HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Ms AB King MP
Mr R Molhoek MP

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

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

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 8 DECEMBER 2021

Brisbane

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The committee met at 11.03 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impacts on the Queensland public health system. My name is Aaron Harper. I am the member for Thuringowa and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. With me here today are: Mr Rob Molhoek, the member for Southport and deputy chair; and Ms Ali King, the member for Pumicestone.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the 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.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. I ask people to turn their mobiles phones off.

We are very keen to hear from witnesses about the impact on the public health system in Queensland and how best to address the challenges of things such as an ageing population.

GROTH, Mr Allan, Director, Policy and Strategy, Services for Australian Rural and Remote Allied Health (via videoconference)

JOHNSON, Mr Edward, President, Services for Australian Rural and Remote Allied Health (via videoconference)

MALONEY, Ms Cath, Chief Executive Officer, Services for Australian Rural and Remote Allied Health (via videoconference)

TOSH, Ms Rachel, Speech Pathologist, Services for Australian Rural and Remote Allied Health (via teleconference)

CHAIR: I now welcome via videoconference representatives from Services for Australian Rural and Remote Allied Health. Good morning. Would you like to make an opening statement before we move to questions?

Ms Maloney: I begin by acknowledging the traditional custodians of the Ngunnawal and Ngambri people from whose lands I am speaking today. I also acknowledge the Wiradjuri people on whose lands my colleague Ed Johnson joins the meeting and the Jagera, Giabal and Jarowair people, the traditional custodians of the lands around Toowoomba from which our colleague Rachel Tosh joins us today. We acknowledge the traditional custodians of the lands, seas and waters throughout Australia and pay our respects to elders past, present and future.

Thank you for inviting us to contribute to this important inquiry. I am Catherine Maloney, CEO of Services for Australian Rural and Remote Allied Health, or SARRAH. I am a physiotherapist by background and have broad experience across public, private and in rural settings as a director of the rural primary health network board and manager of a remote Aboriginal community controlled health organisation.

I am joined by Ed Johnson, President of SARRAH, a speech pathologist who lives in Blayney in central-western New South Wales and who has extensive experience practising in rural and remote settings. Ed has been a member of the clinical council of a rural primary health network and has a PhD researching online therapy in rural and remote settings and lectures with the School of Health Sciences at Western Sydney University. Rachel Tosh is a SARRAH member based in Toowoomba providing a range of allied health services to Toowoomba and surrounding communities.

We have extensive experience working across the public, private and community based health systems, the NDIS and in aged care and other settings. SARRAH is the peak body representing rural and remote allied health professionals. Our members live and work across regional, rural and remote Australia in public, private and community sectors, health, aged care, disability and other settings. Our Queensland members include at least 14 distinct health professions working in many locations across the state and the service systems identified by this inquiry.

We are informed by the breadth of our members' experience within and across service systems. Our evidence focuses on allied health. We acknowledge the vital role our nursing and medical colleagues play. However, the allied services workforce shortages are even more severe than for GPs—markedly so, especially in rural and remote areas including Queensland. This is a major systemic issue that has been apparent for many years and has obvious well-known access and health impacts for people living in rural communities.

We welcome the breadth and scope of this inquiry. It is very rare for inquiries to take the broad view and consider the interactions of major health and associated service systems, yet it is those interactions that have an impact on how well the health system functions. None work well if key elements are missing. It is especially obvious in smaller communities where resources are fewer. Some work because committed locals know how to be innovative and flexible and to make things work. Often they work despite the barriers and impediments imposed by a system designed for a metropolitan population and market.

The Commonwealth is responsible for primary care. Their focus is overwhelmingly on GPs however. GPs are, of course, crucial and the Commonwealth supports for GPs and medical pathways, practices and training are needed to promote distribution. These investments appear to have an impact. However, medical practitioners make up around 15 per cent of the total health professional workforce in Australia. The rest are nurses, midwives, allied health professionals, Aboriginal health practitioners, dentists and so on. SARRAH estimates around 80 per cent of the $1.5 billion to $1.6 billion per annum spent through the Commonwealth health workforce program goes to the medical profession, leaving around 20 per cent to support the training, practice and distribution of the other 85 per cent of the health workforce.

Doctors need support, but so do other health professionals because without the formal multidisciplinary workforce people cannot access the care they need. Some simple facts help set the scene. Seventy per cent of allied health professionals in Australia work in the private and non-government sectors. The Commonwealth does not collect data on the number or location of the self-regulated professions—almost half the allied health workforce—including some that are eligible to provide NDIS, MBS and other Commonwealth services. Primary health networks are essentially GP focused. Some are starting to look into the allied health workforce and services to meet local health needs, but even their efforts are at an early stage and hampered by a lack of infrastructure to support targeted engagement.

The consequences of what we hear about from our members in terms of aged-care recipients receive little or no enabling care are that, when the avoidable incident occurs, they go straight to the local hospital. Hospitalisations are caused by falls due to deterioration that could have been avoided; malnutrition that could have been avoided with speech pathology support, better nutrition and enough mobility to reach the food on offer; and serious complications due to lack of access to dental care. The aged-care royal commission shows an average of eight minutes per week is spent on allied health services in residential aged-care. That is amazingly low given the needs of this cohort of people. Yet the Commonwealth budget response to the aged-care royal commission includes little to enable allied health services and workforce to deliver.

Allied health professionals are specialists in things like childhood development, preventive health, rehabilitation, enablement and optimising independence. These investments put downward pressure on hospital and other health services. They are critical to the effectiveness and sustainability of our health and social support systems. Prevention is better than cure.

Australia compares poorly on prevention at 1.5 per cent of total health spending—about one-third of the OECD average. Our system is configured to perpetuate demand such as avoidable hospitalisations. Despite some very recent changes to the MBS, allied health services are too constrained to ensure people with complex comorbidities can access the care they need. Where access to allied health services in the community is lacking, it puts extra demand on public health resources already under immense pressure even without the impact of COVID. As a result, where few allied health services are provided through the Commonwealth MBS in rural and remote Queensland, where NDIS participants cannot access allied health services and NDIS funds go unspent, and when older Australians miss out on home care services to keep them well and independent, it all has an impact and the consequences are often felt at the local hospital.

The local hospital or public health service may have an allied health workforce but it is too often not available, under supported or overstretched. Queensland Health does comparatively well in supporting allied health compared with other jurisdictions, as evidenced by programs such as North West Queensland Inter-agency Allied Health Workforce Strategy that enables a collaborative, regional approach to allied health workforce developments including recruitment, retention and capacity building in health services in north-west Queensland.

Greater flexibility is needed to enable multidisciplinary and cross-sector models of care that make use of the available workforce capacity in rural communities. The extreme short supply of these resources mean that they must be drawn on wherever available. There are successful examples of public-private partnerships providing services to hospital inpatients, aged-care recipients and outpatients in outer regional townships that are translatable and scalable to a variety of situations. SARRAH would be happy to see more of these examples embedded.

SARRAH will also provide a written submission to this important inquiry. We will include recommendations for what could be done now and what is needed to address the issue fundamentally. We would be happy to be of further assistance. I would now like to hand over to my colleague Rachel Tosh, whose experience in trying to deliver allied health services may be of particular interest to the committee.

Ms Tosh: I would also like to begin by acknowledging the traditional custodians of the land where we are all gathered and pay my respects to elders past, present and emerging. I also extend that respect to Aboriginal and Torres Strait Islander people who are in attendance today.

Workforce issues with regard to allied health such as recruitment, retention problems, skills gaps, high turnover, attrition due to burnout and mental health issues—especially markedly in regional, rural and remote areas—are not a new thing. I feel that we are on the brink of disaster right now because of a nationwide shortage. According to the employment website Seek, the No. 1 hardest vacancy to fill in Australia across the country right now is speech pathologist. Based on the 20 years of experience I have in the industry, I see four key factors at play.

Firstly, the funding models just do not match the desired outcomes. For example, as an organisation we do not provide Department of Veterans' Affairs services or Medicare bulk-billing because we lose money if we deliver them because the rates do not even cover wages, much less overheads. The NDIA has not increased therapy pricing for close to three years now. In the same time our wages and payroll related expenses have increased by more than 17 per cent as we desperately try to attract and retain key members to regional and rural areas. Even attracting them to our lower socioeconomic metro locations is incredibly challenging.

The second factor I see at play is a lack of communication, collaboration, cooperation and trust within and across sectors that is preventing innovation. This is not just the interface between private providers and the NDIS; it is across different levels of government. It is across health, education, and disability sectors. It seems like there are a whole lot of unnecessary turf wars going on. Meanwhile, people with disability and people who need our services are falling through the gaps and getting caught in that crossfire.

The third element is that therapists and their clients—or providers and participants, to translate for those who are fluent in NDIS speak—are being strangled by red tape right now. For example, I have had to help local GPs in Toowoomba complete NDIS access request forms because they could not get any clarity from the NDIA directly. They were getting rejected for amputees or people with other obvious permanent disabilities simply because a poorly worded question meant they ticked one wrong check box on the form because nobody explained to them what that question actually meant.

The fourth element is that because of this we are not able to harness the inherent creativity and capability within the existing workforce, which is then further compounding those other three factors.

By way of background, I have worked across the private sector. I have worked across the public education system and the disability system. I have worked in health services in community and acute settings. I have worked in both the UK and Australia. I have provided services across multiple funding models, including: DSS; Helping Children with Autism; Better Start for early intervention for disabilities; the NDIS; Medicare; DVA; WorkCover; and a lot more. In a past life I was the lead project officer for the Queensland Health Allied Health Rural Generalist Development Pathway. I have worked in this industry for a long time in a lot of different roles and I have seen it from a lot of different perspectives.

I started my private practice in Toowoomba back in 2012. We grew extremely rapidly even before the NDIS days and we added OT, physio and dietetics to those services. In 2018 a fellow speech pathologist in Chinchilla approached me in the hope that someone could try and keep the

local service that she founded going. We not only managed to keep that speech pathology service going, we added OT and a paediatric physio outreach program. Shortly after I took that on to try and help that local community, I started increasing our efforts to highlight the Chinchilla and Toowoomba allied health workforce issues and offer potential solutions for those issues. I engaged in multiple forums, in pricing committees, another parliamentary committee and contributed to multiple submissions.

As a sidenote, I have to admit that after years of unpaid labour for the NDIA you get pretty tired and jaded, but I keep going for the sake of our clients in the hope that some day—maybe today—someone with some sort of leverage has the seed of an idea planted that can lead to influence or action in the parts of the system that I cannot directly affect. I can see the ramifications of it, but I cannot change the system.

In 2019 we trialled using a locally trained allied health assistant paired with a remote speech pathologist via telehealth to deliver interventions for clients who normally would not be considered suitable for either allied health assistance or telehealth services. Clinically, combining those two worked well and provided a service for these clients who otherwise would not be able to access either of those options, but it was not financially viable. The NDIS billing rules and rates did not fit or work for that sort of integrated service delivery model. The allied health assistant hourly rate was too low to break even. We were also told that we could not bill for both an AHA and a speech pathologist simultaneously for the one consultation, even though we explained that both services were being delivered and that we could not deliver the speech pathology without the AHA support and that the AHA services needed the support of the speech pathologist in order to be effective as well.

On the back of that initiative—which we found highly valuable clinically and we could see great translation across to a variety of challenges for accessing services in rural and remote areas—I proposed a pilot program to the NDIA to try and keep our Chinchilla services running plus deliver local jobs, provide better quality and more affordable services than traditional outreach programs. I provided a proposal where costs were minimal, the adjustments needed were going to be minor tweaks, and we were already on the ground with the infrastructure, local knowledge and contacts to make it work. I warned them multiple times that our allied health services for Chinchilla were at risk of imminent collapse and how urgent the situation was. This is back in 2019.

In February 2020, after a year of trying to get someone to listen, I finally secured a meeting with the director of Queensland provider and market relations. I outlined the issues to her. I provided our ideas to solve them. She seemed genuinely interested and asked for a written summary to investigate 'innovation funding', or something like that. I sent through a written draft proposal soon after that meeting. She stated that she would make sure we had monthly meetings to follow up and keep things moving. Our next meeting was cancelled by her office. I was told that it would not be rescheduled. There would be no further meetings. No response or reasons for the termination of communication channels was provided and no alternatives were given.

After a three-year battle we made the heartbreaking decision to close our local Chinchilla service due to ongoing recruitment and retention issues. More than 100 people in that community now have no speech pathologist, OT and paediatric physio services. It is completely unnecessary. Shortly after we made the closure announcement I had three phone calls and two emails from an LAC and their manager. Suddenly, after actively ignoring our repeated pleas and warnings of service withdrawal for over three years, they wanted to talk to me about those clients' needs. They demanded urgent meetings where they asked me to tell them what our solution was to help participants transition and minimise risk to the local community, which is obviously not our role. As a private service we are not responsible for solving service access and systemic issues across the country. Then, to top it all off, one of them actually asked me to provide them with a list of affected participants, so once again the NDIA and their partners were asking and expecting us to do their job and fulfil their duty of care and to do that on our own dime and without recognition or thanks.

I am at a point where I am really worried about our Toowoomba services too. We already have extensive waitlists, particularly for speech and OT. We are only two hours from Brisbane, so it is a very attractive city and a great place to live, but just in the last few weeks we have lost four of our speech pathologists and one of our OTs, all of whom left because they had to relocate back to metro areas for family support reasons or because they have been headhunted to Brisbane or the Gold Coast due to the national workforce shortage I highlighted earlier.

If we keep doing what we are doing, our regional, rural and remote workforce will keep deteriorating in both quality and quantity when there are already critical issues. The further you are from metro areas, the more those allied health workforce issues—it is like a magnifying glass on the problems.

CHAIR: Rachel, I must just pull you up there. We are pretty much on time, and a good chair will keep things running on time. Can I just commend you and thank you for the outstanding work you have done in trying to collaborate with other services to deliver those vitally important services in primary and allied health care, which is No. 1 on our terms of reference. That is exactly what we want to hear in terms of the provision of care and the impacts you have just articulated very passionately—clearly you care about the people that you treat—and the outcomes when that does not work. I commend you. We are looking forward to your written submission and your recommendations. The provision of primary care sits under the Commonwealth remit. We want to hear these stories. We commend you on your work. We are almost out of time, but I am going to go for one really quick question from either side.

Mr MOLHOEK: I have about eight questions written down, but thank you. I would just echo Aaron's sentiments and thank you so much for joining us today and for the ongoing work that you do. Just to declare an interest, I have a son and daughter-in-law who work in rural and remote Queensland as an SMO and paediatric nurse, so they know some of the challenges and I get some of those stories firsthand.

It seems that there is almost a merry-go-round of referrals that goes on. You mentioned speech therapists, occupational therapists and paediatric specialists. Is all of that work referred out, or are there people also available within Queensland Health services that work in our hospitals and health services that could be providing some of those services as well?

Ms Tosh: I can certainly respond to that. In the local communities that I work within there are Queensland Health services. There are education department services as well for speech pathology and occupational therapy, but they are extremely limited and they obviously cut off as soon as they are eligible for NDIS. There are also aged-care service access issues. For example, we were the only speech pathology service provider for an aged-care facility in that Chinchilla community. They now are faced with the prospect of getting services from the Gold Coast or Brisbane, which is four hours away, provided they can get through when the weather is good.

Ms KING: Rachel, I think you have almost left us speechless with the scenario you have outlined. You have painted a picture of a service in crisis that has then gone on to collapse. You have expressed that 100 people in that community are now no longer going to have those services. What are the implications for the people who will not have those services in their lives? What will happen for them when they cannot get OT, speech pathology and paediatric physio? What are the outcomes for them?

Ms Tosh: I will give you a specific example of one of our clients who has had access to those services. When she started with us, she was non-orally fed and she required one-to-one support at all times from a support worker due to her care needs. Now, after three years of intensive intervention across those disciplines, she is able to independently self-feed and she is able to attend school without support. This has had a profound impact on her life. She would still be requiring one-to-one support work right now, she would not be able to eat, she would still be PEG fed and she would still have a tracheostomy tube in without those services.

That is a tangible example of the difference this makes. If you do not have that, you are looking at increased pressure on support, public hospitals and aged care—because aged care have to take in people with disabilities because they cannot live independently and they cannot live in the community without those supports because they do not have the capacity building. We see capacity building getting cut in plans, which then is the whole basis that the NDIS is funded on. It is killing the golden goose basically by doing that.

CHAIR: I might make an observation. Some of the information we got back from the Queensland Department of Health is exactly what you just said—that people who do not have their needs met end up in public hospitals. We have just over 600 people, of which half of them are NDIS people who could get services in the home, that is costing $2,000 a bed per day or $1 million a day to put them in a public hospital. It is very clear that, if the system is corrected and care can be provided in place, there would be a significant saving to the public health system in Queensland.

I thank all of you. I am sorry we could not hear from all of you in the limited time. We look forward to your submission and to your recommendations. Keep doing the outstanding work that you are all doing. Thank you for your time today.

MOHLE, Ms Beth, Secretary, Queensland Nurses and Midwives' Union

PRENTICE, Mr Dan, Professional Research Officer, Queensland Nurses and Midwives' Union

TWIGG, Ms Deborah, Senior Research and Policy Officer, Queensland Nurses and Midwives' Union

CHAIR: Thank you for attending today for what is a significant inquiry by the Queensland parliament about the impacts on the public health system. There is no-one better to inform us than the body that represents nurses in this state. Beth, would you like to make an opening statement before we go to questions?

Ms Mohle: The Queensland Nurses and Midwives' Union thanks the committee for providing us the opportunity to comment on this important inquiry. We are here today to represent the interests of our membership—over 66,000 nurses and midwives who provide health services across the state. They work in a variety of settings—from single-person operations to large health and non-health institutions, as well as in the private and public healthcare system and in aged care and the NDIS sectors. Our membership includes almost 40,000 members in the public sector, over 9,000 members in the private sector and over 9,300 members in aged care.

We will be providing a detailed submission that addresses the terms of reference and includes a focus on: workforce planning and the need for health professions to work to their full scope of practice in order to meet the growing needs of an ageing population; fragmentation of the healthcare provision resulting in services provided in the acute sector, primary health care, and aged and disability services not being joined; the need for appropriately skilled staff to provide health services in the aged and disability services sector and adequate community housing for people with a disability to meet the needs of the hundreds of people who are currently being inappropriately cared for in acute public health hospitals; palliative care and ensuring these services can be accessed by all, regardless of where they may live in the state; the increasing need for mental health care not only in our hospitals but also in the community; the lack of bulk-billing services in primary health; ambulance ramping due to our hospitals being at capacity; demands on emergency departments with an ever-increasing volume of presentations to emergency departments; funding models that are innovative and ensure a financially sustainable healthcare system; and nurse-led and midwifery-led models of care in the context of multidisciplinary healthcare teams.

Nurses and midwives know the health system. They work in it 24/7 and our members are telling us that workloads are unsustainable. Our emergency departments are overrun, with ramping commonplace and hospitals running out of beds. They have the solutions to the many problems that exist. Unfortunately, their voices are far too often not heard. We saw last year in the initial COVID response what was possible when the potential was unleashed and nurses, midwives and other health workers were able to work to full scope. We need this to continue. We need empowerment of the health workforce to get on and do the job they are capable of doing.

Recently, four Queensland unions—the QNMU, Together, the United Workers Union and the Electrical Trades Union—joined forces to launch the Health Needs Urgent Care campaign. This is in response to QNMU members and other health staff experiencing firsthand the impacts of growing and unprecedented demand on our health services and beds. This demand is occurring in every state and territory—so much so that health ministers from all jurisdictions wrote to the federal health minister, Greg Hunt, calling for additional funding to deal with the system that is under stress.

The QNMU was particularly concerned about our exhausted healthcare workers across both public and private systems. Even before the COVID-19 pandemic there were demands on health services and beds that were impacting QNMU members and other staff. The anticipated surge in Queensland of COVID-19 cases will have enormous impacts on an already understaffed and underresourced workforce and the ability to provide safe, quality care.

We acknowledge the complexity that this inquiry faces and that there is no one answer to fixing the problem. However, we urge the Queensland and federal governments to: invest in the health system by committing to working with us on joint immediate solutions, such as nurse and midwife-led models of care that are part of a multidisciplinary health care team in community settings; identify long-term solutions for a sustainable health system, given that the economy includes workforce planning, recruitment and retaining of not only nurses and midwives but all health practitioners; and commit to smarter funding that is in the best interests of patient care and staff safety, such as the establishment of an innovation fund to trial and evaluate new models of funding that will complement

the current activity based funding. In particular, we urge a fifty-fifty funding split for public hospitals between the federal and state governments and the removal of the current cap on healthcare funding growth until such time that a new and more responsive funding model can be put in place. Lastly, we urge the governments to commit to keeping our health system in public hands and not privatising services or beds. Thank you very much. We are happy to answer any questions the committee may have.

CHAIR: Thank you. I think it is worthwhile starting by commending the nursing cohort who have navigated COVID in the last couple of years and helped keep Queenslanders safe by doing either the fever clinics or the vaccinations which are so important. We are very mindful of that. If you can pass that on to your members, that would be fantastic.

I want to give a couple of numbers about walk-ins, and you touched on this. Over 10 years the Darling Downs HHS has gone from 30,000 to 130,000 walk-ins; Metro North, from 41,000 to 105,000; and Metro South, from 130,000 to 194,000. Across Queensland we have gone from one million to almost 2.4 million walk-ins. You are right that the current model is not sustainable. The committee is keen to explore why we are getting such an impact on the public health system. Is it because people cannot access a GP and they need to wait days for that to occur?

I also want to touch on the 9,000 members you have in aged care. You would be familiar with the work of previous inquiries. You made submissions to previous inquiries which made recommendations to increase the nurse-patient ratio in the 16 state-run facilities and recommendations for the 464 remaining private facilities that we still cannot get a view on, although they were supposed to advertise their nurse-patient ratios. We have seen improvements and there has been some good data about that—more eyes on patients, fewer falls, fewer hospitalisations, reduced length of stay and things like that. With those things in mind, we will go to questions.

Mr MOLHOEK: I add to Aaron's comments and express my thanks and gratitude to the work of your members. We all know how much we rely on them and we know how much pressure there is in the system. That just goes without saying. Beth, you are an experienced health professional and you have been at the coalface for quite some time.

Ms Mohle: Decades.

Mr MOLHOEK: I was trying to be kind. To provide a bit of context around the current challenges that the health system is facing, do you think the Queensland health system is under greater strain now than it was, say, 10 years ago?

Ms Mohle: Certainly, it is, and I think COVID has revealed the cracks in the system. You cannot have a system that is running at more than 100 per cent capacity all the time and then have something like a pandemic come along and not be under pressure. What I am really frustrated about is the fact that we do not look at the causes of that pressure; we look at the symptoms. The symptoms are ambulance ramping and things like that. They are the symptoms of the bigger problem.

The problem is the drivers of this demand, and one of the biggest drivers is the fact that our funding model is not fit for purpose. It totally needs a fundamental revamp. You cannot have a focus on activity based funding alone—be that in the number of presentations at EDs or elective surgery or even in primary health care its fee-for-service arrangements for doctors. You cannot have that because it is a constant driver. Activity just begets more activity. We are not focusing on quality outcomes for people and doing things differently, so we need to quarantine funding for new models of care that will relieve pressure on our system. That is one thing.

