that was about all the MBS items. There was a particular point that goes to the question of the member for Lytton and I would like to hand over to our Acting Chief Nursing and Midwifery Officer.

Ms Miller: The report that the director-general was referring to is the MBS Review Taskforce report and recommendations which provided no additional access for nurse practitioners to be able to provide adequate services to chronic disease patients in the community.

CHAIR: Director-General, I asked about some work to be done around the impact on the QAS of going into residential aged-care homes. Can we also get some data on walk-ins to hospitals? In my electorate of Thuringowa, Townsville Hospital has around 280 people a day going in. That is not sustainable. I want a breakdown per HHS of the walk-ins and not just the ambulance arrivals. I acknowledge that ours is a retrieval hospital in the ADF space. It might help the committee to know that.

Dr Wakefield: We can certainly do that in great detail.

Ms KING: Could we have the increases over time?

CHAIR: Yes, I was going to ask for the last decade.

Mr ANDREW: Firstly, I put on the record my appreciation for the hospital and health services' care that has been given in the past. I extend my best wishes to the people who may be leaving hospital and health services going forward, given the situations that are arising. In the opening statement you talked about increases in certain issues with health, mental health and so on. Have people been presenting with more issues to do with vaccine injuries, conditions or symptoms arising out of the vaccines that are making the system a little more cumbersome and overloaded?

CHAIR: Member for Mirani, I will allow a bit of latitude because you have been patiently waiting, but it is not really within the terms of reference we are looking at. Are you willing to answer that, Professor?

Prof. McNeil: The short answer to that question is, no, we have seen no tangible impact on our health service delivery—other than obviously prevention of COVID by vaccination. They have not caused any negative effects in terms of health system demand.

Mr ANDREW: So we are actually seeing no increase in myocarditis, pericarditis, stroke or blood clot in any of those situations?

Prof. McNeil: We have seen occasional presentations but they are very rare and they certainly do not add significantly to the demand on the health system.

CHAIR: I think perhaps the member is reflecting on our QIMR visit last sitting week where we were provided with some research interestingly of long-term COVID and the effects on cardio tissues. Perhaps that is the connection he is making there.

Prof. McNeil: Queensland has done so well that we have had very little COVID in our community, so the impact of long COVID on Queensland is yet to bear out. We have not quite seen the effect of that from overseas jurisdictions yet either, because they are still within the acute phases. That is very much a story that will unfold.

CHAIR: We will get back to the inquiry. Member for Mirani, do you have anything else?

Mr ANDREW: People in my electorate keep calling me and saying that they are having issues with it and there is a lot of presentation, but there does not seem to be much said about the situation and how it is unfolding. Are any statistics kept on how this is actually working? One of my uncles has had a stroke and I know that a lot of people in Mackay have suffered adverse reactions but it does not seem to be mentioned much around the HHSs.

Dr Wakefield: The place to go for the data on the AEFIs—the adverse events following immunisation—is the TGA website. The TGA publish the data on the significant complications, where they do exist, or adverse events from immunisation. However, as the chief medical officer said, in the perspective of impact on our hospital system, it has been negligible.

CHAIR: Member for Mirani, we are drifting off the terms of reference.

Mr ANDREW: I just wanted to clear it up.

Mr LISTER: Dr Wakefield, you were understandably cautious about speaking for the GPs. Obviously, you do not have the luxury of them reciprocating there and I know that when this inquiry was called a number of stakeholders commented their views on the issues which are contributing to waiting times and so forth in hospitals. Can I ask for some context on those statements from the

QNMU, the union representing paramedics and the AMAQ. I have an article here that was published on 18 November in the *Courier-Mail* quoting them as having their own views. Are you familiar with what they have said?

Dr Wakefield: I do not know what you are quoting from.

Mr LISTER: I can put them to you, if you like. The QNMU said that there had been momentum for reform earlier in the year which has been lost. The AMAQ said that Queensland Health needed to provide extra beds and staff. The union representing the paramedics said that they were concerned about ramping, patients being cared for in corridors and staff being forced to regularly work in unsafe and chaotic conditions. I think it is only fair that you have an opportunity to provide some context from your department on those comments.

CHAIR: The first thing I will say, member for Southern Downs, is that that is a media article. I do want to keep it within the provisions of the terms of reference that we have in front of us. I think the director-general has gone to extreme lengths to articulate the pressures on emergency departments, notwithstanding the 500-odd beds that are being occupied by older patients. Director-General, I will allow some latitude in your response.