There are other issues as well in terms of the fact that we do not genuinely have people's voices heard within the system. I do not like the term 'consumer'. I have never liked the term 'health consumer' because in my view it is not a market transaction. Access to health care is a human right. The people who use our healthcare system unfortunately do not have a big enough voice and neither do the workers in the system. The workers have the solutions to the problems in the system and the pressure that is on there, but we need to fundamentally take a step back and look at the funding drivers and the policy drivers.

We also need to look at the fact that, for example, we have not had any federal health workforce planning done for nursing and midwifery since 2014. The last time Health Workforce Australia did a review was in 2014, and that was just before the federal coalition government disbanded them. We have not even got the planning done in terms of what our health workforce needs are. I think the last Health Workforce Australia planning demonstrated that we needed 85,000 nurses by 2025 and 123,000 nurses by 2030, and that was before the pandemic came along. We need to take a step back and not just put bandaids on the pressure that is on the system. We need to fundamentally look

at the funding drivers, it is not fit for purpose, and the policy framework and the lack of planning that has occurred, particularly at the national level but also at the state and local level. We need to join that all up.

The most frustrating thing is that we have not got a joined up health, aged-care, disability and primary healthcare system. Unfortunately, everything will end up in the lap of the public health system when things go wrong, when things turn to crisis—as is the case in aged care. We have just heard, for example, that in Rockhampton the Gracemere nursing home are short 14 staff. They cannot recruit in rural areas. Similarly, on the Darling Downs and out in Western Queensland, the Churches of Christ nursing home have had to close in recent months because they cannot recruit due to the failures in the aged-care system. Unless we join what the federal government is responsible for—which is the funding of aged care, disability and primary health care—with what the state is responsible for, we are going to continue to get more of the same. In our view we need to have a fundamental look at the drivers, otherwise we will just keep putting bandaids on a haemorrhage.

CHAIR: I want to revisit the model of care that you spoke about. We did a body of work and made 77 recommendations in the aged-care and palliative care report. A lot of that was focused on the Commonwealth government. We have not seen a response to date, which is highlighted by what you have just said. It needs proper attention if we are going to do this. Let us say that the model of care was correct in a residential aged-care facility, and let us pick a privately-run facility that has a nurse practitioner and where GPs can visit and deliver care. That would reduce the impacts of unnecessary ambulance transport, and we do have data on that, for things like a catheter change. The Ambulance Service talked about a million calls to service last year, which is reflective of the numbers. Can you articulate what the model of care that you just talked about might look like in a residential care facility?

Ms Mohle: We absolutely and fundamentally need to rethink the way that we deliver healthcare services. They need to be in the community and as close as possible to people's homes, whether that home is a nursing home, a disability service or a community based centre. For example, the Australian Capital Territory has six nurse-led clinics that remove pressure on the emergency departments because they are nurse-led clinics that provide low-acuity care.

You are quite right that in aged care it is about having nurse practitioner-led models where we can. We have some great examples of that in Queensland. We have the GEDI project, which is operating in some Queensland Health facilities where we do have outreach to aged-care facilities. We have nurse practitioner-led models in those areas. We have a nurse practitioner branch. They are absolutely chaffing at the bit to do this. They have made submissions in relation to how they can be part of the solution here. We need to grow more nurse practitioners but also roles like nurse navigators so that we can navigate the course of people through the system and back into primary health care or aged care or disability care wherever they are.

We need to join up the system. Nurses and midwives have a critical role to play in doing that. But we need to invest in creating more nurses and midwives and the models to be able to deliver that for the community. It will be much more sustainable for the community. It is so expensive to run those services out of acute-care hospitals, as we know. We need to fundamentally tip it on its head. If we want genuinely person centred care, it starts with providing those services in the community, close to their home.

CHAIR: Thank you, and thank you for putting me back on track, too.

Ms KING: Thank you for what you and your members do each and every day right across Queensland. I want to focus briefly on the wellbeing of your members. You have talked about workforce planning and we know a lot of that is retention of members. We know that we are losing nurses in what is a high-stress working environment. Can you outline what your members are telling you about the experience of providing nursing care in private aged care at this time? If you want to reflect on our public aged-care facilities as well, absolutely feel free. What stories are you hearing from members about that?

Ms Mohle: That is a sector that is in total crisis. We believe that at the time that the royal commission was called by the Prime Minister the situation was serious enough to require a royal commission. It was a disgrace what was happening in our aged-care sector. Unfortunately, we were concerned that it would just kick the can down the road and we would not have any action. Unfortunately, we have seen in regards to improving staffing numbers in aged care that that can has been kicked down the road until next year. There will be no improvement in staffing numbers until next year. There is not even going to be a commitment to one RN 24\7 until next year; it will be one RN for 16 hours a day. I do not know what is going to happen for the other eight hours a day.

The pressure on our members has been enormous and you are seeing the effects of that with what is happening in rural aged-care facilities, in particular, across the state right now. As I mentioned before, we have the situation with the Gracemere nursing home in Rockhampton. It is going to be a similar situation to what happened at Earle Haven on the Gold Coast a few years ago where the state government had to go in and take over the running of that facility because it just imploded. That is our fear. You have an overworked, stressed and undervalued workforce that is paid—taking an RN as an example—hundreds of dollars a week less than what their counterpart in the public sector or private hospitals are paid. We are not attracting people to work in the sector because the workloads are unsustainable and because their souls are being destroyed effectively with having to provide care in a system that is in crisis. That is having a significant impact on our members in terms of their morale.

It is desperate times, I have to say, for aged care. That is going to have a flow-on impact for our acute-care system because when there is a lack of nursing in aged care—and that is what has happened over recent decades since we changed the Aged Care Act in 1999-2000. They even took the word 'nursing' out of nursing homes. They are now residential aged-care facilities. We have removed the nursing from those facilities and that is at the heart of the problem. Again, getting back to the root cause of the problem: it is the fact that it is a denial of human rights, in my view, that health care is not being adequately provided in residential aged-care facilities or, as we prefer to call them, nursing homes across the country. That is having a devastating impact on our members. More importantly, it is having a devastating impact on those residents and their families.

The federal government has to take urgent action. It is not good enough that that waits until next year. There has been some additional funding provided in the federal budget this year, but that funding has not been tied to the provision of care. There is not adequate accountability for that funding. Until we actually join the systems up, we have better transparency and accountability and we make the sector a sector where people are attracted to work, it is going to continue to spiral and create bigger problems for the system as a whole, including the public hospital system.

Mr MOLHOEK: Beth, you have been on the record as being a little bit critical about the terms of reference for this inquiry. When your members heard that the minister had launched the inquiry into everything but Queensland Health, what sort of commentary and feedback did you get about that?

Ms Mohle: To correct the record, I said that the terms of reference never stop us from saying what we think needs to be put on the record so we do not limit ourselves to the terms of reference. We will certainly address the terms of reference, but as a union we have a long and proud tradition of making many submissions to many inquiries.

To answer your question, our members were really pleased to hear that there was going to be attention paid to that. We have met with the health minister and delegates from our unions and other unions recently so that the minister could hear firsthand of the pressure that is on the system. Our members got a very good hearing from the minister at that meeting. They know firsthand what the problems are and the stresses that are on the system, but they also know that it is a complex picture. I have been around the traps for a very long time so I know that this is not going to be a quick fix with just one solution. It starts with taking a big-picture look at the funding model and the policy drivers and the need to do things differently.

Last year, for example, the stress of COVID was quite worrying for our members, being confronted with a pandemic, but at that time last year they were freed up. Potential was unleashed in our system for nurses and midwives and other health workers to get on and do the job, and that enabled them to work to their full scope of practice. That is what they want to do. They want to be unleashed, really, to be able to do that and make the system more sustainable. They are well aware of what the concerns are. For example, a couple of weeks ago I was up in Rockhampton addressing our members and delegates up there. These were nurses who work in our public sector. They were saying that there is only one bulk-billing GP clinic in Rockhampton and there is a three-day wait for people to access care so, of course, they are turning up to the emergency department.

Our members can see the full picture. They know that it is complicated. They want to be heard—at the state level but also at the federal level—that there is a need for urgent action. I firmly believe—I am a bit of a Pollyanna in terms of always seeing opportunities—COVID provides us with an opportunity to reset and to point us in another direction, because the services that our members and other health workers provide not only keep our community safe in a health emergency, the work underpins a robust economy and a cohesive society. It is about prioritising the work of health workers. I think we have an opportunity now to pivot so that we are all paying attention to the fact that we cannot continue business as usual; things have to fundamentally change.

Mr MOLHOEK: I think we all acknowledge that there are many issues outside of Queensland Health's jurisdiction that are having an effect on the running of the public health system. You would have to concede that there are also significant issues within Queensland Health. Earlier this year the Queensland Audit Office reported on the lack of workforce planning, the lack of strategic planning being undertaken by Queensland Health and the fact that there is no long-term capital works program for the expansion of hospitals.

CHAIR: I am going to pull you up there, Deputy Chair.

Mr MOLHOEK: Well—

CHAIR: Let me finish and make my point.

Mr MOLHOEK: I will get to my question. What are the burning issues that your members have with the way that Queensland Health is being run currently and some of those challenges, particularly around labour force planning?

CHAIR: With respect, Deputy Chair, the terms of reference are very clear around the provision of primary, allied and private health care, aged care and NDIS care and how those impact on the public health system that we have in Queensland. I will allow a little latitude, but I want to keep within the lanes of the inquiry that we have. I will allow the response.

Mr MOLHOEK: To clarify, the core issue I am really looking at—and you have touched on it both in allied care and within Queensland Health—is that we have significant issues around labour force planning or workforce planning and shortages. How do we address some of those challenges?

Ms Mohle: Health Workforce Australia being disbanded in 2014 was an absolute disaster, I have to say.

Mr MOLHOEK: Who disbanded that?

Ms Mohle: It was the federal coalition government, unfortunately. Health Workforce Australia—no agency is perfect, but certainly in terms of the modelling it is critical. Unless you have that federal oversight, you cannot do effective local planning. Of course we can always do better at the planning level but our system is joined up at the federal and state levels so both levels of government have to take responsibility for that. Our members are keen to have a focus on health workforce planning. Since 2014, it has been a fair few years since we have had that vacuum that needs to be filled. It is demonstrated in areas such as midwifery, mental health, alcohol and drug services where there are shortages of nurses and midwives that need to be filled. Particularly in the context of a pandemic, the need for mental health services is something that I am really concerned about.

Yes, our members are certainly concerned about the fact that we need to do planning better. We need to also keep in mind that right now we need more hospital beds. That is a given. That is the case. But we cannot be so narrow in our thinking. It is not only about more beds. We have to change our thinking. We have to have fundamentally different types of services—community based, non-acute services—that are things like nursing and midwifery-led services that involve allied health workers and others providing services out in the community. Hospital beds are very expensive things to provide. If we can keep people well and keep them out of hospital, then that is what we should be doing. That is what we should be focusing on.

Our current funding model, which is driven by the federal government, does not allow for that or sufficiently allow for that. It privileges activity over innovation and over doing things differently. We have to break that deadlock in terms of our thinking. We do know that acute-care beds are needed, but it is not only that. That is a frustration that I have. It is not only about beds being the solution, it is fundamentally doing things differently and unleashing the potential that exists within our health system—not only for nurses and midwives to work to their full scope but allied health workers too. There is more than enough work for everybody to do, but unfortunately our policy and our funding levers are leading us down the same path and we have to change direction right now.

Mr MOLHOEK: I think all systems of government have become more and more risk adverse in recent years. Do you think this sort of focus on specialisation has disempowered or stripped from the system the ability of very qualified nurses to provide a broader range of services? For example, in some rural and remote areas there are no dialysis services anymore because it requires a specialist whereas for decades those services were simply provided by a specialist nurse or a rural health nurse. Now people have to get on a bus and travel to Rockhampton or Townsville for what should be fairly straightforward procedures.

Ms Mohle: From our perspective, a discussion about power imbalances within the health system is something that is long overdue. It would not come as any surprise that we would be saying this. Our members and, as I said, other workers such as allied health workers are not able to work to their full scope to do things that they are educationally prepared to do.

Yes, culture and power imbalances need to be addressed as part of this story. I have to say that that is hard long-term work. Cultural change takes a long time, but we have to incorporate that as part of any review. Our members need to be empowered. As I said in our opening address, last year during the pandemic they were empowered and able to get on and do the job. That is what needs to happen. As I said before, we need to unleash the potential and discuss power. Unfortunately, the people who have the least power in the system right now are the people who use the system. We need to partner with consumers to deliver the best sort of services that we can that meet the community's needs.

Ms KING: I am reflecting on a comment you made about your visit to Rockhampton and the one bulk-billing GP clinic with a three-day wait. I reflect on my community where if there was a bulk-billing clinic with a three-day wait people would be dancing with joy in the streets because it is more like a three-week wait to get a GP appointment. I note also your earlier comments about the way that the lack of a joined up system means that everybody washes into our public hospitals. I wonder if, from your members' perspectives, you could reflect on that. Are they telling you that a lack of GPs and allied health is resulting in presentations to hospital?

Ms Mohle: Absolutely. I have to say our great success in Queensland in the COVID response has reinforced that in our community's mind to a certain extent, as well as the fact that our public hospitals are a very safe place to go. They are great institutions. But the pressure on them is just enormous, particularly in primary health care. If you have a look at the fever clinics, for a long time primary health care were not even able to do testing if people had respiratory symptoms, for example. They were literally saying, 'Go to your public hospital to do this.' It is the place of last resort. Our members working in emergency departments in particular are feeling that pressure every day, which is why we need, as I said, fundamentally a pivot to new models of care and that includes a close examination of who is doing what in primary health care, what services are needed, and the funding models in that area because is the fee-for-service model currently fit for purpose? I believe it is not and we need to look at fundamentally changing that and having more application based funding models so that we have other drivers.

Right now we are not always measuring the right things, the things that matter in terms of outcomes for the community. Our members know firsthand the impact of having people who cannot get into their GP, because they will turn up in the emergency department, not having adequate nursing in aged-care, because they end up in our emergency department, not having appropriate community based housing for people with NDIS, because they end up in our emergency department and then in acute-care beds for a very long time. It is an incredibly expensive way to provide services to those people. It is much more cost effective to provide them in place, in situ in the community, to relieve pressure on our members in the public system. It opens up new opportunities and new ways of doing things in the community as well.

Ms KING: Often better outcomes.

Ms Mohle: Better outcomes for communities. That is what we are all about and that is what we should be focusing on: measuring better outcomes for the community.

CHAIR: Around that, the department advised there are almost 600 beds being used up by long-stay patients who either cannot get NDIS suitable accommodation or residential aged-care and it is costing a million dollars a day so it makes sense to invest in the right areas.

Ms Mohle: We actually have examples from members at hospitals that it is not good for those people who are waiting inappropriately in an acute-care facility—a very expensive acute-care facility. It is not a good outcome for them, but it is also not good for the people who are caring for them because they need a different model of care, they need different types of support and that is not always the support that is available in an acute-care facility.

CHAIR: We are over time and we have Health Consumers Queensland sitting patiently behind you. We will give them extra time. Thank you to the QNMU—and all of your members—for your contribution today. We look forward to your submission and recommendations. Thank you.

Mr MOLHOEK: Hopefully we can get you back at the end of the hearings to dig a bit deeper on some of the issues because half an hour really does not do the entire nurses' union.

Ms Mohle: We will put in a detailed submission. Deb is working on it already.

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

CHAIR: Thank you for your patience. Welcome again. We certainly enjoy the feedback that we get from Health Consumers Queensland on all of our inquiries. Over to you for an opening statement and then we will move to questions.

Ms Fox: Thank you, Mr Harper. I would like to start by acknowledging the traditional owners of the land on which we are gathered, the Jagera and the Turrbal people, and pay my respects to elders past, present and emerging and acknowledge that sovereignty was never ceded.

We welcome the opportunity to speak to you today, having consulted with, many consumers over the last few years, in particular many grassroots consumers through our kitchen table discussions—over 200 of those—throughout communities across Queensland, diving into the issues that your inquiry is looking at today. That has included many rural, remote and regional consumers. That is the focus that I would like us to hold in mind in particular today as I speak: the inequities that exist between First Nations consumers and other Queenslanders and those living in rural and remote areas—the unacceptable variations in health care for those people.

We know that when there are failures and gaps in private, allied health, aged-care and NDIS services the buck stops with our public healthcare system. This safety net that we have is evidence that here in Queensland we value health care perhaps more, or as much as, those who value it the most around the world. In many ways we have an incredible system which many are resistant to any kind of erosion from, but can we say, hand on heart, that are we putting public dollars and consumers' out-of-pocket costs where they should be spent, do consumers get true value and do we get the best health outcomes possible—the outcomes that truly matter to us? Does anybody ask us what those are? Do we do all that we can do to prevent disease and, most importantly, to prevent that postcode lottery and to ensure that there is equity of health outcomes for all Queenslanders?

Consumers need to receive evidence based care as close to home as possible by the most appropriate health professional. The barriers to this happening at the moment across these sectors that we are looking at include costs—out-of-pocket costs—the lack of bulk-billing, transport costs and, of course, the two-tier system of access to care between public and private, and the value of private health insurance lessening as demonstrated by consumers leaving that sector every year. Workforce shortages and an inappropriate spread of workforce means that we do see waits such as three-week waits for GPs across too many areas of Queensland and then the flow-on effect of a lack of early intervention, prevention and care that is needed in a timely way. Also we see a lack of cultural representation in our workforce: Aboriginal and Torres Strait Islander people in roles right across the system, people from culturally and linguistically diverse backgrounds and people in local, rural and remote communities. A lack of coordination in our fragmented system through a lack of sharing information and all too often a lack of smooth handover between different care providers also contributes to poor outcomes which often end up in our public system.

There are many enablers that could turn this around. Place based co-design models focused on early intervention and prevention would go a long way to reducing the number of ED presentations that may be otherwise cared for earlier in another setting and therefore mean that our tertiary services are there for people who need them earlier than they are now. We know that the ED presentations are appropriate, they are not people going there with the need for a bandaid, so we have really got to get ahead of why that is the case.

A one-stop shop with GP screening, pharmacy and low-intervention ED presentations would also assist. We need a better use of full scope of practice of all health professionals. There are many initiatives that have been happening across Queensland for the last several years that support this. We need a greater scale-up of that and we need to ensure that they are rolled out right across our state. Better funding for independent individual advocacy and systems navigation roles is vital. We receive calls from consumers requiring individual system navigation, whether that is through aged-care, disability or mental health services and there is a huge need for organisations. There are some who do receive some funding but there are some gaps where it does not exist at all. That would go a long way to building individual health literacy and improving health outcomes.

There needs to be a focus on the workforce to look at those gaps that are truly affecting consumers at the moment. We know the huge waits to access mental health services for both children and adults. Our concern is that that may increase depending on the level of local outbreaks we may see with COVID with our border opening. There are gaps that exist for access to specialist services across the state and the unacceptable long waits for some communities to access necessary services. A transparency of data would be a great support—looking at where there are long waits and why and really working with community to come up with some innovative models to solve them.

The biggest frustrating barrier for consumers, but also we see in the system when solutions are being sought, are those funding barriers and the disincentives and the lack of cooperation between jurisdictions. Consumers need the care that they need. We need to take the politics out and put the people back in. Where we have seen that work is when consumers are at the table to bring their solutions, with everyone working together with a shared vision to deliver care that is cost effective but also has the best health outcomes. We are at the stage in the evolution of our health system where this is no longer a should, but a must. Thank you.

CHAIR: Thank you. You mentioned a lack of bulk-billing. I wonder, with those 200-odd consultations you have had, whether you have heard stories similar to mine. I had a constituent just two days ago come to me. Her dad is very unwell and he wants to stay at home and receive care there, but the GP will not do a home visit so in times of pain relief it is another ambulance call and a trip back to ED. Are you hearing those same kinds of stories? Is that more relevant now coming from regional Queensland—and we had some data from the department about GP distribution; I think it is one GP per just over 1,400 in regional Queensland to 700 in a more heavily populated area of the south-east, but that is still significant? Are you hearing those kinds of stories and can you give any of those types of examples?

Ms Fox: Certainly we hear of inequities right across access to services, whether that is having access to allied health within communities or GPs. In terms of spread, sometimes consumers have heard that there is an adequate number of GPs in their communities according to the modelling, but they still experience these waits and these delays in having appointments to even get referrals for scans, let alone then the extended wait times their local area has for scans. What is necessary is a good hard look at that spread of workforce and health outcomes. Are there poorer health outcomes in some areas that might need a higher rate of certain health professionals—it might be GPs or it might be other health professionals—and a targeted, coordinated approach that is going to meet people's needs. Having those conversations with the communities, sometimes hard conversations about sometimes it will not be a doctor who is the most appropriate to see, that evidence supports another healthcare professional, but educating and working with that community and making commitments to get them care out of their community in a timely way if they need it.

CHAIR: I co-chair a regional forum and we have just recently been in Mount Isa, Cloncurry and Charters Towers. We keep hearing that the further west the more difficult it is to attract and retain healthcare specialists, be they a GP or anyone else on the healthcare spectrum. We heard earlier about a speech pathologist in Chinchilla. That certainly has to be an issue, would you think, of importance in this provision of care?

Ms Fox: Absolutely. We hear those challenges. We work with different professional organisations and health services and we know the very real challenges of attracting and retaining staff. There are issues of lifestyle and there are issues of coverage. If they know that they are going to be in a community and not be supported to have time off and to rest and restore it is a very unattractive prospect. It is really about that wraparound support and that good culture to keep them in the community and feeling a part of the community.

Mr MOLHOEK: Melissa, in your opening statement you made a comment to the effect that we needed to put people ahead of politics. I think you said that we need to get the politics out and the people back in, or something to that effect. Do you find it a bit peculiar that the focus of this inquiry is about everything but systemic failures and challenges within Queensland Health?

Ms Fox: We welcome any opportunity to shine a light on these issues and I was reflecting on the timing of this with our border opening on Monday and the challenges—and these are not new challenges—that we are talking about in terms of the barriers to integrated, coordinated health care in any setting. They have existed for some time, but there is the danger that they may worsen, particularly if we see outbreaks in regional and remote communities where the vaccination rates are lower. So any opportunity to come together and share insights, discuss barriers and commit to solutions from all sides of politics is really welcome from our perspective, but it needs all players at the table with consumers present to bring focus back to people.

Mr MOLHOEK: Earlier the chair touched on the ratio of doctors to people in metropolitan areas versus regional areas. I would be interested in your comments or thoughts around how we actually attract more people into rural and remote Queensland. There was an announcement this morning in the media about some incentives for university graduates, but I gather from some of your comments that there are broader issues there. How do we get more people working outside of the cities and get those services in the bush?

Ms Fox: There are many solutions that have been raised, tested, piloted and are somewhat embedded across the system and we would say that when asking questions about what consumers need it is about opening a dialogue with health professionals and with consumers to seek what they are, but we understand they are about funding models that mean that often as small businesses—these health professionals—they need funding models that are going to make their businesses sustainable and ensure that they can employ nurse practitioners and other health professionals to support their work. At the moment there are not those funding levers that make it easy and that is something that does require special attention, particularly with moving forward with COVID care in the community.