Dr Wakefield: Thank you for the question. I assume this is what this committee inquiry is all about. I will not speak to an article that I have not seen or do not have in front of me. What I can say is, as I said in my opening statement, that we are not disputing that there is significant pressure on our public healthcare system. That is essentially why we are here, I understand. The question perhaps is more about why that is the case. Why is it the case that we have double-digit growth in demand when we have less than two per cent growth in population? Why is that perhaps disproportionately impacting our public hospital system? Some of the things that I have outlined have sought to explain some of those what I will call root causes. There will be lots of different opinions about that but I can only tell you from my experience and my tenure as director-general, given the shoes that I walk in and what I see.

It is true to say that our system is complex so there is no single answer or diagnosis of the problem, and if there is it is probably wrong. There is no doubt in my mind—and I think the evidence supports this—that we are seeing significant demand growth which is not simply explained by either increased population growth or increased utilisation per person. I am merely presenting on the facts that we have. I am providing some context and there are areas that are managed and where it is the responsibility of the Commonwealth to come to the table with us on to try to solve this together.

Again, I think I come back to the beginning statement. Why is it okay that if there are too few providers in a town—not just in rural Queensland but in regional Queensland towns like Rockhampton, Gladstone, Bundaberg and Mackay as well as the western towns—the Commonwealth in essence gets off scot-free because there is no billing and that then means that community is underserved? It is gross inequity. All we are saying is please let us come to the table and make sure the funding is directed to a population. Even if there is not a provider there, let us still get the money to that town or region and figure out how we can apportion that and use that to deliver services, even if it is not the traditional GP. Maybe there is a different way of doing that. It is just shining a light on this and asking whether we are prepared to think differently. This inquiry is about the Commonwealth's piece of that puzzle.

Ms PEASE: You mentioned in your opening statement that the work you are doing to try to be preventable is all part of that conversation, so you are already doing it at a cost.

Dr Wakefield: Yes. One example would be the satellite hospitals—a major investment by the state government to essentially bridge that gap. They will provide a place which is not a very high cost acute hospital, but it is also not the traditional general practice. It is where services can be provided in that missing middle—be it closer to where people live; be it urgent care which is not in an emergency department but someone needs that care today; be it chemotherapy, renal dialysis and so on; or be it ambulatory care, outpatients or chronic disease care. It is the sort of place where that care can be provided. We would argue that is the Commonwealth's responsibility but we are stepping in to do that.

Equally, going to your point about the current challenges in the system, the government has invested significant amounts under Care4Qld. There was an additional $482 million put in this year. As a consequence of that, we have mobilised approximately 300 beds out of a 400-bed target to increase the capacity of the system so that we can diffuse some of the demand at the front end and get the flow happening. As you have heard the Premier and minister outline publicly, that has led to a 30 per cent reduction in the lost time on the ramp, which makes a real difference to patients waiting

for an ambulance, makes a difference to people waiting for room in the ED and also makes a difference to the staff who are trying to make sure they can move patients through the system. We are trying many ways to tackle this. We need to do it together.

Ms PEASE: Can I give a quick shout-out to Gundu Pa, our Wynnum-Manly Community Health Centre, which is very much aligned to that. It is not a satellite hospital but it is a great community health centre.

CHAIR: There is another question on notice on that. In terms of ambulance call-outs, I recall the commissioner coming before us last year and saying there was something like a million calls for service. Can we get some data from QAS on the increase in demand for service over the last decade? This goes in correlation with an ageing population and people living longer with complex medical issues, but I think that might inform the committee on the growth. Could we also get some regional breakdowns on that? That is a question on notice.

Mr LISTER: Dr Wakefield, thank you for your response to my earlier question. You spoke about the inequity of the withdrawal or the absence of primary health services in rural and remote areas and how that leads people to default to the emergency room and so forth. Speaking in the context of my electorate of Southern Downs, Millmerran is a town in my electorate and the Darling Downs Hospital and Health Service operates the hospital there. When the sole doctor in Millmerran ceased practice in 2019 or 2020, the health service set up a primary health clinic with Queensland Health doctors in a building in the grounds of the Millmerran Hospital. Presumably they were charging a Medicare fee for seeing patients on a primary health basis. If that has stemmed the difficulty in dealing with people at the primary health level, why can that not be done elsewhere?

Dr Wakefield: That has been a feature of our system for decades. Going back to my own history, I was the rural generalist in Gin Gin. I was there because I was hired by the hospital system. I was the medical superintendent of the hospital, seven days a week. As part of that, I had rights to private practice, so I had a premises provided by the hospital system to run essentially a general practice and I provided cradle-to-grave care. There are hundreds of fantastic rural generalists out there who do exactly that. The backbone of that is usually created by the public hospital system.

On top of those medical superintendents, about 20-odd years ago they introduced a medical officer with rights to private practice and so on. There was a system at its heart that drew doctors in and recruited doctors who would not otherwise go there who provided essentially probably the most difficult job in the system—that is, primary care and general practice but they were also there dealing with heart attacks, strokes, road trauma and so on up the road at the hospital. I think that is the backbone of the Queensland system.

Even that is struggling now in today's world. I will explain why. I was on my own. I had to get my own partner in two days a week. That was close to the coast. It was nothing like some of these really far-flung places. That practice would not have financially survived without my public hospital job. No-one is going to go there without that backbone. In today's world, no employer is allowed to have someone working 24/7 seven days a week on their own.

Mr LISTER: These were not superintendents at the hospital who operated a private practice in conjunction with that. These were medical officers employed by the Darling Downs Hospital and Health Service who were sent out to operate in a clinic that was operated and staffed by Queensland Health.

Dr Wakefield: I understand that and I am familiar with the issue. What I am saying is that the Commonwealth is responsible. They have a market model. That is why we have too many doctors in the city and not enough in the bush. If you are qualified, you set up your shingle and off you go—bill away. There is nothing more than that. There is no commitment to hours of operation. There is no commitment to the population that you serve, per se. There is no commitment, as part of that contract, to serve residential aged care, for example, or anything else. You basically set up and off you go.

What we are saying is that it is time to relook at that at its heart and that will be of benefit. Queensland Health will always have a role in supporting rural and remote areas because the market fails. What is the Commonwealth's role in solving that problem?

Mr LISTER: Do they fund the doctors? When they see a patient for service, is there a Medicare charge which is paid to—

Dr Wakefield: If the doctor is eligible, if they are under the right section of the act, they may be able to bill. I presume they do bill. Again, I think the point is that the Commonwealth are responsible for primary care. I do not think it is good enough to say, 'We'll put out the MBS schedule and if doctors are not there it is not our problem.' I just do not think that is acceptable.

Mr ANDREW: Given that 17 December is going to come around very shortly with the rollout of the mandates, does Queensland Health envisage any issues, especially advantages, for vaccinated or unvaccinated people through the NDIS and Medicare? Will there be any changes to the way we deliver to those people?

Dr Wakefield: I will ask David Harmer to comment on that.

Mr Harmer: The Chief Health Officer in Queensland has made a direction to mandate vaccination for people providing health care as defined in the direction. That will benefit Queenslanders with a disability in that it will afford them the protection that the vaccination offers. They themselves, however, still have the choice that every Queenslander has as an individual to decide whether to get the vaccine or not.

I am not sure I am entirely answering the question, but we have put some frameworks in place that ensure that everyone providing care is vaccinated. That will protect members of the Queensland community and lift our vaccination rates. I do note that Queenslanders with a disability are some of our most vulnerable to COVID, given that often they have comorbidities and other complexities in their life that make them vulnerable. We are doing what we can to protect them.

Mr ANDREW: It was more about the patients rather than the people treating them. Will there be an advantage or a difference in care rolling out after 17 December between vaccinated patients and unvaccinated patients? Will there be any effect through the normal Queensland health system in the way they access the NDIS and Medicare? Will preference be given to vaccinated people over unvaccinated people?

CHAIR: We are absolutely drifting out of the terms of reference for this inquiry, member.

Mr MOLHOEK: In regard to the question asked about ambulance numbers, I think we have put that question on notice. Can I also ask for a breakdown by each of those service areas in terms of lost hours? I think that is something we have been asking questions about for some time.

CHAIR: What is that?

Mr MOLHOEK: In the last five years.

CHAIR: Sorry. Can you put it in context?

Mr MOLHOEK: You have actually asked for—

CHAIR: Increase in demand for call-outs, yes.

Mr MOLHOEK: At the same time, could we have that same data by service area in terms of lost hours and some commentary around the increase?