Mr MOLHOEK: Does there need to be a greater recognition or appreciation, I suppose, of the role of nurse practitioners, because most of the nurse practitioners I talk to feel unappreciated, undervalued and are frustrated that in many cases they are actually carrying out the work of doctors and specialists and we do not have a lot of them? I think there are only about 2,000 nurse practitioners in Australia, or that was the figure that I have had quoted to me. Is there scope to expand that area of allied health or health practice?

Ms Fox: Just as I would hope that Beth would not speak for consumers I would not like to speak for nurse practitioners, but it really is about looking at all of those roles and the contribution that they can make to a patient's journey and again mapping where they can be of help across the state and getting that good spread and that good mix of access to workforce.

Ms KING: Thank you so much for coming in today, Melissa. We appreciate very much all that you do to engage with often the most marginalised health system users in Queensland. Earlier today we heard from Cath Maloney, the CEO of SARRAH, which is Services for Australian Rural and Remote Allied Health, as I am sure you are aware, and one statistic that Cath quoted struck me greatly. She noted that approximately 80 per cent of Commonwealth health funding goes to doctors and 20 per cent goes to other health professionals whereas the system has only approximately 15 per cent of the health workforce in Australia as GPs yet it is overwhelmingly designed for and around GPs in terms of the Commonwealth system. I wondered how those factors might impact on the health journeys of the consumers that you work with, particularly those maybe marginalised, maybe isolated people that you engage with in your role.

Ms Fox: Thank you for that question. The system's reliance on GPs as the navigator for consumer care, whilst having benefits, also creates many challenges. There is the assumption that every consumer has a known GP to support them. We know that that is not true, whether by choice or by circumstance. Equally, that does create a system where they may be the gatekeepers and it depends on whether they work with consumers to let them know about access to other health professionals and enable that through the plans that mean that those consumers get Medicare rebates and know about the different models of care. We do not really have transparency of that and checks and balances to ensure that it is happening, and that comes back to my point in my opening statement around what matters to consumers.

If we start with someone having a sore knee and what is most important to them is gardening, then we can work back and think what the treatments and interventions are that could be started that may be low intervention to begin with and cost-effective and then move along a pathway where surgery may not be the first consideration and may not actually meet their needs even if it is undertaken. That is where healthcare pathways can be good to support consumers, but again it is my understanding that they are implemented by GPs and so it is really about coming back to those multidisciplinary place based models of care where people are looked after in a team and have access to a range of health professionals at the time that they need them.

Ms KING: I can comment that in my community, again in the same way that there are three-week waits to get into a GP, many people who may have retired to the area tell me that they cannot get on to the list for a local GP and they are still commuting very significant distances to access their former GP and the impacts for connected health care are quite grave as a result. Do you have any reflections on the experience of consumers perhaps in outer metropolitan areas in addition to rural, regional and remote?

Ms Fox: Yes. So we know that anecdotally there can be higher numbers of bulk-billing GPs in those areas, but again there can be long waits. There may be a proliferation of large medical centres where there is not a relationship with a known care provider and there is still the challenge for many consumers where they might be deciding between the up-front fee for a GP service—whether they have that in the first instance—but then can they afford to be out of pocket for that gap as well as the transport costs? We also know that the cost of allied health services is out of the reach of many people who would benefit from that.

CHAIR: I just want to move to a cohort of your consumers in that I would imagine that you would be talking to consumers of residential aged-care facilities and/or those with home care packages, and I will put it in context. The previous body of work we did talked to people who had become unwell applying for a level 1 or 4, depending on their illness, home care package. There was one I remarked upon in the last term with a lady in Hervey Bay. There was a large number of people in the audience who came and this particular lady held up an envelope and said that her husband's level 4 home care package had arrived two weeks prior to our public hearing there but that he had died 2½ years prior. You could have heard a pin drop.

The royal commission—and we shared a lot of our data with them—are now required to release quarterly home care package data and they are saying that as at 30 September 2021 21,566 Queenslanders were waiting for their approved level of home care package. For a level 1 the wait time is expected to be six months and for a level 2, 3 or 4—where you are particularly unwell but you do not want to go to hospital; you want your care in your home—it is up to nine months. Do you hear those types of stories from your consultations that you have made through Health Consumers Queensland that these are desperate times for people who just want to access care but it does not arrive in time? Can you perhaps give some practical examples of that?

Ms Fox: Yes, absolutely. First up I should acknowledge the work of our partner organisation COTA Queensland—

CHAIR: Of course.

Ms Fox:—which very much sits in this space and this is their core business. We speak to many carers who have perhaps parents or partners who are in these circumstances and hear their stories of anguish and delay. In particular, again back to rural and remote, we hear issues where local hospital beds are taken up by people for whom if there were local services provided that were more appropriate, as we heard from the QNMU this morning, they could remain in their communities and be taken care of close to their families but if they transfer to that care then they will need to move to other towns. It really is, as we heard, a system in crisis. We have had the inquiry, but it really does need consideration of how, with all the best intentions, to put the focus on consumers at the centre and the aged-care packages in terms of the same principles that have been applied to NDIS and people being in charge of their care such as people with a disability. We really need a good hard look to see again where profit and politics have prevented people from getting the care that they need. There is quite a bit of work that we have been involved with in terms of models that support people to stay at home in their residential aged-care facilities and not have to go to hospital for care, so we would encourage those being spread out across the community again to prevent unnecessary hospitalisations and the risks that come with them for older people.

Mr MOLHOEK: Do you think consumers across Queensland would benefit if there was more data released around availability of services and flows so that they could make more informed choices about where to go and what to do? What information do you think needs to be shared that perhaps is not being shared now to help consumers?

Ms Fox: Transparency of data is something that is so critical to ensuring a better system, and we did quite a bit of consultation around this for the development of the Inform My Care website which was a great start to sharing information in a quarterly manner from the public healthcare system so that people can look at health outcomes in their local communities and start to make those informed decisions. But what is on there at the moment is really just the start and what we would like to see is at a facility level that data around wait times for screening—all kinds of screening—around procedures and around health outcomes, but the transparency around those wait times would mean that people could see the waits that they might experience if they are in the public system or the private system and support them if they are not being given those other care options by their health professionals to maybe seek out second opinions and consider other options.

Mr MOLHOEK: The Auditor-General just released *Improving access to specialist outpatient services* which effectively is the nexus between primary and tertiary care in Queensland. Do you think that it is to the detriment of people accessing healthcare services across our public hospital system that projects like the patient portal system have been delayed by two years? Do you think that is of concern?

Ms Fox: We think that anything that gives greater transparency and access to those services is a good thing. Where there is a standardised requirement for GPs to do referrals that follow the pathways that I described earlier which mean that people can get access to prevention rather than straight into surgery, with opportunities for the consumers to ask for reviews and seek more urgent care if necessary, that is very good. Sharing information across the systems through the IT platforms

is also vital and it is perhaps an irony of the pandemic that we are likely to see this at a greater level than before with the need for coordinated care across our systems so that people can get the care that they need if we see an increased number of cases.

Ms KING: I am hearing from NDIS system participants that they are facing at present a large number of plan re-evaluations and reassessments. Recently, I read an article in the *Guardian* in relation to a man living with terminal motor neurone disease who has had his NDIS plan reassessed, leading to the removal of his 24-hour nursing care. This is a man who is now in a motorised wheelchair and evidently requires 24-hour nursing care and feeding and speech assistance. He is now facing re-hospitalisation. Is this something you are hearing from your consumers on a regular basis?

Ms Fox: Absolutely. If we want to look to a system that really has not delivered what so many, particularly parents and carers, fought for, it is definitely the NDIS. The frequent requirement for people to have their plans revised, to pay an exorbitant amount of money for health professional reviews and to submit to those and the questioning of their conditions, which are permanent, is something that we see.

I would encourage our partner organisation, Queenslanders with Disability Network, to put in a submission—I am sure they will. They do amazing work to try to assist Queenslanders to access the scheme. It is co-designed with the health system. Quite often, those consumers who need these services the most have the least opportunity to access them and the least opportunity to shape what they look like. I definitely encourage you to speak to them and see the challenges that they face in ensuring that those individuals and families have someone to walk alongside them to navigate what is an unfair and complex system.

Ms KING: You say that people are paying private specialists for advice and for opinions to justify their plans.

Ms Fox: When they are required to resubmit and they need the documentation to support that they have an ongoing disability I have heard of consumers being required to pay costs.

Ms Fox: That is profoundly disturbing.

Mr MOLHOEK: I have had constituents come to me who have been on waiting lists. I have a manila folder full of letters saying: 'Thank you for coming to see us'; 'We have rescheduled this'; 'We will be in touch.' It goes on and on. Then I have had other constituents say that they have been contacted by Queensland Health about something that they needed and they told them that they will get back to them, and they have waited two years and got nothing.

On one particular occasion, a lady desperately needed a cataract procedure and I said to her, 'Can you give me a copy of the letter or a reference number so I can follow it up?' She said, 'I actually have nothing. I have had three or four phone calls.' Does the administration of all this need a bit of a tidy up? Are the systems robust enough? How do we improve on that from a consumer point of view?

Ms Fox: That story absolutely resonates. We know that ophthalmology waits are so long and so beyond what is clinically indicated.

Mr MOLHOEK: I have seen it with other procedures as well.

Ms Fox: That is just one. For both the health professionals who are trying to support those patients to navigate the journey and then themselves. You are right; there is not consistent transparency and an ability for them to log into a portal to see where their wait is at, how it has been assessed and what the wait might be. I am aware of pilots in that space and where that is going to be implemented. I can find out the contact in the department to speak to. We really need that transparency.

Mr MOLHOEK: Essentially every patient should get something that they can refer to—whether it be a file number or a case number.

Ms Fox: And a phone number to ring to see how they are going.

CHAIR: Or just ask for the GP referral letter, I would imagine. We are out of time. Thank you Ms Fox from Health Consumers Queensland for your contribution. It is always welcomed.

Ms Fox: We look forward to making a submission with those consumer examples.

CHAIR: Thank you very much.

Mr MOLHOEK: I am going to have to make a private appointment to sit down and go through your submission before the hearing because there is not enough time.

BARRON, Ms Karin, Executive Director, Health System Integration and Innovation, Northern Queensland Primary Health Network

DUNSTAN, Ms Libby, Chief Executive Officer, Brisbane North Primary Health Network

CHAIR: I welcome representatives from the Primary Health Network Cooperative Queensland. Thank you very much for being here today. Would you like to an opening before we move to questions?

Ms Dunstan: I will kick off and then I will hand over to Karin. I acknowledge the traditional custodians of the land we are meeting on today and pay my respects to elders past, present and emerging. Thank you very much to the committee for having us here today. I want to make a couple of comments and then I will hand over to Karin.

We are here on behalf of the seven Queensland PHNs that cover the geographical region of Queensland. PHNs or primary health networks are a Commonwealth funded initiative. We could talk about what PHNs do and that would take up all of our time. Fundamentally, PHNs are regional organisations. We are required to understand the local context of our regions. We do a comprehensive health needs assessment every three years that is refreshed annually. Part of what we then do is commission services to meet gaps that are relevant to our particular region.

In saying that, we have a number of key strategic partnerships, and obviously working with our hospital and health services across Queensland is a key one. What we want to see for the consumers in our region is good health available to everybody, keeping people out of hospital and keeping people well and healthy at home. We can talk a little more about that. In terms of relevance to this committee, an effective primary healthcare system is critical and a foundational building block to an effective healthcare system. If primary health care is not working effectively then we have a healthcare system that is not working effectively.

I have a couple of stats for you as well. We had a look at the most recent AIHW report from October 2021. In the financial year 2020-21 Queensland general practices provided Medicare subsidised care to around 86 per cent of the resident population in Queensland. A lot of Queenslanders are accessing care through their GPs. In terms of allied health, only about 39 per cent of the resident population accessed allied health services. It is certainly not as accessible as general practice. Compared to the previous year, general practice services had increased by about four per cent. Allied health services had increased by 14 per cent, which is disturbing because it is still pretty low. That is well above population growth. Primary health care is doing the heavy lifting in terms of the provision of health care in Queensland.

Some of the challenges relate to the fact—and the previous speaker talked to this—that there is such a difference and variation in a local context around the accessibility of primary healthcare services across the region. I guess that is the unique position that PHNs can play because we actually understand and support those unique circumstances.

General practice in particular but also our allied health professionals and other primary health providers are really constrained by the rigidity of the funding model that they operate within. General practice is funded on a fee-for-service basis. Largely what that drives is volume rather than value. I think there is limited ability for general practice to provide what is required in terms of comprehensive care for chronic and complex conditions in the community. As the previous speaker also talked about, we are talking about privately owned small businesses across the state. As a result, the funding model supports episodic rather than chronic and complex care.

From our perspective we have very strong relationships with our hospital and health services and have a number initiatives and things we can talk about in terms of how we provide, support or supplement the provision of care in a particular community to help people avoid unnecessary hospitalisation, but we could do a lot more.

The last point I will make before handing over to Karin is that primary health care has been at the frontline of the COVID response even though we have not had the sort of cases that our southern counterparts have. COVID vaccination has been fundamental to primary health care. Primary health care has taken on additional work and gone above and beyond. Even though immunisation is a core part of that, it has been a significant workforce drain in terms of the capacity of general practice. Karin, I might let you speak now because you have some points that probably supplement that, and then we can answer any questions.

Ms Barron: I would also like to acknowledge the traditional custodians of the land on which we meet today and pay my respects to their elders past, present and emerging. I also acknowledge the Yuibera people—the country from which I come in the Mackay region.

I also acknowledge the federal Department of Health. It is through their funding that our work is delivered. I would also like to respectfully acknowledge our Queensland Health health and hospital partners. At the local level on the ground we are very well connected and are working very hard collectively through COVID but also through a whole range of other initiatives. I acknowledge also the PHN Collective across Australia.

I thank you for the opportunity to share our experiences in the context of regional, rural and remote PHN. I am the executive director of integration and innovation for the Northern Queensland Primary Health Network. I am based in Mackay, but my portfolio goes from St Lawrence to Badu Island and Saibai Island north of Thursday Island. The provision of the healthcare workforce is adversely affected by rurality. The further rural you go the worse the impact is on those communities. This places them on the thin edge of workforce provision which is a precarious and unsafe place.

The COVID pandemic in Australia has resulted in quite a spotlight being thrown on this area. A large component of my work in the last particularly 12 months has been around the workforce. The recruitment and retention of professionals into rural, remote and regional areas has been adversely impacted by the closure of international and also state borders. What has resulted for us is persistent and escalating regional, rural and remote primary care workforce shortages. I want to talk about why that is first and then why it is impacting on Queensland Health services. I have some statistics and a couple of recommendations.

We have longstanding workforce shortages in health. It is nothing new and a meld distribution of that workforce. You tend to find your workforce in bigger urban areas for a whole host of reasons, which we are too short on time to discuss today. COVID has adversely impacted the workforce. I have mentioned access to that transient workforce, international medical graduates and issues across borders in Queensland, New South Wales and Victoria. We have one practice in Mackay that had relied quite heavily on locums coming in from Victoria. Once that supply was cut off, that practice—and it is what we call a corporate practice—was almost on its knees. It is unusual to see a corporate practice with that broad a scope for workforce.

Access to general practitioners is constrained by cap fees. The current MBS billing model and the freeze on Medicare has made it quite unsustainable in rural and remote areas to have universal bulk-billing. I have heard bulk-billing mentioned a lot. I might touch on that a little later and just explain a little more why that is so for high-quality primary care. There is already what we call blended billing. They bulk-bill and have fee for service but you would be surprised how high the bulk-billing is even though it is not universal.

The final part in terms of contributing factors is the failure of some of the workforce programs. I will mention some by name, but they are not limited to these. There is the distribution priority area, the DPA, which is causing great angst throughout the sector. The 19(2) exemption, which the federal government has just done a review of, is not doing what it was meant to do. It is not making more primary care accessibility and workforce. It is causing some problems with workforce distribution. There is also the MBS billing models and the utilisation of the Modified Monash Model for rural classification. The example I will give is Mackay. We are classed as outer regional the same as Toowoomba. Toowoomba is one hour from Brisbane. We are four hours from Townsville and a 12-hour drive from Brisbane. These are compounding.

Why does this impact on the provision of services by Queensland Health? The delay in people seeing a GP who is the gatekeeper for referrals means that people become more unwell and they have exacerbations of conditions, ultimately resulting in more community members presenting on your doorstep at Queensland Health through EDs unwell and with exacerbated conditions.

Limited access to general practitioners results in poor discharge rates. If you have patients within your system in your specialist outpatients department who need to be discharged back into the community into primary care—in Mackay I have 33 per cent of our practices closed to new patients—they cannot be discharged, so your flows are disrupted quite significantly.

Reduced access to general practitioners in regional, rural and remote areas is resulting in some significant issues around residential aged-care support and access by general practitioners. That has been mentioned here today. Ultimately, they will end up on your doorstep, in your EDs. If the crisis continues, you will be stepping in to run these services.

I know that our time is limited today. I look forward to meeting you up in Cairns. My understanding is that you are coming to Cairns. We will have some further conversations there. I have some examples and statistics that I want to give you, as well as a couple of recommendations that we think are really achievable now between the PHNs and the Queensland government.

As I mentioned, 33 per cent of the practices in Mackay have closed their books to new patients, and this is because they are at capacity. They have been on the front line of COVID for more than 18 months. In Mackay until the hubs were up and running, 70 per cent of all vaccinations were done through primary care. We have small, rural practices that have delivered 13,000 and 14,000 vaccinations within their practice and with their complex patient demand. In Cairns, we have had five practices close within the last 12 months. We were notified yesterday of a sixth. This is devastating for that region.

Health Workforce Queensland have cited to us 70 registered vacancies for allied health in Queensland, 19 for primary care nursing and 97 for GP vacancies. The Central and Western Queensland PHN provided me with data yesterday. They have 27.5 GP vacancies and 21.9 nurse vacancies and nearly 19—some of these are FTE halves—allied health professional vacancies.

We again respectfully acknowledge our HHS partners because we do work well and we have great relationships, but we would like to recommend the following three recommendations: that the Queensland government formally commits to joint planning for health services for Queenslanders through a joint health needs assessment with PHNs. We have been doing this for six years. We are very good at it. We know that there is a remit now for HHSs to develop their LANAs, their local area needs assessment. That means you have two peak bodies running around the district asking for information from communities. It should be one, and we should do it really well. It is vital to us commissioning services and meeting those gaps. I think it would be vital if we could bring that together.

Recommendation 2 is that the Queensland government leverages the existing network of PHNs to commission services at a local level. This would reduce duplication of effort and resources across the system and appropriately address local need. You have heard a lot today about place based local need—multidisciplinary teams. I think we have to come together now and start to deliver in a really innovative, flexible way.

You may not quite get why I say this next one. Recommendation 3 is that the Queensland government consider how their planning and resource allocation can be better shared with the primary healthcare sector, including but not limited to housing, public transport, education, early childhood development, employment, and community and disabilities services. Often when we implement something innovative—one of them is the incentive program for rural allied health in the Isaac and Whitsunday regions, where we were able to recruit 13 new allied health professionals to the region—we hit problems with transport and shared housing. I went to the education department. We had to have conversations about whether we could share housing and they had to come back to the state. If we have state government housing in our rural areas, we should be able to share that across the health workforce, education, transport and other Queensland government areas.

I thank you again for this opportunity. I want to reiterate that we believe there are systematic issues. Everyone I see working in the sector is working their hardest and to the best of their ability. I think the system does not fit, I think we need to use collective approaches and I think we are ready. I think COVID has made us as a sector, as a state, ready for something new. I thank you very much.

CHAIR: Thank you very much, Ms Barron, for your opening statement and to you too, Ms Dunstan. I want you to unpack the bulk-billing blended funding. Could you give us a couple of minutes on that?

Ms Barron: I heard a statement that GPs will not do a home visit. I would suggest that GPs cannot do a home visit. They are absolutely at capacity. What is happening with the bulk-billing is, if you are getting $39—I think it is $38.90 or something—for a bulk-bill, if you are delivering high-quality primary care, which 95 per cent to 99 per cent of our practices are, you are seeing four to six patients an hour. That is $144 an hour that the GP walks away with. He has to pay his public indemnity insurance, he has to do his education and training, and the practice then gets the other part of that. When it comes to sustainability for that model when you do not have large numbers in rural and remote areas, you just cannot. You will go broke and you will not be there. These are private businesses. These are professionals. I do not think you would see another professional like a lawyer earning those sums of money. That is not to include all of the additional work and travel that does not get covered.

When I talk about a blended billing model, all healthcare cardholders get bulk-billed. All children generally under 12 get bulk-billed. Sometimes under 16 get bulk-billed. If you are a complex patient or a frequent flyer, they bulk-bill you after one appointment that month or in a two-week period. Generally, 80 per cent of a general practice is through bulk-billing. Universal bulk-billing is unsustainable in a lot of parts. It may be in a metro city area where you have lots of numbers coming

through and maybe you are not practising that high quality of care—where you have nurses doing prework and the nurses are calling with their test results and following up on things. When you have a bulk-billing practice, to make it viable the patient is being called back for everything—for your scripts as you get one script at a time; for your results; for your blood tests. That is how a bulk-billing practice becomes highly profitable.

Ms Dunstan: If I can just add something there, in a metro context, what GPs would say to me is that they use private billing or copayments—where people provide a copayment to almost supplement the bulk-billing that they do in a practice. It is difficult for a bulk-billing practice, given the types of funding amounts that they get from an MBS item, to sustain the provision of comprehensive primary health care. We heard a bit of discussion earlier about the practice team. I think we would argue that comprehensive primary health care needs to have a team based approach. It is not just about the GP. A lot of the practices say they simply cannot provide that level of service if they are not privately billing.

CHAIR: I had a conversation with my own GP just yesterday in Townsville. He will be making a submission, as will his practice. The reason we do not have bulk-billing in residential aged-care facilities in Townsville is the cost of the Medicare rebates. That is basically what it is. He can see four of me in an hour. Going to a residential aged-care facility to see multiple patients is just not worth the bang for your buck. I think his words were around the fact that the Medicare rebate has been frozen for 20-odd years and not modernised so the dollar value is not worth it. I give credit to those GPs who have done it for many years, but they have since retired.

Ms Dunstan: You are exactly right. In terms of taking an hour out of your day to go to a residential aged-care facility to provide that care, it is far more I do not like to use the word 'profitable' but perhaps economically viable to do that in terms of the patients coming to you. I am aware in North Queensland that a number of GPs are not going to residential aged-care facilities, but in Brisbane North where those GPs are doing it they will often do it at the end of their day. They have had a busy clinical load during the day. Then they go to the residential aged-care facility. That is because they do want to provide comprehensive care to their patients but they almost have to do it on top of their existing clinical load.

CHAIR: If there was a better rebate, would you say that perhaps the delivery of care in residential aged-care facilities could be met and there would not be the impact on the public health system?

Ms Dunstan: I think what I would say is that—and it goes back to the comment that I made in the earlier part of this conversation—fee-for-service medicine provides episodic care. What we are talking about is comprehensive primary health care. We need to think about different funding models. I think the MBS rebate is but one element of it. What we want to do is incentivise and work out ways in which we can provide comprehensive care.

As Brisbane North PHN, we were involved in the Health Care Homes trial. That is much more about capitation payment—receiving a payment for comprehensive care. Within that model you can then think about how you provide that care and how you use that funding to provide care to those patients rather than what we have which is income generation by seeing a patient—you must have the patient in front of a GP so you can bill appropriately. We need to look at different funding models that do not rely on episodes of care, funding models that support some of the concepts that we have talked about like service navigation, connecting people to other services, using the practice team much more comprehensively—the role of practice nurses in terms of providing supplementary care to the GP.

CHAIR: I know I am going over time. I hope my colleagues indulge me for a moment.

Mr MOLHOEK: I have questions too, Chair.

CHAIR: I was very pleased as co-chair of the regional forum in Mount Isa to engage with the PHN out there—Western Queensland PHN. I will give them a plug. They were doing fever clinics when I arrived. They were very collaborative with Gidgee health and the health network out there. I cannot say the same for Northern Queensland PHN. I have been based in Townsville. I have been in the medical arena for three decades. You have put a lot of things back on to Queensland for joint planning. I would contend that the PHN could do a lot more with the HHS. I will give you a practical example of that.

In my electorate of Thuringowa, I had GPs who were unable to get face masks and PPE when COVID first hit. Queensland Health was standing up all of the fever clinics. Six months after the pandemic started, the Upper Ross fever clinic was stood up from the PHN. That is not good enough,

in my view as the local member, for a very vulnerable area. I would contend that the PHN needs to work closer in collaboration with the HHS in North Queensland. I did give a wrap for Western Queensland. I thought they did a very good job. My observation is that more improvement is required for North Queensland and the office based in Cairns.

Ms Barron: There are offices in Townsville, Cairns and Mackay. There is a big office in the JCU Clinical Practice Building.

CHAIR: We do not get a lot of engagement from them. We do from the HHS, but we certainly do not from the PHN from a health perspective. That is my observation only. I am sorry to be critical. I think they do a wonderful job in Western Queensland.

Ms Barron: I will come and visit you when I am up from Mackay.

CHAIR: I look forward to it.

Mr MOLHOEK: Chair, I do not know where to start! I want to go to the issue of workforce shortages. I note that there were some earlier comments about the fact that the international borders have been closed and we cannot get people in like we used to. What do we need to do to encourage more Australians—people who are actually here—particularly young people, because we have incredibly high rates of unemployment amongst young people, to be more engaged in career opportunities within the health system and to pursue those opportunities? We cannot just keep taking the best from the best from overseas and leaving those countries bereft of good doctors and nurses and allied health workers.

Ms Dunstan: There is so much in that question. Certainly from our perspective what we have noticed is that—if I start with general practice—general practice as a career option is declining in attractiveness. When I look at GP registrars from 2016 to 2019, there has been about a 20 per cent decline in applications for registrar training programs. Not only do we have workforce shortages, but general practice as a career for a whole range of reasons is declining in terms of the numbers that we are able to put through.

In terms of the broader primary healthcare provision and getting people interested into career pathways that are supporting the primary healthcare system, some of that comes back a little bit to the funding. If you are an allied health professional setting up a practice, running a business with limited support and funding constraints, one of the big things we hear—and I am from an urban PHN so it is perhaps different in rural and remote ones—is that access to affordable allied health professionals is a significant issue. A lot of GPs will refer into the hospital and health service as a way to get affordable allied health for people with chronic and complex conditions. If you are a private allied health professional, you are running a small business and trying to run that in a sustainable way. There is that side of things, too.

Then there are new pathways for workforce roles that I think we need to think about. Brisbane North PHN brought in a qualification that was initially seen in the United States called medical practice assisting. That is a particular qualification that provides an upskilled workforce in a primary healthcare setting to support the GP and the practice team in providing additional capacity to do some of the more comprehensive primary health care that we think is required. Again, perhaps they are the entrepreneurial or visionary practices that see opportunities for those types of roles. There are obviously differences in rural and remote areas. An integrated primary healthcare team is something that we need to think about. It is probably not answering your question in terms of how we are going get people there.

Ms Barron: In North Queensland we have stood up a North Queensland health workforce alliance of 21 members—RACGP, ACRRM, CheckUP and the PHNs from beside and below us. We are looking at grow your own. We are testing programs that start kids in years 11 and 12 in partnership with the HHS. We are Indigenous focused. We running them through their certificate 3s and 4s and then articulating those with other qualifications. Grow up your workforce is where we look at our workforce and add to the qualifications, whether it is a rural, generalist, allied health qualification or you are a pod and you need to do some physio because you are the only allied health worker in the region. We are looking at those programs and delivering some of those. Data is an issue. The data is convoluted; it is fragmented. We are working to bring data together. HeaDS UPP data, which the federal government uses, tends to have anyone who has walked on the patch of North Queensland counted as a GP, but they are not. They might be in outreach. It is about the validity of the data.

We are working on tertiary and VET pipelines. I see that the committee has ACRRM coming in later. I am sure they will talk a bit more about that. We are trying lots of things. The biggest one we are going for is a flexible model of care and workforce strategy. We are working with Kristine Battye

and associates, an Australian consultant, around the workforce. They have recently completed the exemption review. I am looking at a test model we can try that is multidisciplinary, place based and is flexible in the way it deliver services but client centred. We are doing multiple things in this space.

Mr MOLHOEK: There is an interesting nexus though, is there not, between primary health care and Queensland Health in that once you graduate as a health carer, whether it be a doctor, a nurse or whatever, the pathway into the future is still through Queensland Health. You have to get a placement, an internship, a trainee doctor position, a trainee nurse position or whatever. I am hearing that once people are in the system there are not enough opportunities for specialist training. The reason we have shortfalls at the other end is not just perhaps the lack of places through university but also the lack of specialist training opportunities within the health system. Have you heard anything to that effect?

Ms Dunstan: It is probably not an area of expertise from my perspective.

Ms Barron: No. There are a couple of issues about the training which I think ACRRM will better answer for you. For example, in Mackay the DPA classification has been removed, which means bonded students and international medical graduates cannot work there. There are Canadian nationals who have done all of their training—

Mr MOLHOEK: Did you say DPA?

Ms Barron: The distribution priority area. It used to be the district of workforce shortage. These guys have gone through our complete health system but they are not residents. They are still international medical graduates. Half a dozen of them sitting there can only work at Queensland Health but would be happy to go out and work at Bowen and places like that, but cannot because of this classification. There are these barriers within the system that are impeding the provision of health care.

CHAIR: To clarify, we have written to the Department of Health to explore this area of distribution priority areas and get a proper definition. We will make recommendations around that.

Ms KING: I note that in relation to my area of Pumicestone where our distribution priority area status was removed in 2019, I wrote first to the federal health minister who said that we had plenty of GPs and then to the federal rural health minister who said that we did not have enough and that the system was broken. There is a lack of agreement about the issues. To move to a slightly different issue, particularly the role of PHNs, I want to reflect on some statistics that the chair shared earlier in relation to ED presentations in our public hospital system. Some 10 years ago, Metro North ED had 139,000 walk-ins and this year 194,000. You can see very substantial growth in the order of 40 per cent. In that time, Cairns HHS went from 34,000 to 220,000 walk-ins. The children's HHS went from 24,000 to 60,000. West Moreton went from 31,000 to 55,600. Over that period of time, how much has PHN funding increased? I am happy for you to take it on notice, but in your view would the funding for the PHNs have increased by a corresponding extent?

Ms Dunstan: PHNs get a level of core funding and that supports the core operations of the organisation. That has been pretty stagnant over the time you are talking about. We then get different buckets of money for different purposes. Given the types of figures that you are talking about, no, PHN funding has not increased at similar proportions, albeit that one of the clear purposes from a primary healthcare network's perspective is to try to keep people out of hospital and healthy in the community. It is better outcomes for the consumer. It would be nice if it was funded. We talk with Metro North Health on a regular basis about these exact sorts of challenges. I do not think it is a one size fits all in that this has led to this and has led to that. Some of the things we have seen are accessibility into practices, affordability of allied health services, increasing complexity, a lack of pathways for people for comprehensive care and declining rates of private health insurance—there is a list that goes on and on. We have an ageing population, arguably, with increasing complexity of healthcare needs. We have had an overlay of COVID where people perhaps have delayed treatment because at times they have been afraid to go to the hospitals. There is that side of things and then what is happening in general practice.

We made some comments earlier about DPA. I absolutely acknowledge the challenges in rural, regional and remote Queensland, but the challenges in outer metro in terms of delivering primary health care are equally problematic in terms of accessibility, affordability and comprehensive primary health care. There are so many factors that come into that. It goes back to Karin's earlier point. I hear the chair's point about PHNs and hospital and health services coming together to comprehensively plan, to understand the needs of those communities, not to duplicate effort and to put the consumer front and centre so that we can provide comprehensive health care. Of course everything is a journey and we do need to make sure that we are moving in that direction. We would certainly appreciate any recommendations of this committee that would further embed that.

Ms KING: I value your suggestions for what Queensland Health can do more and better and how we could better work with the PHNs. What I see from those figures is that Queensland Health is more than carrying its share of the load and it is being used as the system of last resort for a primary healthcare system that is not uplifting necessarily, for a range of reasons, to meet the need of the community and to match that catching facility that our hospitals are providing.

Ms Dunstan: I think it is a good description saying that it is the last resort. The reality is that in all situations our hospital system needs to provide acute care for those who are most unwell but often is seen as a place for those perhaps who cannot access care in other ways. It goes back to the comment I made right at the beginning. We have to have an effective health system and well-functioning primary healthcare system. There are challenges in terms of how that is operating. The Commonwealth has just released its 10-year primary healthcare strategy. We are eagerly awaiting information from the Commonwealth about what funding and support comes to realise some of the concepts in that 10-year primary healthcare plan, which goes to some of the things we have been talking about today.

Ms KING: I would really appreciate it if you could take my initial question as a question on notice and get back to the committee with specific answers about that increase in funding over that 10-year period.

CHAIR: Per the seven areas that you cover in terms of PHNs. We have gone back to the department and asked for a decade to look at the figures. We have seen record funding each year since I have been in. It would be good to get a comparison proportionally with population growth and so on. I am always going to fly the regional flag; I am passionate about where I live. We always want to see more funding and make sure that we have the best of care for everyone in Queensland.

Ms KING: Do you have access to the Commonwealth primary healthcare funding amounts that are spent in your PHN areas? If you do, could we additionally get that?

Ms Dunstan: Sometimes. Do you mean MBS funding? We will have a look and see what we can provide.

Ms KING: What you can provide would be most welcome.

CHAIR: We have previously written to the Commonwealth Department of Health in relation to a previous report and we got nothing, sadly. This is the aged care, end-of-life care and palliative care report No. 33 from the last term. There are three references to PHNs in here. I will quickly link you to recommendations 44, 47 and 48. This is about people at end of life basically and what the PHNs could do to work with relevant agencies to improve access. One of them was to link other strategies and plans to the recruitment and retention of staff. That was a year ago. We would really like to see some go-forward on that body of work. It is over 400 pages. A lot of people throughout regional Queensland came before us. They want better services. It is about everyone working together. I thank you. I know we have kept you well over time, but we look forward to whatever information we can get in the best the interests of providing the best level of care for Queenslanders. Thank you so much for your time today.

Proceedings suspended from 1.14 pm to 1.30 pm.

ELLWOOD, Professor David, Head of School of Medicine and Dentistry and Dean of Medicine, Griffith University (via videoconference)

CHAIR: I now welcome Professor David Ellwood from Griffith University Professor Ellwood, would you like to start by making an opening statement before we move to questions?

Prof. Ellwood: As Head of the School of Medicine and Dentistry at Griffith University, I am the dean of medicine responsible for the medical training places that Griffith University has. We produce approximately 235 graduates each year. I want to talk about two things in relation to the provision of medical training places in Queensland and the impact on the public health system.

Firstly, there is apparently a looming shortage of junior medical officers in the Queensland health system that has come about because of the inability of international graduates to come into the country over the past two years. Every year a number of junior medical places in public hospitals are occupied by graduates primarily from Europe and the UK. Of course, those people have not been coming in for the past two years so there is concern that there is a looming shortage, that the medical schools in Queensland are not producing enough graduates to fill all of the places and certainly that that will be exacerbated once the shortage because of a lack of international graduates becomes apparent.

There are two points that I want to bring to the attention of the committee. Firstly, Queensland has four medical schools. We do not produce enough graduates from those four schools to fill all of the intern places that we have in the public hospital system. There is a requirement for places to be filled either by graduates from other jurisdictions or else by international graduates.

The second point that I want to raise is that at the moment—and this is the case across the country—international students who attend our medical schools—and of the four schools in Queensland the supply is tipped for only three: James Cook University, the University of Queensland and Griffith. International students who attend are given a very low priority when they apply for internship. They have to wait until very late in the year before they find out whether or not they do have an intern place within the Queensland system. They are not guaranteed an internship when they are given a place to study at our medical schools.

It has always seemed to me, and I think to many other deans, that we have a workforce here that is ready-made for the Australian environment: they are trained in Australia, they have been selected into our medical schools, many of them want to stay in Australia for several years after they graduate and many of them have partners who are Australian. If they were given the same currency as domestic graduates, I think it would lead to a much more equitable arrangement and we would have a ready-made workforce for the Queensland public health system.

At the moment we rely on incoming international graduates who have trained elsewhere. They have trained overseas. They do not understand the Australian environment. They do not understand our health system. Whilst many of them are extremely well trained and they do fit into the system, I think we would be much better using our own homegrown workforce. Those are really the points that I want to make to the committee.

CHAIR: Thank you, Professor. I worked with a number of those international graduates over my own clinical career. Obviously there has been a notable decline due to COVID. That is the reality of it. I am all for homegrown graduates as well. You mentioned that you have 235 graduates per year out of Griffith. Can you give us a rough number for UQ and JCU?

Prof. Ellwood: I do not have those numbers in front of me and I would not want to speak for my colleagues.

CHAIR: You can take it on notice.

Prof. Ellwood: Of the 235, there are 200 domestics from Griffith and 35 international students. I believe the JCU numbers are slightly less than that, but I do not know the proportion of international students. UQ has a larger number but they also train quite a number who return to the North American market because of their offshore clinical schools, through the Ochsner Health System. I do not have those numbers at my fingertips, I am afraid.

CHAIR: Who makes the decision on the priority of domestic over international, in terms of keeping the graduates in order?

Prof. Ellwood: That is really a Queensland Health decision, but it would be consistent with what happens across the rest of the country that international graduates are not given priority in cadetships. There is a grievance between the medical schools, and this operates through the Medical Deans Australia and New Zealand group, that when international students are admitted they are

certainly not guaranteed an internship, although they know that they are eligible to apply for that. I believe it would be something that Queensland Health could decide to do, if they chose, to give the international graduating students the same priority as the domestic graduates and allow them to enter the ballot for internship at the same time.

CHAIR: My final question is around the funding for medical graduates or GP training. Are you aware of any federal funding that may have been reduced over recent years in terms of attracting more medical graduates into those placements?

Prof. Ellwood: Not specifically any reduction in funding. Certainly there has not been a reduction in the income that we receive from the Commonwealth supported places. We are just going through the rounds of renewal of the funding for rural places. That funding level seems to be capped at the same level as it was three years ago, so it has not increased but it certainly has not decreased. I am not aware of any decrease.

CHAIR: For those three years, and given everything that we have heard this morning around availability of GPs in rural and remote Queensland, would you contend that that funding be increased to attract more GPs for those areas to fill the gaps?

Prof. Ellwood: The funding that I was referring to was the funding that the medical schools get for training students in the rural places, which hopefully will then encourage them to consider working there once they have graduated. I think it is a complex question as to how to encourage more people to work as GPs in rural locations. The large public hospitals are extremely good at soaking up medical graduates. They have an almost insatiable appetite for junior medical staff. Again, if we can retain as many of our international graduates as we can then it will all help the system overall.

CHAIR: To clarify, it is Commonwealth funding that you are talking about here?

Prof. Ellwood: Commonwealth funding for the medical student places. The funding for internship is through Queensland Health or through the hospital and health services through Queensland Health.

Mr MOLHOEK: Professor Ellwood, I wish we had a lot more time to chew the fat on some of these issues. One thing that concerns me is with the rural health specialty or the rural health generalists—I cannot remember the exact title. One of the deterrents is that a lot of trainees do not want to take on that particular focus because it locks them in and makes it really difficult for them to come back to metropolitan Queensland or Australia. I was intrigued because the DG, Dr Wakefield, said that he was a rural health specialist and now he is the DG. He was almost saying, 'There should be more of us!' Do we need to review some of the pathways and categorisations or specialisations so that we can provide incentive for people to do country service and come back? I would have thought that a rural health specialist coming back into a metropolitan hospital would have more to add rather than being at a disadvantage. Just to declare an interest, my son is a rural health specialist.

Prof. Ellwood: There are a couple of things that I would say in response. The challenge for medical schools is that what we want to do is to train our students in rural locations and, hopefully, they will become rural doctors and they will stay there. They will become part of the community. I think that is our primary aim. At the moment, international graduates do not have access to those rural places because it is Commonwealth funding that is specifically aimed at domestic graduates.

I agree that perhaps the ability to work in a rural setting for five or 10 years and then return to an urban setting, we should not be putting up barriers for that. That is quite a natural progression for some people. Once they have children they may want to bring their kids back to the coast for schools and that kind of thing. That is a fairly common pathway that people follow. I think we really need to do whatever we can to train people who feel comfortable working in rural settings and will stay there.

Our Commonwealth funding requires us to ensure that 20 per cent of our graduates spend at least one year doing a longitudinal placement in a rural setting. Most of them are out on the Darling Downs, so west of Toowoomba. They really like it and many of them do return to work there as rural generalists.

Mr MOLHOEK: The system is very heavily dependent on international specialists, GPs and people coming in and that has created some challenges with border closures. I will ask you the same question that I asked the PHN people: how do we get more Aussie kids to study and explore career options in health and allied health services? How do we get them into Queensland universities and on a pathway to a wonderful and rewarding career when we have such high youth unemployment?

Prof. Ellwood: In relation to medical training places, we do not need to encourage more people to apply. We have thousands more applicants than we can ever take; they are academically very suitable. For some of the other health professions, there is a shortage of people who come from the rural environment applying for those programs. I can speak from my own experience at Griffith with dentistry. We have quite a shortage of applicants who come from a rural background.

It is a very complicated question. I think we are addressing it to an extent in Queensland with some of the regional programs. Examples are the program we run on the Sunshine Coast. UQ is about to open one in Rockhampton and in a few years time there will be the one at Toowoomba. They will certainly do something to encourage people who have been to school in those areas and are deciding that they are happy to apply for medicine and to make the commitment to years of study because they can do it locally. I think the same thing applies to other health professions. The more that you can study in a regional setting, the more likely it is that you will then choose to work there.

Mr MOLHOEK: You say there are thousands applying. Why can we not take more in? Why have we set the bar so high? It seems to me we have a lot of people trained that are incredibly academic but not necessarily very practical, although I guess GAMSAT and some of those processes sort some of that out. Why can we not take more into the system given the shortages we are seeing?

Prof. Ellwood: The number of medical training places is determined by the Commonwealth. There are capacity issues in relation to the number of placements we can put into public hospitals, but I think the medical deans would generally agree that we have not reached capacity, we have not reached a natural saturation point, so we can certainly increase the number of places if the Commonwealth would fund them.

Ms KING: To confirm, in your view, to the extent that you can answer, are you of the view that Griffith University would appreciate the opportunity to have more medical training places through the university?

Prof. Ellwood: Yes, we could certainly cope with more places. I think the number of places has to be linked to the availability of training spots, but with the expansions happening at Logan Hospital and the plans for the new Coomera hospital I think there is certainly capacity growing within the system and I think we need to take advantage of that. It makes sense that we train more of our own rather than import lots of international graduates.

Ms KING: Just to confirm, it is the Commonwealth that funds those places?

Prof. Ellwood: The Commonwealth determines the number of places available. The funding of medical training places at medical student level is complex. It is Commonwealth funding, but there is also a very significant in-kind contribution from the public health system. There have been attempts at working out the actual cost of looking after a medical student for a whole year and who pays what, but I am not sure anybody has ever completely resolved that. It is really a shared responsibility, but the Commonwealth determines the number of places.

Ms KING: I certainly acknowledge that. We have heard submissions about the declining number of GPs in practice and also about the declining number of medical graduates who are interested in following a general practice pathway in their professional life. I wonder if you could give us some comments about why you think that might be?

Prof. Ellwood: I think there are a couple of reasons that might be, but there are also some solutions, I think. The first thing is that in general, general practice is not as well remunerated as specialist practice in the hospital system and it is (inaudible) hard work of disciplines. I am in awe of GPs who can work across the full breadth of medical practice. Myself I work in a very narrow area. I have become an expert in a very narrow area, but GPs have to be experts in wide areas. I think it is both challenging but also not particularly well remunerated compared to other specialties.

I think one of the things that we can do to encourage medical students to consider general practice as a career is to introduce them to general practice much earlier in their training. Historically they have usually done GP placements towards the end. In our Sunshine Coast program we have introduced what we call longitudinal GP placements where they start at year 1 and they go right through for four years with the same GP. We are restructuring our program on the Gold Coast to do the same thing in 2023.

Ms KING: Does the data show that that leads to an increased interest in pursuing general practice?

Prof. Ellwood: We do not have any strong evidence for this. We have some qualitative studies that suggest that if students are introduced to GPs as their initial role models, they become their mentors and their role models, then they are perhaps much more attracted to follow that profession.

Ms KING: I am sorry, I interrupted you. Feel free to continue with the comments you were making.

Prof. Ellwood: That is fine. What we are doing on the Sunshine Coast is that our students are introduced to clinical skills training in the setting of general practice by GPs so they are really the first professionals that they come into contact with. Hopefully that will encourage them to see that as a career.

Ms KING: I know from my own experience, my husband is a former rural GP who went on to become an anaesthetist. He recalls, as a high-performing medical student, the shock with which his declared intention to become a rural GP was received, as though 'why on earth would anybody want to do that'. Yet he went on to very much enjoy that area of practice. Clearly there is a need to provide exposure to the opportunities.

Prof. Ellwood: A greater involvement of GPs in medical training I think would be fantastic. It is difficult given that GPs are essentially all self-employed practitioners. In placements with Griffith we work through the local PHN for those placements. We have to negotiate those placements. It is not always easy finding places for our students.

CHAIR: Before I go back to the deputy chair, I have one question. You may take this one on notice but I am sure you have a great team there that might be able to do some comparisons with other jurisdictions in terms of medical training places. Where does Queensland sit compared to a similar population base, say Victoria, of around about 5 million? In fact, why do we not look at all other jurisdictions. I want to get an idea of whether Queensland is being left behind in terms of Commonwealth funding for places given that we have significant population growth. We have plenty of evidence that has been given to us from the department. Would you like to take that on notice, Professor?

Prof. Ellwood: I would have to take that on notice. I can direct you to the sources of that information. It is the information that the Commonwealth holds. It is information that the medical deans organisation holds. That would be where I would go to find that. It keeps changing as populations keep growing and new medical schools spring up in different places. I cannot answer that question off the top of my head. I do know that we do not produce enough graduates in Queensland to fill all the intern places so we are reliant on the international graduates to make up the balance.