CHAIR: I am not understanding your reference to 'lost hours' in the context of what it is. I simply asked for data around the increase in call-outs for demand for service. I do not know how that impacts on lost hours. I have been working with the ambulance for 30 years and I do not understand your question.

Mr MOLHOEK: The issue with ambulance ramping is that because people are spending more time waiting to get into the hospital there is an increase in lost hours or lost productivity by ambulance officers. I am wondering if we can see that data by service area and catchment as well. I am putting that as a question on notice.

CHAIR: I think it is slightly outside of the scope. I am happy with the data on the increase in demand for service. I think the director-general went to some lengths to explain access block, bed block, because of beds that are used by people who should not be in the hospitals but are. If we could move those people out—those 500-odd beds—that would be one way of freeing up the front door, so to speak. That is my observation. Can we have an offline conversation about that last question?

Mr MOLHOEK: I think it is just as relevant as your question on notice.

CHAIR: I am cognisant of the fact that we have one more question on my right and we have had the most patient person at the end of the table from the Department of Education with seven minutes to go.

Mr MOLHOEK: We have not asked a question yet.

CHAIR: I do not know how pressing your question is.

Ms KING: I can leave it.

CHAIR: I thank the executive director for the Department of Education for the briefing. I know that there have been some developments particularly around GPs in Schools. I have one of those in my electorate, so we are excited to see what that does in terms of providing not just advice but also some care in schools. Will that lead to a reduction of walk-ins going forward? I know that is hypothetical because GPs in Schools does not start until May next year.

Ms Ybarlucea: May I refer this to my colleague the Executive Director for Child Protection and Wellbeing, Hayley Stevenson? She manages the GP pilot.

Ms Stevenson: It is a really exciting initiative. The GPs in Schools pilot will be in 50 schools. It is all across Queensland, so it does cover all of our education regions. We anticipate that those GPs will be based within the school, in a fit-for-purpose clinic at the school. They will provide some of that early intervention and support for secondary school-age students. With that early intervention we may see a reduction in some of the presentations.

Also, it is important that we will see those young people increase their health literacy and learn those skills around making an appointment and having a discussion with that primary health carer and hopefully when they leave school they will have established a relationship so that they do seek support from a GP as opposed to presenting at a hospital when it is not necessarily needed.

CHAIR: You currently have a number of nurses in schools as well.

Ms Stevenson: Yes, that is right. We also have just shy of 120 full-time school based youth health nurses across our schools in Queensland. They are in secondary schools. They provide that proactive, preventive support for our young people. There are also some registered nurses that the department employs who provide support for students with disability and other medical needs.

Mr LISTER: This is something of interest to me as I have 30 or 40 schools in my electorate. How are you going with recruiting to those funded positions in terms of the health professionals—doctors, nurses and allied health?

Ms Stevenson: Is that for the GP pilot?

Mr LISTER: In that case, yes.

Ms Stevenson: Part of the application process was that schools needed to liaise with a clinic or a general practitioner in their area and engage their support for being the GP to ensure they had capacity. Our schools did the hard work in contacting a GP clinic. Now they are in the final processes of exchanging contracts for that service. That was a condition of being part of the pilot—already having identified a GP.

Ms KING: Dr Wakefield, I wanted to ask for your reflections specifically on mental health. You have noted mental health as an area where we have seen part of this unprecedented increase in demand for service. I was hoping that you might provide us with some comments about the appropriateness of a fee-for-service model given the thin market and market failure issues in remote, regional and outer metropolitan areas of Queensland specifically in the area of mental health.

Dr Wakefield: At the back end of the meeting it is a big issue to open up.

Ms KING: I apologise.

Dr Wakefield: There has been a lot published about this and particularly recently after the Victorian commission of inquiry, particularly that Productivity Commission report. There is no doubt that all levels of government need to work together to make sure that at a community level citizens have access to—I think this is where it matters—free-at-the-point-of-care, 24/7 mental health and wellbeing support. People talk about that as the missing middle—that is, free 24/7 mental health and wellbeing support. There also needs to be crisis intervention that does not leave emergency departments as the only choice for people.

That is the focus for all of us. It is has to be the focus of our Queensland Health public health system. It has to be the focus of the Commonwealth, bearing in mind that this is predominantly the remit of the Commonwealth—that community level primary care. That is a lot of what general practice and the extended general practice and the primary care and allied health community do.