CHAIR: We are hoping that we might get a response from the Commonwealth Department of Health on that so we will wait to see, but any additional information that you might have would be beneficial.

Mr MOLHOEK: There are a whole lot of questions that I would love to ask around training of GPs. One of the comments that has been made to me around the lack of specialisation and availability of specialist nurses and doctors is that once they graduate from university or the college that they have gone to and they actually enter the Queensland Health system there are not enough training places for specialisation offered each year. The example that was given to me was that last year there was only one training spot offered for ophthalmology, for example. I had a list of others, but I did not bring it with me. Is that an important part of the progression of training health specialists?

Prof. Ellwood: It is very important. One of the other hats that I used to wear until fairly recently is president of the Australian Medical Council. I cannot speak for the council now because I have stepped down from that role, but the AMC is the body that accredits training programs: specialist training programs, intern training programs and medical student training programs. Certainly in some of the surgical subspecialties, the number of training places available in particular regions is quite limited. Again it is a complex question as to whether or not the numbers of training places is determined by community needs or whether it is determined by capacity for the system to train. Ideally it needs to be both. The specialist colleges really regulate their own training numbers. Unlike with medical student places where the Commonwealth determine how many places are available, the number of training places is determined by the colleges.

Mr MOLHOEK: The comment that was made to me was that one of the problems is that the health system trains people to be specialists and then as soon as they have their specialisation they go off into the private sector. Ophthalmology in particular is one area where that happens. My comment was why do we not train more people and in a sense create an oversupply in that space and then maybe people will not be so quick to leave Queensland Health to go and do that. How do we get more specialists into the public health system? That is really the question.

Prof. Ellwood: It is often the people who are working in the private sector who are also involved in training the next generation of specialists so you might say they have got some self-interest in not flooding the market.

Mr MOLHOEK: It is an interesting quandary, is it not?

Prof. Ellwood: My last comment is perhaps a little bit flippant, but there has to be a balance between training capacity and community needs. I think sometimes there is a mismatch there. I am an obstetrician gynaecologist and I was involved in the regional committee for Queensland until a couple of years ago so I am very familiar with the training system in Queensland. There are factors

that determine the number of training places that are available, and my specialty is incredibly popular—we have literally hundreds of new graduates every year wanting to train in obstetrics and gynaecology. There are careful decisions made about what the training capacity is. I do not always agree with those decisions. You cannot just turn the tap and suddenly double the number of training positions because you are reliant on the specialists who work within the system to train.

Mr MOLHOEK: Given that we are, in effect, facing a health crisis—and I do not mean that to sound political in terms of Queensland Health or anyone else—but it is generally considered that we have massive shortages of specialists and specialist healthcare workers across the board, whether it be Queensland or Australia, is it not time that we turned on some of those taps and took the view that we need to stop being so conservative and start to think more broadly about training a larger number of people for these specialisations into the future?

Prof. Ellwood: The Commonwealth's health workforce strategy has done some projections to look at where we might be in five or 10 years time, and certainly there are some specialties where there is a predicted oversupply and some where there is a predicted gross undersupply. I have been involved in this myself over quite a number of years. The only thing you can be certain about when you are trying to make predictions about medical workforce needs is that you will get it wrong because of the various factors that are unknown. Nobody knew about COVID two years ago so we could not have possibly predicted that. I think there is an argument for increasing training numbers in certain areas and I do think that the health jurisdictions and the Commonwealth need to work together to be more persuasive of the colleges that control the training numbers to ensure that the training numbers do meet community needs and are not just determined by what the college thinks they should be doing.

CHAIR: Thank you very much, Professor, for your time and for your insights. They are most valuable to the committee. We will wait for the Commonwealth Department of Health to provide that information so we do not tie you up.

Prof. Ellwood: They should have the most up-to-date figures. I would be going to the same source as you to find them.

CHAIR: We welcome your contribution and thank you very much for your time today.

HYDE, Ms Carly, Senior Policy Adviser, Cancer Council Queensland

PRESTON, Ms Paige, Advocacy and Policy Manager, Lung Foundation Australia

THOMPSON, Ms Emma, Chief Executive Officer, Arthritis Queensland

CHAIR: I welcome our next group of witnesses. Would you like to make an opening statement before we move to questions?

Ms Preston: Good afternoon, Chair and committee. Before I begin I acknowledge the traditional owners of the land on which we meet and pay our respects to elders past, present and emerging.

Lung Foundation Australia is the only charity and leading peak body of its kind in Australia that funds life-changing research and delivers support services that give hope to people living with lung disease and lung cancer and a range of other key activities. For over 30 years we have been working to ensure that lung health is a priority for all, from promoting lung health and early diagnosis, advocating for policy change and research investment, raising awareness about the symptoms and prevalence of lung disease and championing equitable access to treatment and care. We work across all states and territories. We have connected nearly one million people with our resources, support services and programs. We have four consumer advisory committees and a number of clinical advisory committees. These committees advise us on service gaps, community need, strategy, research endeavours and health system issues.

Today Carly, Emma and I will speaking together on our shared priorities. As an alliance of not-for-profit health organisations we look forward to making a formal submission to the committee next week. Today we will be speaking on our shared support for the following three priorities: increasing investment in preventive health; taking action to address health inequities in the community; and committing to a coordinated, person-centred approach to the delivery of health care. I will speak to the first point, which is investment in preventive health.

Currently, chronic diseases are the leading cause of illness, disability and death, with respiratory disease, cancer and cardiovascular disease responsible for some of the greatest death and disease burden. The Australian Institute of Health and Welfare recently published a report which found that more than 38 per cent of the disease burden in Australia was preventable due to modifiable disease risk factors. This is significant, and much more needs to be done to address these factors and prevent disease. That will enable Queenslanders to live healthier, happier and more productive lives and—importantly, relating to this inquiry—it will keep people well and reduce the burden on excess expenditure and the health system.

In Queensland the rate of health service provision to meet community demand has been growing exponentially over the last decade. Even before the COVID pandemic there was an increase of $1.137 billion to Queensland Health's operating budget. Queensland is second lowest, only ahead of the Northern Territory, for health expenditure per person. Without a commitment to increasing investment in long-term preventive health measures, demand will continue to put Queensland's public health system under extreme pressure. Investment in preventive health measures has proven to be cost-effective, with significant benefits stemming from helping people live healthier lives and preventing disease at a population level. Specific benefits include: reduced pressure on the public health system; reduced burden on individuals and communities; better use of health system resources; healthier workforces and communities; increased health literacy; and improved economic performance and productivity.

While the Queensland government's investment in preventive health fluctuates, it is well below the level needed to ensure optimal health, wellbeing and economic benefit. Specifically, we recommend an investment of at least five per cent of the health budget. It is important to note some of the great work that has gone on in preventive health across Queensland across a range of groups including, but not limited to, the not-for-profit sector, universities, the Mental Health Commission, PHNs and of course Health and Wellbeing Queensland. There are people and organisations there that are ready to help tackle the issues with evidence based solutions. Notably, successful efforts in tobacco control over the last two decades have resulted in a 50 per cent reduction in the rate of daily smokers in Queensland to just 11 per cent, which is lower than the national average and is very commendable. We want these efforts to be reinvigorated across a much broader range of diseases and risk factors, and this will have a great impact.

The Queensland government has a responsibility to protect the health of Queenslanders, and there needs to be a significant shift towards investing and supporting a focus on preventing disease. COVID-19 has highlighted how agile our health system is, and this is commendable, but our health

professionals have done it tough. We need to ensure that as Queensland's population grows we are aiming to keep the population healthy and prevent disease in order to reduce mounting pressure on both health professionals and the health system.

Ms Hyde: Cancer Council Queensland is dedicated to improving the quality of life for people living with all types of cancer. We do this through research, patient care, prevention and early detection. We have nine offices statewide and operate six accommodation lodges, providing regional cancer patients with a home away from home while they are undergoing lifesaving treatment in Queensland's major cities.

One in two Australians will be diagnosed with cancer by the time they turn 85. A Queenslander is diagnosed with cancer every 20 minutes. Cancer touches us all, which means a well-functioning health system that is accessible, equitable and provides quality and timely treatment and cancer care is an important priority for all Queenslanders. Unfortunately, we continue to face challenges in ensuring equitable access to quality care and equitable outcomes for every Queenslander. Health inequities are experienced by our First Nations people, people from culturally and linguistically diverse backgrounds, those are live in regional and remote areas, people with a disability, LGBTIQ+ communities and those who experience socioeconomic disadvantage. The prevalence of chronic disease is higher for people who identify with one or more of these groups, and for this reason efforts to ease pressure on the health system must include additional support tailored to their needs.

Queensland has a pivotal role in closing the national gap in health outcomes for Aboriginal and Torres Strait Islander people, as 28 per cent of First Nations people live in Queensland—second only to New South Wales. Unfortunately, the target to close the life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians is not on track. In Queensland the three leading drivers of this life expectancy gap are cardiovascular disease, cancer and diabetes, with cancer being the leading cause of death. The burden of cancer weighs heavily on our First Nations people as they face inequitable outcomes, including higher cancer incidents and lower survival rates than other Australians.

Socioeconomic disadvantage is also associated with the higher prevalence of, and mortality from, most diseases, particularly the major chronic diseases. Queensland sits at the centre of this crisis, as seven of Australia's top 10 most disadvantaged local government areas are in Queensland. The financial burden of chronic disease is significant but is particularly prohibitive for people on low incomes. Those from low-socioeconomic backgrounds are less likely to have private health insurance, which has implications in terms of equity, access to health services, consumer choice and increased burden on the public health system.

Queensland's public health system also faces challenges due to the size of our state and the highly dispersed nature of our population. People living in regional and remote Queensland wait longer to see a GP, have to travel longer distances to receive treatment and experience a lack of continuity in their care due to shortages of clinicians and a lack of critical services. These issues can delay treatment, which can have serious and life-threatening implications and place unnecessary pressure on the public health system. As a result, people living in regional and remote areas experience high levels of disease burden, notably including respiratory disease, and have poorer survival rates for diseases such as cancer.

COVID-19 has changed the way we access health care in Queensland. Under temporary MBS telehealth items, health providers, including allied health, have embraced technology to help patients stay connected to vital health services. Surveys indicate this has been welcome, with results from Health Consumers Queensland and Lung Foundation Australia both showing over 80 per cent of patients rate their telehealth experience positively. We support the continuation of these telehealth options under the MBS, particularly if conducted via videoconference, to enhance access to timely health care in regional Queensland. However, there is still much more that needs to be done to improve health equity across the community and ease pressure on Queensland's public health system. We must take a holistic view of health outcomes for all Queenslanders, and that requires coordination and collaboration across all levels of government and sectors to actively address the sociostructural barriers that prevent people from living healthy lives.

Ms Thompson: Arthritis Queensland represents 730,000 Queenslanders who live with a form of one of the more than 100 diseases that fall under the banner of arthritis. Arthritis and musculoskeletal conditions are some of the most common, costly and disabling chronic conditions in Australia. While no form of arthritis is curable, there is much that we can do to treat and prevent disease. We support the comments already made by Carly and Paige around the vital importance of prevention and equitable access for all Queenslanders.

Our third collective priority area will be no surprise. We have been listening to the presentations this morning so we are very aligned with what has already been said: the need for increased coordination across the delivery of health care in Queensland. I acknowledge the representation from the PHN and Health Consumers Queensland this morning, which really reiterated a lot of what we stand for as well. People living with lifelong health conditions require ongoing support and they need access to many different types of health professionals. The consumers whom we represent often live with multiple conditions, making their treatment complex, time-consuming and expensive. We advocate for access to multidisciplinary care for people living with chronic health conditions.

A multidisciplinary approach to health care, as you have heard already, involves patients being supported to build their own team of health professionals who work collectively to support the patient's needs. This can include GPs, allied health professionals, pharmacists, nurses and medical specialists. Ensuring that people who live with chronic conditions have access to multidisciplinary care results in better health outcomes and a reduced cost to the health system. Just to give some examples of how that works in reality, there is research showing significant impacts around the incidence of limb amputation in patients living with diabetes and also, for my cohort, a huge increase in people being able to come off of joint replacement waiting lists if they can access appropriate allied health care.

The benefits to individual patients and the health system in general are immense. However, as we have already heard, the current structure, funding and workforce issues mean that delivery of multidisciplinary care in Queensland is not well supported currently. Our health system is still siloed and difficult to navigate for patients, particularly those with lower health literacy. We do welcome the recent introduction of new MBS item numbers to support GPs and allied health professionals to undertake case conference meetings; however, there are still funding issues. The capped approach to allied health sessions, with only five a year, is insufficient to provide effective care to people living with chronic health conditions.

In addition, as you have already heard, the allied health workforce is poorly distributed and it is too small to meet patient needs. It is particularly true in rural and remote areas, where recruitment and retention of every type of healthcare professional is a significant issue. Lack of access to care close to home results in increased cost to patients and in the very worst case, which does occur, a complete barrier to care. We call for an increased focus on workforce mapping, planning, training, support and development. I note a comment from the Deputy Chief Health Officer yesterday, who referred to the Queensland Health workforce as being somewhat traumatised due to their experience with COVID. I think that now more than ever we need to invest in supporting our healthcare workers.

We appreciate that the health system is working in a period of increased demand and that this is likely to worsen over the next 12 months. In this climate, the importance of embracing innovation and sharing knowledge is absolutely vital. We strongly support the importance of the statewide clinical networks, which facilitate information sharing and build connections across the silos of our health system. The work of those networks is vital in reducing duplication and achieving systems-level thinking. Innovative models of care, such as GPs with a special interest and outreach hub-and-spoke models, are needed—as are increases to the scope of practice for allied healthcare workers and nurses—if we want to maximise the limited resources we have available to us. This can only occur through collaboration and communication.

We welcome the recent creation of the Queensland Aboriginal and Torres Strait Islander Clinical Network and call for all other gaps in the provision of those statewide clinical networks to be addressed.

Finally, we call for strength in partnerships between the health system, health charities and non-government organisations. Our specific areas of focus allow us to provide bespoke services to the cohorts that our charities exist to serve. These are specific services that are often not available in the wider health sector. Our organisations have reach, expertise and deep community connection which has great value to offer the health system in Queensland. We thank you for the opportunity to attend today and we welcome any questions.

CHAIR: Firstly, thank you to everyone who works in your relevant organisations for the work they are doing throughout Queensland. If you were following this morning, you would have heard that we asked questions about the impacts on people—whether it is people with a respiratory disease, going through a cancer journey or suffering arthritis. I want to ask this question as I come from regional Queensland. Based on that GP distribution data we have, are you hearing from people you work with about issues with treatment in small rural towns because of a lack of access to a GP? Paige, I might start with you in terms of someone who is suffering CID, emphysema or another respiratory disease—

and let us not talk about long COVID and the ongoing effects of that. How important is it to receive care in your community? Are there impacts because of a lack of access to GPs or allied health, remembering this is about primary and allied health care as well?

Ms Preston: Even before COVID, we absolutely had intel from our consumer committees, in particular, and our clinical committees that there is a huge workforce disparity out in the regions. COVID has definitely exacerbated it because people living with a respiratory condition have had increased stress and concern around what it means for their condition and how to manage it ongoing. We have obviously heard things throughout the pandemic of access to medicines, and there is of course the issue around telehealth and people who have a respiratory condition being unsure if they can go to their GP because they are experiencing COVID and flu-like symptoms. There are a number of issues. They certainly rely on telehealth and some of these other services, which is really promising that they have come into effect, but they are still reaching out to us and others to help fill that gap which definitely exists. We have some great telehealth respiratory nurses and lung cancer nurses who are able to provide some of that gap but it is definitely an issue.

CHAIR: Does anyone else want to comment on that issue?

Ms Thompson: Just to reiterate what Paige said.

CHAIR: What is the solution? You mentioned Queensland Health funding. This terms of reference sit around primary and allied care, which is Commonwealth funded. What are the solutions?

Ms Preston: I will take first crack at this. At the end of the day, there are a number of areas that we are going to outline in our submission next week so we will definitely provide some clear recommendations in there.

From an initial standpoint of some of the points I noted in my opening address, one of the key things to consider is that preventing disease reduces the burden on the health system, both primary care and allied care, and also the hospital system. It is definitely twofold. Of course there is a responsibility at the Commonwealth level, but Queensland also has a responsibility to look after Queenslanders and improve their health. As I noted, some really good things have happened in the past and we need to build on that and make sure Queensland is doing all it can to protect health and prevent disease from occurring. That would then flow on to reducing impacts on both the GPs and the hospitals. That would be one area of work.

Ms Thompson: I think there are some really interesting options around changing the models of care and there is some great work being done already. Unfortunately, it is being done in pockets of excellence and not being replicated across the whole system. Things like the GPs with a special interest allow for people to go into general practice in a regional area but then also have access and support from specialists and physicians probably working out of a larger metropolitan centre. It gives that growth opportunity to see some GPs who are looking at that as an option.

We feel there is space to improve the workforce planning to understand what needs to be done and how allied health teams in particular can be relied upon. We could activate more allied health access. I heard Libby Dunstan mention quite a low figure of 35 per cent of people accessing allied health in Queensland or Metro North. If we could increase that, we feel that would have a strong impact on preventive health as well, reducing the workload and the need onto GPs.

Ms Hyde: I would third the comments that have been said so far in terms of the shared models of care. GPs need to be supported to have some of those prevention strategy conversations in their consultations, which is not really a priority in a busy GP setting but is really important not only for preventing the cancers emerging but also preventing recurrence in cancer survivors and to make sure they have links to those allied health supports that can keep cancer at bay and prevent those chronic diseases becoming more debilitating and putting pressure on the public health system.

CHAIR: I note that the member for Redlands, Kim Richards, is in the public gallery and no doubt has a keen interest in this.

Mr MOLHOEK: I thank you all for coming along today and for your various submissions. My opening question is probably a bit of a chicken and egg question. For those people in rural and remote areas, what is their port of call? If you think you have cancer, a significant health issue or a lung disease, do you roll up to your local GP and expect to get the next stages of service, or do you go to your local hospital or health service in the hope that you will get a more complete solution?

Ms Hyde: The cancer diagnosis typically happens in the GP setting, but from there it is referred on and lots of people find that their primary care relationship becomes with their oncologist, who may be in a major hospital many kilometres away. That tends to break that relationship between the patient and the GP. If they have that longstanding relationship, they can have better outcomes in terms of their long-term care over the life of their disease and beyond.

Ms Thompson: We always promote the GP as the first point of call. However, I also acknowledge that allied health professionals have a strong role in prompting diagnosis to happen in the first place. We find a lot of people with inflammatory arthritis might have it first suggested to them by their podiatrist or physiotherapist, so it is a broader approach than just falling on one person's shoulders.

Ms KING: Paige, I note your comments about the importance of Queensland Health's role in preventing presentations to start with, although I do have some concerns about that. In many respects, the Queensland Health system at our hospital level is not only picking up our most acute cases but also picking up everybody who cannot get in to see a GP and who then presents at ED. I wonder what work is being done at the primary health level to make sure those people are better cared for. In that context, what are your members who you advocate for each and every day telling you about their ability to access those primary health services, whether that is their allied health or their GP? What are they telling you? Is it easy for them to get a GP appointment out in their communities the length and breadth of Queensland?

Ms Thompson: It varies but it can be very difficult. It can be very difficult to get an allied health professional appointment, and it can be very difficult to get a specialist appointment. These people are facing vast distances to travel. Quite frequently, what we see happening is delay. Delay in a cancer diagnosis, a lung disease diagnosis or an inflammatory arthritis diagnosis is the worst possible outcome that could happen.

Mr MOLHOEK: Correct.

Ms Thompson: We want to see early intervention where possible. That is why we really do believe that workforce planning should be prioritised and whatever growth we can achieve in the workforce should be the priority for making sure that everyone has got access to the care they need.

Ms KING: In that context, do you think the fee-for-service model—the small business model of GPs being run as an individual small business right across Queensland—is a suitable model to provide Queenslanders with the increasingly complex health care they need into the 21st century?

Ms Thompson: That is a big question.

Ms KING: It is. I will not hold you to your answer. I am interested in your thoughts.

Ms Thompson: We are realists to a degree as well so we work in the system we have and we are interested in creating as much improvement in the system that we have. We are seeing a decrease in private insurance uptake so obviously there is some kind of strain. We do see that fee-for-service models can cause problems for consumers accessing care. It is a situation where I think there is a lot of efficiencies that could be achieved within the system that we already have. I do not think it is a complete scrapping of the system, but it is certainly a solid review.

Ms Preston: Further to your point, when you consider health inequities, that fee for service maybe becomes more of an issue. At the end of the day, I do not think the Lung Foundation would want to be commenting on if that is a suitable model or not.

Ms KING: One final question I have is just to hear the experiences of your members. What are people telling you about their private health insurance and how it is supporting them at the moment and beyond when they get their diagnosis of cancer, a serious lung disease or inflammatory arthritis? Is their private health insurance helping them in the way they expect it should?

Ms Preston: I would have to take that on notice. I do not know off the top of my head, I am sorry.

Ms KING: I would love it if you could. I recognise that you may or may not have information about that. Does anybody else have information about that?

Ms Hyde: We have some anecdotal information through our 131120 hotline in terms of people who get referred on through the private system because they have private health insurance. Once they are on that pathway, the financial costs tend to mount and the out-of-pocket costs for that pathway can be quite high. Some work has been done at the national level around GPs providing that financial informed consent and an awareness that, 'If we go down this referral pathway, this is what the out-of-pocket cost is.' Anecdotally, people are saying, 'If I had known it would cost me this much to deal with my breast cancer diagnosis in the private system, I would have chosen to go public.' That certainly is anecdotally what we hear.

Ms KING: Could we please request that information?

Ms Hyde: Sure. We can include that in our Cancer Council Queensland submission.

Ms KING: That would be very welcome. Thank you.

Mr MOLHOEK: I would be curious to know if there is any data on the efficacy of treatment or people's recovery journeys around cancer through the private health system versus the public health system. I have heard some horror stories of people who have been waiting an incredibly long time to get diagnosed, let alone treated, because of failings in the public health system—actually, my niece is one of those—versus people who have private health insurance. I would be interested to know if there is any noticeable difference in that.

Ms Hyde: I am not sure. With COVID and with the workforce challenges that have been highlighted throughout today, coming back to that equity issue, we do not want people to have really poor outcomes in the public health system, but at the same time some people have been providing feedback that their out-of-pocket costs for private health are prohibitive even with insurance. I would have to take that on notice.

Mr MOLHOEK: Perhaps that is a question on notice if we could see something on that.

CHAIR: That would be a big body of work.

Ms Hyde: Okay. Maybe I will not take it on notice then.

Mr MOLHOEK: You could see what is available.

CHAIR: We will leave you with that. Questions on notice are due back by Wednesday, 15 December, but if you put it in as part of your submission that can come back on 16 December. To summarise this section, Queensland Health gave us some figures the other day of private health insurance. The cost to Queenslanders is so prohibitive now that 60 per cent of Queenslanders find it out of reach and they do not use it. The 40 per cent who remain are questioning now because the gap is so big. When they do get told of what that gap might cost, with that change of policy, it is too prohibitive so they go to the public system. Again, the burden then increases on the public system.

I was only at my own GP yesterday discussing things and if I go and have a certain procedure it is going to cost me this much in the private system, so I was informed, but that is just an interesting observation to make. I think our public health system does wonderful work and I do not think the increases coming through the front doors are sustainable with an ageing population and people living longer with more chronic diseases. In my own area of Townsville 280 people a day go to the hospital, and most are walk-ins from GPs because they cannot access their GPs. I think we need to fix the cause and make GPs available to people because that is just not sustainable in any model. Interestingly enough, private health insurance is an absolute cause of that as well because we have Mater Private EDs that people could go to but they do not, for whatever reason. I would say it is cost. Anyway, with that, we have summarised this section. I thank you all for your contributions today. They have been really informative to the committee and we thank you for that.

PRYCE-LUNT, Ms Kim, General Manager, ForHealth Group

TUCKER, Dr Clive, Regional Clinical Director, ForHealth Group

CHAIR: I welcome representatives from ForHealth Group. I invite you to make an opening statement and then we will move to general questions. Thank you very much for being here.

Ms Pryce-Lunt: Thank you for having us.

Dr Tucker: It is indeed a privilege to address you, Chair and committee. Even at relatively short notice, we were excited at the prospect of being able to share in this process. First I would like to acknowledge the traditional custodians of this land, the Jagera and Turrbal people, and their leaders past, present and emerging. Today I speak as a GP who has worked in Australia for the last 20 years and would like to demonstrate a few of the changes of how our current health system could hugely impact the Queensland public system and the health and welfare of our fellow Queenslanders. I represent, as you are aware, ForHealth, which is a bulk-billing private health organisation, and we provide both primary and allied health care within the private health system.

Never again would I like to work in a healthcare system where I have seen mothers who have walked many miles in the hot sun with babies on their backs and standing in the hot sun waiting and when they unwrap this bundle you would find a baby who has either died or is at death's door. Never again would I like to work in that system, but even more so, as some of you may be aware, the recent death of a young child in the emergency department in Western Australia demonstrates again how important accessible and timely health care is and how needed it is. Had that young patient been seen in a general practice setting some hours earlier, the outcome might have been very different. Never again would I like to turn away more than 20 patients in one night just like this last Monday evening where people just flocked in after hours because they were unable to go to their usual practices or even see the doctors in our practice as there were just insufficient appointments in daytime hours, and this included babies, mums and dads, injured workers. Never again would I like to support colleagues who are burnt out and fatigued with overwhelming patient numbers and patients who have needed to walk in with no appointment and those patients having waited between two and four hours and some of the frustrations and discomfort that they have experienced.

In Queensland our organisation has 170 doctors in 14 medical centres. We have a network of dentists and allied healthcare workers as well. Since the start of the pandemic, we have had more than a 50 per cent decrease in international medical graduates who now work for us in addition to a threefold increase in the retirement of older general practitioners. We have also had to reduce our operating hours by 30 per cent over the last three years, and most of these hours are in fact on the weekend and after hours. Even the number of doctors available during those shifts, either evenings or weekends, has also significantly reduced. The impact of the shortage of general practitioners in accessible and affordable health care has led to extreme stress in hospitals with unprecedented numbers of code yellows and ambulances are ramped and hospitals are on bypass. Just yesterday I spoke to a former GP who now works for the PHN in West Moreton and she is immensely overworked and stressed and concerned about this very problem.

In terms of preventable health care, as we just heard from the previous submitters, patients with chronic illness are unable to be effectively managed in general practice. In fact what ends up happening is that there are increased admissions in hospitals with patients with uncontrollable diabetes, COPD, late cancer diagnoses. The impact is increased hospital presentations where the hospital system is overwhelmed and the clerical staff, the nursing staff and medical personnel have dealt with increasing stress and also a lot of patient aggression and patient frustration. The stress on patients and their families is tangible. I just mentioned the aggression being shown, and we see it in our own medical centres with patients. There are just so many stresses and I do not think COVID has made that any easier with patients having to check in, distance, masking. There are a lot of frustrations.

What are the recommendations that we can foresee being helpful? We believe that actions from this committee and the Queensland government affect the future of primary health care by lobbying the federal government to make changes and Queensland Health being able to make changes in areas under their jurisdiction. We believe an urgent review of the DPA system, the distribution priority area, in Queensland is urgently needed. I am mindful too though that it is all very well to change the DPA areas, but that might even further stress the rural health system. Support and assistance of medical registration via visa requirements and recognition of qualifications for the practice in Queensland of international medical graduates would also really facilitate the process. We believe there needs to be an urgent review of Medicare rebates in order to incentivise Australian

graduates to enter general practice. As we heard in one of the previous submissions, many doctors and people are making lifestyle choices in more comfortable nine to five, mostly urban specialties, and, as a result, general practice has suffered.

In Australia I have worked in both a rural general practice for seven years and a metropolitan practice for 11 years as well as in the hospital system for two years and have noted over the last few years that the stress on the system is unprecedented. I believe that it is almost clichéd to say that general practice is in crisis, both metro and outer metro. We can see that a model of affordable, accessible and comprehensive health care is at a tipping point and we believe that urgent changes such as those that we have mentioned are urgently needed. I believe that we have passionate people working within our health system—we are very dedicated people—and if we can continue to support the profession I do believe we are up to the challenge, but obviously we need significant help.

CHAIR: Thank you very much, Dr Tucker. Did you want to add to that, Ms Pryce-Lunt?

Ms Pryce-Lunt: I concur with Dr Tucker. I just wanted to add one additional thing. ForHealth has recently submitted a proposal to Dr Michael Reardon outlining our capacity with eight equipped-to-function centres to introduce minor illness and injury centres which would play a vital role to protect our hospital system from overcrowding and to serve patients at a third of the public cost. We cannot do that without funding which is why we presented the proposal. We have not had any communication since that proposal was submitted. We have reduced the operating hours of our medical centres by 30 per cent and most of that is evenings where we would introduce an urgent care centre. It is easier for us to probably employ doctors rather than have most as subcontractors in that sort of environment. At the moment the average cost of a patient going through A&E is $556 and the average cost for us to open an urgent care centre and see those patients is $120, and we are just talking about the category 4s and 5s who do not really need to go to the emergency department.

Mr MOLHOEK: How come you have reduced your hours by 30 per cent? I have heard it mentioned twice but no-one has said why.

Ms Pryce-Lunt: It is doctor shortage. We just do not have the resources to open.

Mr MOLHOEK: It was not lack of demand; it was shortage of doctors?

Ms Pryce-Lunt: No, it is shortage of GPs, yes. Most of our centres have a three- or four-hour wait.

Mr MOLHOEK: Right. Where to start? Dr Tucker, you finished your statement by saying we need significant help, so what does that look like? You touched on DPA review areas and Medicare rebate reviews and all of that, but what does significant help mean to the GP sector?

Dr Tucker: Our health system is almost entirely dependent, whether we like to admit it or not, on international medical graduates, of which I am one. I also realise that under Michael Wooldridge in 1997 they had the district workforce shortage which meant that when doctors came here they had to work in an area of workforce shortage or need for at least 10 years after coming to Australia and that was seen as a way of trying to solve some of the rural doctor shortage. That is one way of doing it. You can imagine: after graduates or international doctors had been in Australia they are citizens after three or four years, so now you are telling an Australian citizen that he or she has to work in a remote practice for another six years as a citizen. That almost seems dictatorial. By the same token, a fair market system where doctors are better remunerated to work in some of the more uncomfortable and remote areas would be one system, so Medicare reform would, I believe, be helpful in addition to facilitating us being able to employ international medical graduates. At the moment there is an exam process for foreign degrees and the assessment of it is quite a clunky process, expensive and time consuming and it is only the doctors who are already motivated and fairly well heeled that are available to go through that process.

Mr MOLHOEK: In one of the earlier sessions today I asked some of the academics about our dependence on international doctors. At the risk of offending you, why can we not just train more doctors and encourage more young people to engage in allied health specialties and nursing and all these other areas from within Australia?

Dr Tucker: We absolutely can. As you talked to the professor earlier, there are numbers that are capped and some of those numbers have fallen far short and sometimes it is simple mathematics where young doctors end up having families and are taken out of the workforce and often that is not even thought about. That was one of the initial issues when they found there were doctor shortages. That is just one of them. Unfortunately, some of the specialties are some of the tightest trade unions known to man where basically it is supply and demand that determines how things work.

Mr MOLHOEK: So it is the colleges that are holding—

Dr Tucker: To become an ophthalmologist or dermatologist, you just about have to be born in the family. Unfortunately, while there is supply and demand and there is a lower number of graduates, a lot of people are choosing to go into easier specialties which I mentioned earlier where they can work nine to five and spend more time with their family and they are well remunerated for what they do. It is quite well known that an ophthalmologist can do two cataract operations and earn more than a GP working a 10-hour day, especially a bulk-billing GP. I am not complaining for one second. We are comfortable in my family. I have been able to educate my children in the private system and all that and I am grateful for that, but at the same time there are large inequities in our healthcare system. I believe that incentivising general practitioners to get out there and more people to take up the profession is something that needs urgent attention.

Mr MOLHOEK: Just so I understand clearly, the pathway to any area of specialisation is you graduate from university, you find a place within the public health system and then at some point you specialise and then later down the track you leave that system and go into private practice. Is that the pathway?

Dr Tucker: That is correct.

Mr MOLHOEK: Earlier this year we heard from the Queensland Audit Office a criticism of Queensland Health and the lack of workforce planning. Do we need, in your opinion, to create more traineeship and opportunities within Queensland Health for young people to become doctors and specialist doctors and then specialists?

CHAIR: Just before you answer that—I am sorry, Deputy Chair—we heard from the QNMU that there has not been any national workforce planning since 2014. It was abolished under the current federal government. I think it is starting to step outside the scope of this inquiry. Can I ask you to think about that for a moment and I will ask the member for Pumicestone for a question.

Ms KING: We have heard a lot about the decreasing appeal of general practice as a professional pathway over probably a generation now. I want to raise an issue that I have read about that might be a bit of a left-field issue—the feminisation of the GP practice pathway, particularly in relation to the linked issue of it being a lower remunerated area. I know there has been quite a bit of academic writing about the fact that, as general practice was seen as an area of practice where you could potentially work part-time and you could to a larger extent control your own hours, more women took it up. I have heard the really somewhat offensive, I would say, phrase of 'smears and tears'. Is that something that you have heard?

Dr Tucker: Sadly, yes.

Ms KING: I want to hear your thoughts about this degrading of the value of general practice as a career pathway when we all know the value and the importance of GPs as the front line of keeping people in our communities healthy. Do you have any thoughts to share about those issues generally? I know they are complex ones.

Ms Pryce-Lunt: There is definitely a different generation of doctors coming out of training now. We operate bulk-billing centres that are open after hours. For most of the doctors coming out these days, 35 hours is a full-time week for them and they do not want to work nights and weekends. It is their right to work whenever they like. Definitely, it is not female versus male. It is nothing like that. They are all coming out with the same thoughts. Young male doctors are working 30 hours and want to do this during the day, nine till five.

Ms KING: I am the member for Pumicestone so my area is Caboolture and into Bribie Island. We have lost several GP practices in recent times because they cannot get doctors any longer because we lost our distribution priority area status.

Ms Pryce-Lunt: We have Morayfield and Caboolture and we are really struggling, yes.

Ms KING: I did not know that you were in those areas.

Ms Pryce-Lunt: We have 14 medical centres around Australia. The eight of them that are ex-DWS or DPA are the ones that are in crisis.

Ms KING: For the benefit of the committee, could we hear what areas you provide services in and which of those you are finding difficult to staff at this point?

Ms Pryce-Lunt: I will start from the Gold Coast. We have Tweed Heads, which is quite stable, Robina, Southport and Beenleigh, which is probably a harder area to recruit doctors to. We have Browns Plains, Oxley, Springfield, Ipswich and Toowoomba, which are very difficult to recruit to. Victoria Point is another very hard area to recruit to. Then we go to Murrumba, Morayfield and Caboolture, which are also very hard, and we have one in Minyama on the Sunshine Coast, which is stable.

Ms KING: That is certainly the feedback I have received from practices in my community.

Dr Tucker: Ms King, going back a little, you mentioned the feminisation of general practice. It is a sad day when many of the female GPs are seen as, you say, 'smears and tears'. Many of those women are fantastic. They are dedicated and caring people. Many of them are mothers and they have compassion that makes many of my male colleagues, myself included, look pathetic. At the same time, they are working longer consultations and fairly heavy emotional consultations and sometimes they are remunerated less because of how the system works. Someone who is running a dysfunctional practice where they are running five minute nets with patients in and out of the door, there is little chance of diagnosing difficult disease, little chance of maintaining a relationship, little chance of supporting someone who is really suffering, and they are actually remunerated very well relatively for doing that. There are some changes that need to happen within the system and I acknowledge that.

I worked as an associate lecturer at the University of Queensland in my early years, when I first immigrated to Australia. When one spent time with young people, once they found out, often they would ask to come and do placements in your practice because people appreciate genuine hardworking people. I have found more and more that, amongst our body of colleagues, most doctors have their hearts in the right place. Most of them are intelligent and dedicated people, but many of them are really burnt out and are just treading water in the system and are really struggling. It is difficult to make the profession look remotely appealing.

Ms KING: What we are seeing there, just to sum up, is a funding model that rewards poorer quality practice and disincentivises the best quality care in terms of that five-minute medicine—

Dr Tucker: I think that is a fair comment.

CHAIR: Dr Tucker and Ms Pryce-Lunt, of the 190 GPs that you have across the 14 centres, do any attend aged-care facilities? If not, why not? We are hearing from bulk-billing practices that it becomes difficult to get into those and that becomes an added pressure and burden on the public healthcare system in terms of minor procedures, catheter changes and things. We have significant data about increases in ambulance transports from residential aged-care facilities. Can you make some comments about that and what might be the disincentive around GPs going to those large facilities?

Ms Pryce-Lunt: Largely across our network there would be probably one or two doctors in each practice who visit aged care. I think it goes back to the patient numbers. There is a volume inside the centre so many of them do not have time to go out and visit the nursing homes. We certainly do. Do we do it enough? Probably not. The doctors cannot cope with their own patient load.

CHAIR: Is there an incentive to fix that situation?

Ms Pryce-Lunt: We have to get more doctors. That is the only fix to any situation, really. We are well behind. We have not taken international medical graduates for nearly three years so it is critical. We are behind. I do not know how we catch up. We are losing doctors to retirement. We just cannot see the patients.

CHAIR: I think you said it well when you said they are treading water at the moment.

Ms Pryce-Lunt: Yes, we are.

Mr MOLHOEK: Going back to that point, how do we get more doctors in the system?

Ms Pryce-Lunt: I think DPA is probably the quickest and the most likely solution. We have just done a recent UK recruitment drive. It was a very successful one. We do have a great pipeline of UK GPs. Unfortunately, we do not have DPA. We did put in our special circumstances applications at the end of September. We have heard nothing. We have doctors waiting in the UK to come over to these areas—Caboolture, Morayfield, Ipswich, where they are really struggling—but we cannot do anything until we get—

Mr MOLHOEK: What would the DPA mean, say, in Caboolture or Morayfield?

Ms Pryce-Lunt: It would be a big life changer for the community.

Mr MOLHOEK: Explain to me how that actually works and how it advantages, because I do not understand that.

Ms Pryce-Lunt: In what way?

CHAIR: You say you apply and write.

Mr MOLHOEK: What are you applying for? Do they get a higher Medicare levy as an incentive to go there?

Ms Pryce-Lunt: No. It is just that overseas trained doctors can only work in these DPA areas and they have to do a moratorium of 10 years. They cannot work anywhere else.

Mr MOLHOEK: Are you saying that UK doctors do not want to come and work at Morayfield?

Ms Pryce-Lunt: Yes, they will. Australian doctors do not.

Dr Tucker: The challenge is that without DPA approval you cannot employ an international medical graduate—even someone who has the Australian Medical Council exam—until they have served the 10-year moratorium. They have to work in either the public sector or what used to be a district workforce shortage area and now is a DPA area for 10 years before they can be openly registered. Without that registration you can only employ an overseas trained doctor as a locum, part-time for six years, and then they have to move on. It is very difficult.

Ms Pryce-Lunt: It is not about them getting Ahpra registration. They can get that without DPA. It all sits with the provider number to provide services.

Ms KING: Tomorrow we are hearing from Dr Steve Kearney from Ningi Doctors. When he completed the special circumstances application, he had the view that he was being set up to fail with the application. I took a look at it myself. Those were his personal comments. Having filled out the forms, he felt that the prospects of success were slender. Did you have any concerns of that nature or are you comfortable with the process that you went through?

Ms Pryce-Lunt: We did a lot of research and we had all of our figures. I do not think the process was so much overwhelming as that it just feels like it has gone into a deep dark hole. I do believe that New South Wales are receiving their DPA approvals today so their rural workforce is obviously more active than ours.

Ms KING: I think his point was not so much that the process was overwhelming, but that the criteria was not easily achievable by practices in our area—in his view—despite the very real workforce crisis being experienced. I guess time will tell.

CHAIR: Are there any final supplementaries?

Mr MOLHOEK: I do not know where to go, Chair. I am trying to get my head around the fact that people see Beenleigh, Morayfield and Toowoomba as bad places compared to other parts of South-East Queensland.

Ms Pryce-Lunt: It is not the UK doctors; they will go anywhere to come to Australia. It is our Australian doctors who want to work in the city, they want to private bill, they want to work in more city locations and they are in mixed-billing clinics.

CHAIR: That is why it is harder and harder in regional Queensland to attract and retain them.

Ms Pryce-Lunt: Exactly. Bulk-billing centres at Morayfield probably do not appeal to them.

Ms KING: Can you give us a brief explanation of why a GP might see working, say, in Clayfield as more advantageous than working in a bulk-billing clinic in Morayfield?

Ms Pryce-Lunt: The reason for that is that they are probably in a mixed-billing clinic so they are working in a higher socioeconomic area where patients can afford to pay. They are probably seeing four patients an hour, a patient every 20 minutes, and are able to really concentrate on that patient regardless of good medicine or bad medicine. In Morayfield you probably have a room full of patients waiting who cannot afford to pay and it is lower socioeconomic.

Mr MOLHOEK: I think you touched on it earlier when you said that more and more doctors want to work lifestyle hours.

Ms Pryce-Lunt: It is work-life balance views that are changing.

Mr MOLHOEK: There are some interesting things to unpack around the whole system in that sense, as well.

CHAIR: Thank you very much for your contributions today. It has been welcomed by the committee. We will adjourn and return at 3.15 pm to hear from the Australian College of Rural and Remote Medicine.

Proceedings suspended from 2.59 pm to 3.16 pm.

HALLIDAY, Dr Daniel, Board Member, Australian College of Rural and Remote Medicine (via teleconference)

CHAIR: We now welcome Dr Daniel Halliday. Would you like to start with an opening statement before we move to questions?

Dr Halliday: Thank you for the opportunity to address the hearing. Firstly, on behalf of the Australian College of Rural and Remote Medicine, ACRRM, I acknowledge the Australian Aboriginal and Torres Strait Islander people as the first inhabitants of the nation. We respect the traditional owners of the lands across Australia in which our members and staff work with and we pay respects to their elders past, present and future.

I am a board director and an identified member in Queensland. I fill the role of a rural generalist obstetrician and a dual role as medical superintendent at Stanthorpe Hospital in South-East Queensland. ACCRM's vision is the right doctors in the right places with the right skills providing rural and remote people with excellent health care. It progresses this through the position of quality vocational training, professional development education programs, setting and upholding practice standards and through the provision of support and advocacy services for rural doctors in the communities they serve. The college trains doctors towards fellowship of the college, FACRRM. An award of FACRRM entitles doctors to national recognition as a general practitioner with speciality qualifications and the associated provision of medical support services. FACRRM also reflects doctors' skills in the rural generalist model of practice. ACRRM is the professional home of rural generalist medicine and the ACRRM fellowship is designed to describe the professional standards for excellence in rural generalist practice. The college is committed to building a thriving growth course of rural generalists across rural and remote Australia.

A rural generalist medical practitioner is a general practitioner who has specific expertise in providing medical care for rural and remote or isolated communities and who can understand and respond to their diverse range of healthcare needs. This includes applying a population approach, providing safe primary, secondary and emergency care, culturally engaged Aboriginal and Torres Strait Islander people's health care as required, and providing specialised medical care in at least one additional discipline. ACRRM's fellowship model has had unparalleled success in producing high-quality, long-term rural doctors. ACRRM trainees are selected based on their assessed capacity to become competent rural practitioners and have training experience which reinforces their rural motivation and builds their skills for the rural practice context. Of the over 900 doctors trained at FACRRM over the past 15 years, 75 per cent have remained in rural practice five or more years after completion of their training.

The college submission will provide comments on those issues which fall within its operations and in both the Queensland and national context and acknowledgement of the role of the Commonwealth in a wide range of areas which impact on the primary care provision and its intersection with the public health system. These include: the rural and remote primary care workforce; current and future issues and its distribution; the role of rural generalism in providing as many services as possible as close to home as possible for people; private general practice—its role, viability and sustainability, including funding for MBS and incentive programs—training the future workforce, with a focus on rurally based training; and intergovernmental coordination and coordination between the public and private sector. I will be pleased to answer any questions on these or other issues of interest to members.

CHAIR: Thank you very much, Dr Halliday. We look forward to any forthcoming submissions. You are at Stanthorpe as a medical director?

Dr Halliday: Yes, correct.

CHAIR: How long have you been out there?

Dr Halliday: I commenced on 1 December 2007 as senior medical officer, rural general obstetrician. I have been the medical superintendent in an acting capacity since June 2014 and as a permanent capacity since December 2015.

CHAIR: You are well established to comment on rural and remote health care. Being in health care for 30 years with the ambulance in the northern region, I have certainly seen the challenges of working out in Cloncurry, Hughenden and other smaller places. They certainly value their rural GPs. We have a rural GP training system at JCU that works very closely with the hospital there. When looking at the terms of reference, we are asking questions around the current state of primary and allied health care and the challenges that you might be able to comment on in terms of access to GPs in the rural area. I do not know what the number of GPs is in Stanthorpe, but the information that

Queensland Health gave us recently is that on average in rural Queensland there is approximately one GP per 1,450 people versus in South-East Queensland one per 700. Have you seen that become harder with the impact of COVID and the lack of international graduates who generally go out in the rural system? What are some of the challenges that you are hearing about in terms of accessing a GP and, if they cannot access a GP, going to the public health system? Can you comment on that?

Dr Halliday: Absolutely. Obviously through my colleagues and my local experience in being effectively a border health facility, the issues that the college is getting feedback from its members on, in terms of the time of COVID, which has exacerbated the underlying issues we have had in rural and remote practice particularly, is that for health practitioners—not just the clinical group but the broader spectrum—it has reduced their portability. As a result, recruitment has been difficult. This has had flow-on effects in that, managing the typical flow or changeover of professionals, you have not been able to fill those positions as they become vacant. The other flow-on effect of course is that locum services, medical, allied health and nursing have also been affected. That has had a significant impact therefore on the call on local public health services to cover particularly after-hours and weekends—out-of-hour—services. There is an increasing burden during business hours as well as current general practitioners are stretched to provide COVID related services in addition to what their core business is in managing the everyday health needs of rural and remote Queenslanders and Australians.