Again, as much as there was great fanfare about expanding those 10 Medicare funded psychology sessions to 20, all that has done is increase queues—a la my comments earlier, which is an anecdote. There is no doubt that the evidence suggests that now you have to wait a long time to get in because people now have 20 sessions and the psychologists are full, bearing in mind that also there are out-of-pockets with that. Again, I think for people who are in dire straits, that is not necessarily going to work for them.

For me, I think that has to be our focus. Again, if we flip that to what we have been doing, the public hospital system is not sitting on its hands. There is an enormous amount of work being done. I will hand over to Dr John Allan in a moment to perhaps speak briefly about what we have done.

The one great shining light, just to give you an example, is the mental health co-responder model. Again, it is not that people should have to ring an ambulance—that is after they have gone over the cliff, right? But if they do ring an ambulance, we do know that with that co-responder model, with the ambulance and the mental health experts going out to them, in 60 per cent of cases they do not need to go to ED.

CHAIR: It is a brilliant initiative.

Dr Wakefield: The last place they want to be is in the ED. They get the wraparound that they need. We do not just need fee for service thrown out to solve a problem—'Let the market solve it.' We need that sort of focused policy and practice and delivery that is fit for the particular community, whether it be city, region or bush. That is what we are saying. John, do you want to cover off on some of the other issues there?

CHAIR: Briefly.

Prof. Allan: I will say just a couple of things about mental health. One is that the increased demand for mental health started before COVID and particularly for young people. We have seen a serial increase in demand by young people. Secondly, just to reinforce what the director-general has said, there were some changes to the Commonwealth arrangements—Medicare numbers and allowing telehealth at the beginning of COVID. That was very welcome. There has been a 10 per cent national increase in mental health uptake in items. As the director-general says, that is now all saturated, so the waiting time is three months to get into a private practitioner. For children and youth—I have just been trying to assist a colleague trying to get someone with anorexia to see someone in Sydney—it could be a six-month waiting list. That is a problem. The time for Queensland Health can be that day or very shortly in a couple of weeks. We have had to rearrange things.

There was an investment particularly around that response to COVID which bolstered our acute service—so the ability to see people who are presenting with those COVID type problems. There was an investment to support local councils in the country around some COVID issues. We had to support people in hotel quarantine and people with drug and alcohol problems, and there were some further investments in the co-responder model.

What we have been seeing is that increase in the emergency department presentations. It was 10 per cent last year, continuing again this year. There has been a slight drop in the total number of emergency presentations, but the number of people presenting with suicidal ideation has actually gone up and continues to go up. We are very stretched in dealing with that. We have extra services coping with that. We have a crisis system response which we have been doing, along with the co-responders. We have been building safe spaces for people. We have had a new assessment service on the Gold Coast. We have particular plans around that. We have something that we do with the Commonwealth which is the Way Back Support Service for people who have made a suicide attempt, who have suicide ideation, to follow them up. We do that through the PHNs. That is a very good thing but there is more to happen there. There is a lot happening.

For the Fifth National Mental Health and Suicide Prevention Plan there have been joint plans between the PHNs and the HHSs to look at mental health in the local regional area. There is some further work on a national agreement about that. We are currently working through that. I could go into a lot more detail about that.

The rise for young people I think is really important—the rise in eating disorders around the world and around Australia. We had 100 per cent increase in eating disorder presentations last year. Some of that is something about the pandemic uncertainty and young people in the future and some of it is about the saturation of private services because people who would have gone that way are coming to us as well. That is across the board. Then it is something about youth not seeing a future as well.

I see the data every week about that increase. It is frightening. When there is a lockdown the number of people who contact the telephone services increases exponentially. When there is lockdown there is slight drop in people presenting and then in the weeks after we see this rise. That is going to go on.

CHAIR: Thank you very much, Dr Allan. Thank you, everyone, for attending today. We have gone over time. On the parliamentary website we will soon have our regional public hearing schedule. We want to hear from Queenslanders who cannot get to a GP. Yes, we need to procedurally table that information.

Dr Wakefield: If I may, I table the strategic plan 2021-2025.

CHAIR: Is leave granted? There being no objection, leave is granted. You have taken some questions on notice. If we could have responses back by Monday, 6 December, that would be greatly appreciated. There is a lot of data coming towards us, but it will provide us with the information we are seeking in this inquiry. We thank you all for your attendance today. I declare this public briefing closed.

The committee adjourned at 11.50 am.