Mr MOLHOEK: I should open by asking how Anna's at Stanthorpe is going?

Dr Halliday: As most of you are probably aware, Stanthorpe has had a challenging time in the last 2½ to three years. As a case study, with the reflections of being a rural generalist and a clinician manager in a small rural town, you get very close to community and how they have been able to deal with drought. As you know, we had threatening bushfires in September 2019. We went into day zero and had water trucked in for over 12 months. Most recently, we have dealt with floods as well as being on the border and having a persistent anxiety about the effect of COVID and what that might mean to us when the borders open. The community itself has been quite resilient, but it has obviously suffered.

The health services here have certainly been stretched and with the changes to Medicare funded programs we are facing issues within Stanthorpe and surrounds—and across the Darling Downs and to some extent across other areas of Queensland—particularly in regards to the relative reduction of the Medicare rebate in primary care, which effectively challenges the viability of general practice. There are also the changes that occurred without consultation to the financial exemption program and its associated on-flow in reducing the ability to improve access to primary care services and improve integration between the public and private sectors.

Mr MOLHOEK: Thanks for that. That was not actually the question I asked. I was asking about Anna's restaurant in Stanthorpe!

Dr Halliday: Anna's is still going strong. We had a dinner there with our trainees and doctors not long ago and the food is as fine as ever.

Mr MOLHOEK: My son spent two years at Stanthorpe Hospital as a trainee doctor. The question I did want to ask you is: what do you think Queensland Health can be doing better to make sure that people in rural and remote Queensland get the care they need when they need it? It is a fairly broad question I know.

CHAIR: I will allow the slightest of latitude on this, because this is all about the Commonwealth funding cuts.

Mr MOLHOEK: Hopefully he will talk about collaboration between PHNs and Queensland Health.

Ms KING: A fishing expedition.

Dr Halliday: There are a number of factors. Queensland Health, as some may attest to, is a beneficiary of the development of the rural generalist training program in Queensland. That has been a game changer. Compared to other states it positions Queensland in a very firm light. In championing that program since its conception in 2005 and inception in 2007, Queensland has been able to provide an investment into rural and remote practice via that model, effectively subsidising what the Commonwealth funding streams were able to provide.

CHAIR: Good on Queensland.

Dr Halliday: Queensland is a leading light in the rural generalist program, absolutely. You reference James Cook University which has a very strong, integrated rural training program. It is not just in medicine, of course, but extending to other professional roles. The collaborations, looking at

an extended scope of practice—allied health professionals and nursing, rural generalist nursing and the like—is very mature in Queensland. That has been evidenced by the rollout of the model and appreciation of the costs in strong integration into the national rural generalist training model going forward. In terms of the issues around that though—and you talk about the primary health networks and their interaction with the hospital and health services—my personal view is that the primary health networks and their security of funding and ability to actually prosecute a fully integrated continuum between primary and secondary care has been hampered by the potential to provide a lot of funding in a lot of places. The contracting arrangements to provide services into areas are very short-term with not necessarily longer term health funding arrangements and goals.

As you would realise, to try and set up a small business itself, you generally have to invest for five years before you get a return. Within the scope of rural and remote health care, that investment would definitely need to be three to five years and sometimes longer. The rural generalist model, of which I was a pre-vanguard rural generalist when it was conceived—and I fellowed one year after the rural generalist model was formally implemented in Queensland—was founded on the premise of generational change with a significant investment at that time. We are seeing the benefit of that longer term investment opportunity.

The issue is we have been stretched in terms of some of our recent challenges. However, the structures are there to lead Queensland forward. In saying that, there are some potential issues that will develop in terms of how the MBS and other unrelated funding challenges will impact rural and remote practice going forward. I do not know if you are aware, but National Rural Health Alliance research has indicated that there is at least a $2 billion underspend per capita in rural and remote areas across Australia just on Medicare rebates alone per year. That money is disseminated. Obviously Queensland has a significant percentage of that, being the largest distributed population base across rural and remote areas in Australia.

CHAIR: How do we get our hands on some of that funding if we have a $2 billion underspend in Queensland?

Ms KING: How do we even get our hands on the data?

CHAIR: That is true. Where did you get that information from?

Dr Halliday: The National Rural Health Alliance, the Rural Doctors Association, and obviously the colleges have the data. The references are in the college's submission, so you have access to the references through that.

CHAIR: You talked about cuts to Medicare, rebates and no consultation. What impact has that had on GP services out there?

Dr Halliday: If I can reflect on two practices, for example, that are directly affected on the Darling Downs. Stanthorpe Hospital has integrated the 2019 extension program whereby in small rural towns they are able to accept bulk-billing rebates for patient attendances on behalf of the local rural emergency department with the purpose of creating a local fund which would then be expended on initiatives to improve access to primary care for community members. This opportunity was also afforded to Chinchilla. With the recent changes, noting that this initiative was based on populations and communities of less than 7,000—certainly the Modified Monash Model is a good standard in terms of access-to-care issues—they also have a retrospective clause in terms of capturing rural township populations between 5,000 and 7,000.

The result is that as of 1 January 2022 Stanthorpe is no longer able to access this fund. In the time that we have been able to access the funding, in the last six years, that funding has allowed us to build our registrar training program to 2.2 full-time equivalents, which has been backed by funding from the local hospital and health service district to enable us to employ up to four full-time-equivalent general practice registrars working in the hospital setting. It also provides over four full-time-equivalents into private general practice into the town. By removing that funding opportunity, which has obviously benefitted us in terms of being able to provide extended-hour care and integrated primary care into the community, it potentially affects a cumulative eight FTE positions in the Stanthorpe Hospital. We have retained a budget to cover 2022, but for 2023 that will have a potential significant impact if a funding source is not found.

Cumulative effects are being felt in Chinchilla in terms of the development of its uni-doctor workforce to work alongside the senior medical workforce and provides succession planning and sustainability. There are other models in other states, and certainly they are developing a pilot model called the Murrumbidgee model based out of Gundagai along similar lines of some of the programs that we have implemented in Stanthorpe and out to Chinchilla. Unfortunately the funding streams are

very nebulous at times and those federal funding streams which support primary care integration have not been provided as long-term solutions which are needed to establish considered services within rural and remote practices. As you would understand, you actually need time and the ability to attract a core group of trainees to provide considered training to allow a certain level of pastoral care, both amongst the training group but also for senior doctors to provide that level of care as well and to continue the succession planning process which is needed to make rural communities sustainable in terms of the delivery of health care. ACRRM as a college obviously supports the trainees in that environment, but not having the funding streams to promote that does affect ongoing training and workforce programs into the future.

Ms KING: I am very interested in what you have had to say about the quite bespoke funding models, by the sound of it, that have been created on the Western Downs. I note that earlier in the day we heard from a member of Services for Australian Rural and Remote Allied Health, Rachel Tosh, who is a speech pathologist. She talked about the very significant work that was done by her and other allied health workers to support, sustain and patch together an allied health speech pathology, OT and paediatric physio service for Chinchilla. It strikes me that from submissions in these hearings we are hearing about communities and the doctors and health workers who care for them having to put together patchwork funding models and patchwork service models where and how they can to try desperately to meet the needs of communities and that really the basic funding models are simply not fit for purpose. I would like your thoughts on that.

Dr Halliday: There is probably a significantly layered approach to the reasons that is the case. Coordination around that service delivery and needs analysis occurs at different levels. The needs analysis can occur from the primary health network, which again can only provide short-term funding arrangements to provide ad hoc solutions, generally on a short-term basis, with challenges for providing ongoing care. Then you have core needed service provision, which is provided from the hospital and health services into rural and remote communities. Generally, there is not enough caseload to provide full-time-equivalent positions in smaller rural towns. They generally have an outreach service which might be supported by private services, and in the case of paediatric caseload there might be some NDIS service funding which again might be based on need. There are individual assessments and there might be limited access as well to that service because there is no-one to provide that service or you have a quick turnover. The local hospital may get outreach services from a regional hospital. In the case of Dalby and Chinchilla there might be outreach services from Toowoomba, or Dalby might service Chinchilla, but there is not necessarily any correlation or networking of the pathways to care for those people in the community.

As part of one of my previous roles in continuing engagement with Darling Downs through my role as an ex super in Stanthorpe I have been involved on the HealthPathways project. One of the things I have seen over time is that service mapping is an extreme challenge, often because you have many disparate programs in rural and remote areas which have multiple different funding streams, as you have identified, and these programs sometimes crop up as fast as they go because of the limited funding opportunities available. The ability to bring that all together is very difficult because you do not necessarily have managers in those rural areas who have the longevity and corporate knowledge to bring that all together because of the frustrations that are part of that because of the inability to provide coordinated care. So there are significant challenges with that, and I appreciate the challenges raised by allied health parties in bringing that to your attention.

Ms KING: I have a follow-up question which is slightly different in its approach. We have some data before us in relation to the Darling Downs HHS. In the financial year 2011-12 the total number of walk-ins at Darling Downs HHS hospitals to emergency departments was just under 31,000 people. In the last financial year that number had risen to over 130,000 people. I wonder if you can reflect on why you think there might be such a sharp increase in that 10-year period of people presenting at emergency departments in your region.

Dr Halliday: Of course you have to look at the quality of the data that is being provided as well.

Ms KING: That is Queensland Health data, so it is direct from the source.

Dr Halliday: In terms of the collection of that data, that would more than likely have come out of the Emergency Department Information System. The Emergency Department Information System was not rolled out in Stanthorpe until 2013. In the sense of the digitalisation of the data, you have to look at how the data has been input—

Ms KING: I might just briefly interrupt you there and note that in 2014-15 there were 102,500 and in 2021 there were 130,000, so on that basis alone we have seen a 30 per cent increase in that five-year period.

Dr Halliday: It is an interesting breakdown of the data. It is recognising—certainly I am aware of the crunching of the data through my role with HealthPathways on the Darling Downs—that the majority of emergency department presentations occur outside of Toowoomba. There are 17 rural hospitals of varying sizes across the Darling Downs. There have been significant increases, particularly in terms of the morbidity associated with chronic disease development in the Darling Downs, the ageing of the population and accessibility to general practitioners. Even though around Toowoomba the ratio of general practitioners and access to regional practitioners is reasonably on par, when you get into the rural spaces you will find that those ratios are going to be more stretched. There is a combination of access to general practitioners but also increasing issues associated with the core population we are treating and the greater effect of, for example, a climatic variation in health related comorbidities. When you look at that data, we had a significant period of drought in that time frame with significant issues around socioeconomic distress and financial viability, particularly in the rural areas. So issues around affordability is a thing and patients seeking care late, and that has not just an effect on the rural hospitals but also on more complex related presentations, as they might then go to Toowoomba to seek a higher level of care at the site.

Ms KING: Thank you, that is very helpful.

CHAIR: Thank you very much, Dr Halliday, for the work you are doing out there. We really do appreciate your contribution and highlighting the challenges for our committee's inquiry.

HOUGHTON, Dr Kim, Acting Chief Executive Officer, Regional Australia Institute (via videoconference)

CHAIR: Welcome, Dr Houghton. Would you like to make an opening statement and then we will move to questions?

Dr Houghton: Thank you for inviting me to appear before your inquiry. I should say I am not a useful doctor; I have a PhD in economics, so it is not particularly helpful for the health matters. I do know a fair bit about regional Australia and the things that are helping and hindering the health workforce in regions, and that is something I will touch on quickly. The Regional Australia institute is a not-for-profit think tank that was established 10 years ago—we just celebrated our 10-year anniversary. We are currently funded by a mix of governments, including the Queensland state government, to do work on research and policy that relates to growth in regional Australia. We have had some focuses on health in recent years, but I will draw a little bit on that if you like and I can send some of that work through if you wish.

There are three things I want to highlight now. The first one is around the health jobs issue. I know you have heard this from other people. The number of jobs that are needed is very well known. I want to let you know we do have an online vacancy map which shows about half a dozen regions across Queensland and the number of jobs that are advertised each month. The data is current up to October this year, so it is very current. It comes to us from the National Skills Commission. If you want to keep track of that and use that as a general tool for seeing what those vacancy numbers are like, that is there.

We have two levels of occupations, professions but also underneath that there is some more detail. At the moment, for instance, outside of Brisbane there is about 4½ thousand professional jobs vacant for employers in regional Queensland of which about half are in the health field. Half is important, but it is not the whole story; there are other professions that are needed as well. Around 1,200 of those are medical practitioners and nurses, and around 700 of those are health diagnostic professionals. They are in hot demand. You know that, but I wanted to give you that resource.

On top of those professions, there is also the health workers. We have about 2½ thousand carers and aids who we know are a really important part of the health system more broadly and the NDIS as well. There were 2½ thousand vacancies in October across regional Queensland. Those numbers have steadily been growing. They have had enormous growth over the last 12 months, but they have been growing steadily over the last decade and there are another 330-odd health and welfare support workers. Those numbers are there and we track those monthly. We do some analysis which compares the growth in demand by growth in population. You can see some interesting trends where, generally, the greater vacancy numbers are in places where people are not going, so west of the Dividing Range essentially; those were in the regions. Probably a fair bit of those are background things.

The second thing I want to touch on quickly is around the importance of housing and perceptions of liveability in attracting and retaining the health workforce. You will have heard this from other people, too. We have just finished a lengthy study with the Western Queensland Alliance of Councils on housing needs across those 22 inland council areas. The fascinating thing for us was, sure, there is an undersupply, but around half of the undersupply was in units and apartments. Those are largely targeted at locals who are downsizing, but also professionals who are coming in and going out. We have had this significant underinvestment in housing in regional Queensland for probably a decade or so. The interesting thing for us is the real need for that at the moment is in not so much detached housing, which people think about when they move to a regional area; but we need more supply of units, apartments and townhouses because that is what a lot of our professionals are looking for. The market is really not delivering that at all. We know that is one of the factors that professional couples in particular think about when they are choosing whether or not to relocate to a regional location.

The last one, building on that desirability factor, is this disconnect between the aspirations of young people in regional Queensland in terms of their career paths and what jobs they think might be available in the area and the ability for them to actually pick up and learn those skills in region. We know that when Dennis Napthine founded a sizeable report for the federal government, which was released in 2019, it chronicled the decline in availability of learning in those more advanced courses and qualifications in region. The federal government is responding and, as you probably know, they have just appointed a Regional Education Commissioner, Fiona Nash. It is part of that process; it is a good start. From our point of view we have really been seeing a reduction in the availability of TAFE courses, a reduction in the availability of uni courses in regional centres and in other places, too. The only thing that personally I have seen that starts to turn this around—

CHAIR: I am waiting for a horse or something to neigh in the background!

Dr Houghton: Do you like Great Danes? It is great working with two Great Danes! I would normally be in the office, but I have got caring responsibilities today. My wife is in Sydney having a post cancer treatment check-up, so I am here looking after the kids and the dogs. The kids are much easier to manage than the dogs. The dogs are a law unto themselves. I just ignore them, so please do as well.

Just coming back to that learning issue, the most interesting thing I have seen of these regional university centres, which are not campuses of universities; they are community run places that support learning across a range of institutions but they are doing it in region. The feds have supported quite a lot of these around the country. I know there is a proposal in Queensland through the LGAQ, the Local Government Association, to seek further Queensland government support for establishing these centres in regional Queensland. They are doing amazing things because they are allowing people who are deeply embedded in those places—smaller places as well—to do that post-school learning, whether it is at TAFE or uni, in region. While it was initially conceived that that was mostly going to appeal to young people so they would not have to transition to a uni elsewhere, they are actually finding that most of the people are older. Because they have deeper roots in those communities, they are really welcoming the ability to do some of that learning in region.

We know there are lots of studies that the national university networks have done that show that the more learning, particularly in the health sector, that can be done in region and the less overflow there is in terms of doing some of those prac placements in a city, the more likely people are to stay practising in regions. Bringing back some of that student support in region through these sorts of mechanisms is one of the most exciting things I have found in the last few years around trying to bring back the capacity for people in region to learn in region and thereby practise in region. We know if they have those deep roots in the community already, they are much more likely to stay and practise. Whether it is allied health or social support or medical practice, they are much more likely to do that when they already have those deep connections.

They were just three things I wanted to highlight. I am not a health expert. There are lots more people who are focused on providing those health support systems to a range of health professionals. We do know what is happening in regional Australia and we know that the health sector is a really important part. It is a great provider of jobs. We did some research a while ago and found that about half of the health sector jobs are really high-wage jobs and about half of them are low-wage jobs. They are a very significant contributor to regional economic growth and they are one of the real determinants of liveability. They are both a contributor to liveability and a determinant of liveability. We know that when there are lots of jobs available across regional Australia, people have a range of places they can choose and they will pick the place that resonates best for them and that has some of those key liveability characteristics. There is a real double whammy win; if you can start to build up that health workforce in a place, there is a real benefit further down the line as well.

CHAIR: Thanks very much. Having worked in rural Queensland and certain centres in my clinical career—I will get it out of the way now because my colleagues will say something—

Ms KING: We were not saying anything.

CHAIR:—in the paramedic arena for the last 30 years, I know that it is difficult to attract people. I also co-chair a regional forum. We have just come from Mount Isa, Cloncurry and Charters Towers. We are hearing the same thing. It is slightly outside the scope of what we are talking about, but it is linked. If you want to attract and retain rural GPs and allied health professionals, be they nurses, nurse practitioners or whatever, you do need suitable housing. I will say the Queensland government has invested the single largest investment in housing since the Second World War, $2 billion, and we have the numbers of distribution.

Mr Molhoek interjected.

CHAIR: I think it is great.

Mr MOLHOEK: It is a great promise.

CHAIR: I have the breakdown, too, Deputy Chair, of where those will go. There were a couple of other points. The feds pulled out of Aboriginal and remote housing, put it in the too-hard basket and gave it to the state—NRAS, the National Rental Affordability Scheme. There are a couple of other factors in that. Getting back to the terms of reference, when we have a shortage of GPs, it is about how we fix that. We have been hearing from submitters today, 'I can't get to my GP because there isn't one.' Therefore, the pressure on the public health system has increased. What commentary can you provide around that? I know you come from an economic background, but there is a real impact on people living in those communities.

Dr Houghton: It is huge, as you will have been hearing from people today. We did a quick count of the federal government's budget around regional health—they put out a regional statement when they do the federal budget. By our quick count, the feds alone were spending about $4 billion trying to place GPs and only GPs in regional places. It is an absolute massive amount of money. That includes everything from those subsidies for people to take up surgery practices and some of the incentives for regional medical schools. If you put all that together it is about $4 billion. It is not as though we are not throwing a lot of money at this, but everybody knows it is like housing: there are a lot of moving parts in this particular puzzle.

CHAIR: Kim, we just had a submitter, Dr Daniel Halliday from Stanthorpe, quote that there is a $2 billion underspend in rural and remote Medicare rebates. In comparison to what you have just said, I think that is a really interesting contrast.

Dr Houghton: Is that because the services are not available in regions? Is that why there is an underspend?

Ms KING: I believe so. It is a per head of population Medicare spend on Australians and then the mapping of that across Australia, including regional, rural and remote areas.

Mr MOLHOEK: Either that or they just breed them tougher in the bush! I know how hard it is to get my father-in-law to the doctor.

Ms KING: Shall we put that to them when we go on our regional travel, Deputy Chair?

Mr MOLHOEK: Probably not, member for Pumicestone. I just remember how hard it was to get my cattle-grazing father-in-law to the doctors.

CHAIR: We will let you continue, Kim, and then we will move to questions.

Dr Houghton: Both ends of the table find that deeply troubling, don't you? If people are not getting the treatment they need for whatever reason—whether they think they do not need it and they should be getting it or whether it is not available—that is deeply troubling because there would be a long tail of that for the rest of the community.

My point was there is a lot of money being spent on this and a lot of the building blocks are in place, but we are still not getting the results we need. I have noticed over the last couple of decades the important reliance we have on overseas medical people. It could be anybody from the family who owned the pharmacy in Coober Pedy when I was there a couple of years ago, who were all Sri Lankans. They had been placed there by their migration agent. They were quite happily contributing to that community right through to the professionals and GPs. I know we have been relying on that a lot. Whatever we are doing domestically is still not quite meeting the mark and getting that growth happening that we need to see.

For me, it is partly around the aspirations of our young people in regions. We know we are going to get much better 'stickability' if we can get that training and learning happening for regional young people who are interested in a medical career, they are much more likely to stay and practise in a regional setting. We know that from lots of research that has been done by the universities themselves.

Ms KING: We have heard a fair amount of commentary today about the number of medical training places in Queensland universities and in Australian universities as opposed to the import of overseas trained medical graduates. Perhaps for some members of the committee it has come as a surprise to understand the extent to which those training place numbers are controlled by the colleges. Do you have any views about whether the number of Australian medical training places needs to increase to ideally satisfy our health workforce needs?

Dr Houghton: I would normally say no, but as part of some work we were doing a couple of years ago around these connections between employment and training and learning systems—and this was in Victoria—the most cited problem with growing that health workforce was the lack of availability of training places and training places specifically in regional Victoria. No, I do not know what the number is, but the feedback from that research, which was all regionally based interviews, was that the sheer availability of training places was not keeping up with demand. I would say on the basis of that, it is quite likely that we have a serious undersupply of those training places.

This also comes down to where those training places are. I know there are a couple of regional medical schools and that kind of helps. However, a lot of that training is still centralised in the capital cities. That research that the universities do tells us that any time that chain is broken, any time part of that learning happens outside a region, people are slightly less likely to go back and practise in a region. For me, it is all about rebuilding that regional system and those regional placements.

There is a bit of a business side to this, too. Again, this research in Victoria suggested it was partly because of the employers. In some ways, they were reluctant to take placements because they felt there was a net cost to them. Unless they were really aware of the social good, they felt like there was a short-term net cost to them in hosting these placements and that was taking their staff away from other work. In a tight labour market you can kind of understand but you would want those employers to have a slightly more socially minded perspective.

Ms KING: It is certainly not a cost neutral proposal to take on a trainee. There is no question about that. I know from my other life that it has been quite a gruelling process to convince some private hospitals to take on medical graduates and trainees. Again, props to our Queensland public hospital system for the amount that they invest in ensuring that there are Queensland trained medical graduates. I reflect on the fact that, when I went to university, there were one or two medical schools in Queensland and now I believe we have four so there is clearly growth going through that system. They are very interesting ideas.

Mr MOLHOEK: Dr Houghton, what do you think Queensland Health and the primary health networks should be doing better to make sure that people in regional Queensland get the care and access to services that they need? I know it is a big question.

Dr Houghton: It is a very big question

Mr MOLHOEK: What are two or three things you think we should be doing more of to improve access?

Dr Houghton: There are a lot of aspects to that. I would pick one that maybe has not been given much consideration. I will step aside from the GPs and the placement of GPs for a moment. For me, a big part of the overall health package is the allied health service provision in regions. There has been an interesting spread in the demand for and supply of some of those allied health services. Diagnostic and imaging services are moving into smaller and smaller towns as the large-scale providers of those look for growth opportunities. I know there are issues of licensing around some of that equipment. I do not know the current stance of the PHNs or the Queensland Health policies and programs, but I would be looking to make sure there were not any unintended ceilings on the availability of licences to run those sorts of diagnostic practices in regions, given that the demand is there from consumers and there is also interest from investors in expanding their networks to provide those sorts of things in regions.

I would suggest another thing related to that. This is a bit off the wall, I know, but it comes from my background in small business and entrepreneurship. We know that the allied health mix is one of those liveability factors. It is not just whether there is a hospital and a doctor but whether there is a range of allied health service providers as well. Most of those are independent business operators. There are some really good learning tools in the economic development space around developing clusters of businesses with particular specialisations. To my knowledge, that has never been applied in the health sector, and it is just sitting there as a relatively easy win.

We are looking at active cluster development of allied health practitioners in some of those smaller centres so you are helping people to build the business case. When they are coming in to open those practices, you are giving them the mentoring and support. You are connecting them and networking them with each other and trying to build that early stage demand so that those businesses have a better chance of survival.

I know that is way outside the remit of the PHNs because they take that sort of system as a given, but in my background in business development it is not a given and what we are trying to do here is provide those business skills and nurture those individual operators who are going to provide those services in a regional setting so there is more chance that they will practise and bring those much needed services to those places. I know it is a bit sideways and outside the terms of reference, but it is an important part of the mix for me.

Ms KING: It strikes me that that work might almost fall into the remit of the RDAs, the Regional Development Australia regional organisations. I know we have one in Moreton Bay, and I could picture them doing that planning work to assist specialised health precincts to develop, for example, because they do that work in other industry sectors.

Dr Houghton: They do; that is right. The Queensland government does a terrific job in manufacturing, for instance, but to my knowledge there is no extension of that knowledge and those techniques into the services sector, and health services in particular. Again, you have got lots to draw on in the state; it is just a matter of recognising that this is something that may deliver some good outcomes for the smaller towns.

Ms KING: I will mirror the deputy chair's question by asking how you think the federal government could do better to back in our allied and primary healthcare systems so that we do not see the absolute flood of presentations to our public hospitals that is threatening to cripple them.

Dr Houghton: I am really not sure how those Medicare funds flow from the federal government to the states and then to the providers, so I cannot comment on any of those financial mechanisms. The federal government really have not had a big stake, I do not think, in any sort of active sense in developing that capability across regions. They have really left that to the states and the primary health networks around the regions. They have defaulted back to some of these broad issues around university funding, GPs and some of that migration related work. In that migration space, we need to do a lot better in terms of skills recognition. We have lots of migrants who have landed here who are not practising in the fields in which they are qualified. That has been a very slow take-up. Particularly now that those external borders are closed, we really need to make the most of the people we have here at the moment. That really is a federal responsibility fundamentally.

I am not sure whether there are any direct interventions the federal government can do to stimulate the allied health sector. I presume you have spoken to SARRAH, and Cath has a much better sense of what the particularities are about that. For me, it is more about that overall maintaining the viability of some of those communities as places in which it makes good business sense to practise.

Ms KING: Thank you.

CHAIR: We will end this session. Thank you for your contribution. We appreciate it.

RASHFORD, Dr Stephen, Medical Director, Queensland Ambulance Service

CHAIR: Welcome, Dr Rashford, and thank you for being here. I start by declaring that I have known Dr Rashford for a very long time. We have done some interesting things treating people in some very remote parts of Queensland over the years. I think one included a call when you were on call in London, and I reached out and it all worked. Congratulations on the remarkable write-up the *Sunday Mail* just did on the work you have done with the Queensland Ambulance Service. You should be really proud of that. I just want to put that on the record. You above all people would know the significant impacts on our public health system. We have some interesting data that Queensland Health has provided. Would you like to make an opening statement before we move to questions?

Dr Rashford: I appreciate the very warm welcome, and thank you for the opportunity to present today. Like others, I pay my respects to the custodians of the lands on which we meet, the Jagera and Turrbal people, and their elders past, present and future. The QAS has a very disaggregated health service across many traditional lands, and we work very carefully with the local people.

I would like to paint a picture of some of the work that we do. I am cognisant of the time of day and that it has been a very long day for the members. We respond from over 300 locations across the state and we are the busiest ambulance service in the country. It is important to set the scene about the patients we take to hospital. Data is everything. I am sure you are familiar with the triage categories when you arrive at hospitals: category 1 is a cardiac arrest; category 2 is chest pain, seen by a doctor within 10 minutes; category 3 is significant abdominal pain, seen by a doctor within 30 minutes; category 4 is maybe a moderate fracture, seen by a doctor within an hour; category 5 is most likely an ambulant patient, seen by a doctor within two hours.

What I would propose to you is that the majority of patients who get transported by the QAS actually do need to go to an emergency department. We take about 30 per cent of patients across the state to emergency departments, and about 70 per cent of patients who attend an emergency department walk in. That does not mean there are not sick patients in the walk-ins, but the difference between an ambulance patient and an ambulant patient walking into the emergency department is most significant in the lower ends of acuity. What I mean by that is that the ambulance patients are disproportionately sicker.

There is about a six to seven times chance of being admitted if you are given a category 5 when you arrive by ambulance. If you are looking around South-East Queensland, on any given day, only seven to eight of our patients from the Sunshine Coast down—so the majority of our population—actually get a category 5, so if someone thinks they are sick. Of that, two to three of them are admitted into hospital. That goes to about 40 per cent for category 4s and about 60 per cent for category 5s. It is almost logarithmically disproportionate, your risk, coming by ambulance. That does not mean we should not look at ways of ED avoidance, and I really do not like that term. I think we should be looking at what is the most appropriate place to care for our patients, and often that may not be in an emergency department.

We have done a lot of work with our mental health patients and people suffering mental crisis. We have seen that go up by 20 per cent year on year in the last three or four years. We are very fortunate to have had a lot of investment from government to take outreach teams into the field and we have mental health co-responder programs. In fact we are treating people in their house. What we have shown from that, for instance, in how we can take pressure off the system is that it takes about two hours from the time they call triple O until we finalise their care, whereas it takes about 11 hours if that same patient goes into the hospital system.

We need to increase the efficiency of that system. We are bringing on four to five units per year for the next three years, counting this year. That has been very successful. We have introduced 24-hour mental health clinicians in our operations centre in Brisbane, supporting the entire state. That provides support to our paramedics and our patients on road. We are gradually bumping that up because we recognise that this is a group of individuals who are best served by not being treated in a busy emergency department but being closer to home and closer to their care and organising follow-up care.

In terms of aged care, that is difficult. As I head towards the twilight of my career, I am very concerned about aged care because if all of us live long enough we will end up there. It is very important that we provide the highest levels of care that we can for our elderly community members. They deserve that. They do not deserve to be discriminated against. It does not mean that they need super aggressive care; they need what is appropriate based on their individual needs and it should be nuanced. We are very fortunate that there has been increased funding which supports the QAS

via the extended care programs from the HHSs in aged care, so the residential aged-care teams. Hopefully, their coverage will be even broader which means our paramedics can integrate into those teams and support people to be in their home.

We need to have a much more coordinated approach about what people's wishes are for care and to respect those wishes. I can think of two calls this week where we have not transported people to hospital despite the aged-care facilities preferring that option. It is about supporting those aged-care facilities to look after someone when they are not used to doing it or maybe they do not think they have the capability. It is about enhancing their capability. I think they are all incredibly committed. It is one of the heaviest workload areas in the whole health system. I always ask our paramedics who join us as graduates who has actually worked in aged care because I think it gives them an incredible grounding on how to deal with people and the challenges.

We work very closely with the PHNs, and I am sure you have heard from them, and our general practices, but the reality is if we accept that the majority—not all—of QAS patients are not general practice patients. Everyone says these category 3s, 4s and 5s can be managed in a GP with the right setting, but the business models of the GPs do not work that way. If you say that 40 per cent of category 4s are admitted, you can say that 60 per cent did not need to go there, but you know that once you have got the ultrasound, the blood tests and the radiology and you have actually had a very senior person look at them. Most general practices are not going to be able to sit and watch someone for four to six hours. It is just not possible, unless they are a dedicated service.

I caught the last part of the last expert presenter on that. In fact, we need to have hubs that can provide a level of care that can accommodate some of these patients and take the pressure off the emergency departments and for the odd patient that then requires admission not see that as a failure but have a streamlined approach for doing that. I think some of the work of the satellite hospitals may be good for that. In general, the QAS is trying its best to work with the broader system. The last 10 years has been an absolute evolution, under previous commissioner Bowles, to engage more broadly in the health system, and we will continue that charge because we are a mobile health service and we try to work with our partners to provide the best care.

CHAIR: Thank you very much, Dr Rashford. It is interesting that you touch on the last 10 years. I certainly commend former commissioner Bowles for the work he has done. We have received some data from both the QAS and the Department of Health on those walk-ins that you mentioned. I will get to the walk-ins in a moment. As to the QAS demand for service per LASN, I just pulled four out of the 17 LASNs we have: Cairns from 2011 to 2021, 51,000 to 76,000; Townsville, 56,000 to 76,000; Metro South, 171,000 to 256,000—I am sure these figures are not a surprise to you; and Metro North, 168,000 to 235,000. That is proportional to population growth rates, of course. Then when we look at the walk-ins that we have, it is staggering over that same 10-year period. In Townsville it is 42,000 to 79,000. In Queensland all up, there were 1.2 million a decade ago and there are 2.4 million walk-ins now. For most of the submitters we have heard today, the people they represent cannot access GPs and, therefore, the pressure goes on to the EDs. Do you have a practical example of that—of someone you might know who could have been treated by a GP who ended up going to a hospital? How do we fix that?

Dr Rashford: I have a family example in the last week. I ended up driving them to hospital. They probably would have called the ambulance had they not had someone who was able to risk-assess them. When they looked at their general practitioner, they could not get in until next week. Most general practitioners do keep the odd appointment, but it is very difficult to access someone. Whilst I would propose that the patients who call us are sick and need to go to an emergency department, there would be a percentage of those people who, had they been able to access care three or four days earlier, may well have avoided it. That is not all, but there is a percentage.

I think most people find it difficult to access care in a timely fashion. The QAS is 24/7, along with HCC, the health contact centre, which is now with the QAS. That is the portal of entry into the healthcare system. It is a very safe portal; it is a very professional portal. I cannot blame people for calling us. I would, too, if I was in need. The alternatives just are not there.

A number of my friends are general practitioners. It is not that they do not care. The world has evolved and perhaps people's work-life balance is different. I think the colleges will be much better placed at that. It is one of the reasons we get called. For people who are suitable for a general practitioner we will call their general practitioner, and generally if the ambulance paramedic speaks to a clinician—the general practitioner or the practice nurse—we can get that person seen immediately, but not always. We are trying to redirect people where appropriate. Of the people we go to, only about 65 per cent of patients end up in a public emergency department, so the other 35 per cent we are putting into private emergency, into their GPs or into alternative pathways.

Primary health care is important. I think it is also important for people who have chronic illness. For instance, people with chronic lung disease sometimes start to get an exacerbation. They are often very fearful. They need to talk to their treating clinician, who can talk them through a management plan which may avoid going to hospital, getting a hospital acquired infection—that is just a normal complication that can occur. They want to be treated at home where possible. They do not want to go to hospital. Sometimes it is the only way to get access to the care that they need. Most people who call an ambulance in the middle of the night are not suitable for a general practice. There is something wrong with them. You would know that, Mr Chair, from your experience. We need these options. We need the whole system working together. We have to because we cannot continue traditional models. They are not going to work in the long term.

Mr MOLHOEK: Thank you for coming today. After the *Sunday Mail* article I almost feel like I should be getting your autograph before you leave.

Dr Rashford: It is a little bit bigger than I expected, trust me.

Mr MOLHOEK: Thank you for your extraordinary service to Queenslanders. What an incredible life you have led. I spent a day in a high-acuity ambulance about three years ago and it was an incredible experience. We went to about five or six fairly challenging circumstances. It was certainly an eye-opener for me. I just wanted to ask about ambulance lost time. I note that the director-general made reference to that in his opening remarks to this inquiry. We have been hearing about the volume of calls to ambulances and we have also been told that the amount of lost time has reduced by 20 per cent. I am not sure on the time lines. I am wondering if, perhaps on notice, we could have some data on lost time while ambos have been ramped over the last five years.

CHAIR: With respect, Deputy Chair, it is completely outside the remit. I did raise this when the director-general was here. I would ask that you rephrase your question. I am sure the good doctor might allow some latitude in some answers, but he has just talked about the impact of the service. It is outside the scope.

Mr MOLHOEK: We did allow the director-general to talk about it in his opening remarks and you did not pull him the up on that then.

CHAIR: Just to clarify, I allowed latitude. I am going to allow some latitude with the good doctor.

Dr Rashford: I will be honest: I am not the expert—despite the paper—in all things. Obviously as part of the senior executive team I am across the issues confronting the Ambulance Service, not just in Queensland but worldwide and certainly Australia-wide, in terms of not being able to access into the emergency department and so-called ramping, or POST—patient off-stretcher time—elevations.

In the last three or four months we have seen an improvement in our patient off-stretcher time, and that has been significant. Obviously we want it to continue and get even better. The government, through the Care4Qld strategy from the minister, has invested with the broader health system, because patient off-stretcher time is actually not an ambulance issue but it does affect us. It is very much determined by the broader health system and the efficiency to move people through the system and through the emergency departments. With our partners within the hospital and health services we have engaged to develop strategies to improve that. We are starting to see that. This is not something that you can change overnight.

As I said, I do not think anyone around the whole world has the answer to this. It reflects that the entire systems are getting busier and busier, with an ageing population and the people presenting to emergency departments getting sicker, not less sick—certainly those who present by ambulance. We constantly look around the world and look across the other jurisdictions for the silver bullet. There isn't one. I think Queensland is a very innovative state—clinically, technologically and in a whole lot of other ways—and we are starting to see some improvements, and not insignificant improvements, in the last three to four months. We want that to continue. In terms of the figures, I would have to be guided. I am not sure of the rules.

CHAIR: Thank you, Doctor, for answering that. The director-general answered that with latitude. You have answered it with latitude. I am ruling out of order data collection on the member's question. That is probably best left for the House, Deputy Chair. I want to stick within the lanes of the terms of reference and the impact on the demand for service which Dr Rashford has explained. Whilst you think of your next question, I will go to the member for Pumicestone.

Ms KING: In your remarks you have touched on a couple of different programs that Queensland Health has developed to, as I see it, fill the gaps that we see in primary and allied health care. Some of those are the mental health co-responder model, which we know is working so well, and the

extended care program for aged care where people are not able to get the health care they need in their residential aged-care facility. You also mentioned the satellite hospital program. I am a proud advocate for not one but two satellite hospitals in and near my region, but I would also note the LARU units, the low-acuity response units. They are all examples of Queensland Health developing services and innovative models, trying to evolve to address what I would suggest are gaps in primary and allied health care to stem great need in the community that results in those gaps. I wonder if you are aware of any examples where we are seeing the Commonwealth government make similar evolutions or develop new and innovative models to help address those same issues.

Dr Rashford: I am probably most familiar with the state government initiatives due to the role I play. The PHNs would be able to provide that area of clarification. You see different things along the lines of respiratory clinics and the like, but really most of the innovation in this space has been on a state basis. This is long term. There is that disconnect between Commonwealth and state with the coordination of care. With primary care obviously being under the Commonwealth and hospital based care being under the state, you can see that there is a disconnect often to achieve common goals. It is not because people do not try to do it, but we just need to have the will to actually achieve the results. I guess people need foresight to say that by doing some of these initiatives we will ease the burden on our hospital system, both public and private to be quite honest, and galvanising. We are seeing that. Certainly with the PHNs and our general practice partners the will is there and they are wanting to do that.

I hate to go towards remuneration and talk about some greedy doctor or anything like that, but they have businesses to run and they just cannot afford to provide that level of care. Physicians and even other healthcare providers are still expensive assets in our society. To provide care outside of a model where you are turning people over—the analogy is having a bespoke restaurant as opposed to someone who turns over lots of meals, and that is the model of most general practices. For them to move from that model across to providing a bespoke meal at an aged-care facility is really difficult. Unless we recognise that we need to be prepared to pay for that meal or have something else go on, you are going to find that patronage to that restaurant is not going to be very good—or the provision of care. I hate saying it is a money thing, because I am not a person who thinks we should just throw money willy-nilly. We should get bang for buck. It is the public's money. That is what we think about at QAS. We should be trying to get the best outcomes for our patients for the funding that we have, but there just needs to be investment in some areas. According to my colleagues, they just cannot afford to do that.

Ms KING: Are there any programs that I have missed where Queensland Health is reaching into that allied and community care space?

Dr Rashford: There are lots. There is Hospital in the Home. I think there is some of the legacy stuff with COVID. COVID has been an incredible challenge for us more broadly across the health system and it will continue for some years, to be quite honest, because we are not sure what will happen. I think some of the good legacy things from COVID will be innovations in care. I have noticed that we have been able to change processes at almost light speed and pivot like we have never done before, because people are galvanised and are willing not to take a chance on people's outcomes but to take a chance that we can do that, and the obstructions disappear at all levels.

I am hoping that we have learnt from that that we can actually see great ideas that are often driven from the ground up. Our paramedics email me all the time saying, 'I have an idea.' Sometimes we can do it; sometimes we cannot. Some of our best ideas across the whole health system are driven either by the general practitioners or by frontline nursing staff or allied health staff. We must not forget about the allied health staff. They are absolutely critical in providing care in the community. Often we talk about doctors and nurses and paramedics, but please do not forget about our allied health care.

CHAIR: That is an important point. We did a body of work with the pharmacists. They want to do e-prescriptions in residential aged-care facilities and actually dispense there as well.

Dr Rashford: We now have two pharmacists on staff at QAS and it has revolutionised our care. I have seen what they have done for the safety of our patients at the QAS. I have no doubt that they are a valuable part of the team and we cannot forget about them.

Mr MOLHOEK: You mentioned earlier that people only ring an ambo in the middle of the night if they are desperate so the cases typically have a higher acuity. How is the system coping with some of the challenges we have read about and heard about in terms of the number of ambulances available overnight and staffing and rosters? You mentioned off-loading about 35 per cent of patients

in private hospitals. How does the off-loading of patients work in the private system versus the public system? There are two questions: how is the overnight system working; and how is it going with off-loading patients in the private health system, in comparison with the public?

Dr Rashford: I will take the question about the private system first because that is a pretty easy answer and a pretty short one. The private emergency departments—and I have worked at them over my 30 years of practice—work on a different system. There are fewer doctors and less nursing staff and so they control their inputs. Our private emergency departments will say, at some point, 'We can't take any more.' Generally speaking, we rarely actually end up with patients not being able to be off-loaded immediately. That is part of their model of service and part of their care charter, but they control their inputs. In the public system, we have to keep taking people. We are the backstop for the health system. Obviously, private care is absolutely immensely important to the sustainability and viability of our broader health system, but they are able to manage their inputs.

In terms of response, I think all ambulance services are facing challenges for a whole bunch of different reasons. We have encouraged staff not to attend work if they have a respiratory illness when perhaps two years ago they would have come. Now we do not want them. That places challenges. Absenteeism does place challenges on us more than it might have in the past.

We do triage all our patients to the best of our ability. We have a very complex and sophisticated triage system. Obviously if you are in cardiac arrest or have a very high acuity presentation, we will have to go to you. Like you would in an emergency department, you triage the people who present with the high-acuity problems before the people with low-acuity presentations.

With these challenges in mind, we have invested by having 24-hour clinical deployment supervisors who are ringing people back constantly. We have invested in a clinical hub where we are now doing telemedicine so we are able to see people. Sometimes we provide their consultation in their home without ever sending an ambulance. Certainly our mental health liaison people do that. We have also invested and now have specialist emergency physicians who sit in the emergency department and are actually ringing people back and providing consultations and ensuring their safety.

Sometimes there are some people we cannot get to as fast as we would like to. I cannot sit here and tell you we can. We want to get to everyone as soon as we can. In those circumstances, we layer as much clinical supervision as we can and we constantly check on people to say, 'Hey, how are you going? What are you doing? How can we reassure you?' and we look for alternatives. I am not going to tell you it is not a difficult environment, but this is a broad issue for all of us.

Mr MOLHOEK: I would have thought that, at the point that someone has rung, they are probably panicking.

Dr Rashford: Yes.

Mr MOLHOEK: I am not sure that a doctor on the other end of the phone talking them through their situation—

Dr Rashford: It depends.

Mr MOLHOEK:—is all that calming if you are already in that heightened state.

Dr Rashford: It is difficult. Interestingly enough, my experience is that sometimes people with very severe illness say, 'Treat everyone else ahead of me,' and then someone who has what may be a small fracture of their little toe will say, 'I demand to be seen.' You have that going on but, generally speaking, when they recognise that it is a clinician—our calls are taken by civilian call takers. They are fantastic people. We thoroughly train them and quality-assure them. We recognise that when we cannot get to people as fast as we should then we need to—and we can—put clinical people on. When they hear that they have a senior paramedic, a paramedic supervisor—we are not getting graduate paramedics to do this; these are experienced paramedic supervisors and they are emergency physicians. They are doing one of two things: they are reassuring people and then they are making a decision on, of the people we need to get to, who would be the next person we go to. We have a computer that tells us, but we overlay that—like having an A380 pilot watching the systems. It is challenging. There is no doubt that we are doing our best and we will have continued challenges into the future, as the rest of the health system does across the whole country. We will continue to try to improve and be as good as we can be.

CHAIR: And it works. I did the CDS training and it works. I am glad you said 'senior' and not 'old' or 'dinosaurs'.

Mr MOLHOEK: Is there any data on the success or otherwise of that system? Do we ever lose anyone?

CHAIR: I think that is a little outside of scope as well.

Dr Rashford: I would say that the QAS is a very transparent organisation and we work very closely with the regulatory bodies including the State Coroner, the Office of the Health Ombudsman and Ahpra across that. With any case that we feel needs further review, we review that and we work with our regulatory bodies and the families to improve our health care, as everyone does. We are not robots: we are going to have cases where we could do better, like anyone else.

Ms KING: Thank you so much for the work that you and your teams do across Queensland every day. Having spoken to your paramedics in our electorates and in our communities, all of us see the toll that it takes on them to be part of these decisions, to be presenting to these jobs. This is not just about statistics to be sought at a hearing, but they are people and they are people in crisis so very often. I do not actually have a supplementary question.

Dr Rashford: I know that you mentioned our paramedics but also our wonderful communications staff and our corporate staff—because unless we have the uniforms, the drugs, we get paid—

CHAIR: It is everyone.

Dr Rashford: We are very fortunate. It is a fantastic organisation to work for. I know it is respected in the community but it takes a big team to get it all moving and we are very fortunate to be part of it.

CHAIR: The Office of the Medical Director is pretty important, too.

Dr Rashford: I have a great team. They say to surround yourself with very smart people and I have done that.

CHAIR: Thank you so much for your contribution. On behalf of the committee, I thank everyone involved in the Queensland Ambulance Service. You do a terrific job. I hope they all get some kind of break over the Christmas period. That concludes the hearing today. Thank you very much, members and Dr Rashford. I declare this public hearing closed.

The committee adjourned at 4.39 pm.