



HEALTH AND ENVIRONMENT COMMITTEE

Members present:

Mr AD Harper MP—Chair
Ms AB King MP
Mr R Molhoek MP
Ms JE Pease MP

Visiting member:

Mr JP Bleijie 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 IMPACT ON THE QUEENSLAND PUBLIC HEALTH SYSTEM

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 9 DECEMBER 2021

Bribie Island

THURSDAY, 9 DECEMBER 2021

The committee met at 9.31 am.

CHAIR: Good morning, everyone. 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 impact on the Queensland public health system. My name is Aaron Harper, 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. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we now all share. With me today are: Mr Rob Molhoek, member for Southport and deputy chair; Ali King, the well-known local member for Pumicestone; and Joan Pease, the member for Lytton. We will be joined by the member for Kawana, Jarrod Bleijie, at a point in time.

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. I also remind members of the public that they may be excluded from the hearing at the discretion of the chair. These proceedings are being recorded by Hansard. Media may be present and are subject to the committee's media rules and the chair's discretion. You may be filmed or photographed during the proceedings and images may appear on the parliament's website and social media pages. Please turn your mobile phones off or to silent mode.

Members, it is fantastic to be here on Bribie Island to talk about the pressures on our public health system. Very shortly I will turn to the member for Pumicestone to highlight what that might look like over the last period of time, but we are very keen to hear about what those pressures are on what is an ageing population. The committee previously travelled the state and did a lot of work around aged care, palliative care and end-of-life care. We are most interested to hear from people about their concerns in waiting to access a GP and about the impact on the public health system. I might pass over to the member for Pumicestone to make some opening remarks. With the indulgence of the deputy chair, given that we are in your electorate maybe you could proceed with the first round of questions.

Ms KING: Thank you so much, Chair and Deputy Chair. I too acknowledge our traditional owners here, the Djindubari people of the Gubbi Gubbi nation, and pay my respects to their elders past and present. I acknowledge that later on in today's proceedings we will be hearing from some of our local traditional custodians in relation to the work they do, which I am so proud to support them in.

I am incredibly proud to be the member for Pumicestone. Given the enormous health challenges of the last couple of years, I could not be more proud of the way our community has stood together and taken care of each other. In particular, on the day when Queensland has reached 80 per cent double-dose vaccinated, our community has absolutely embraced vaccination—with flying colours. Bribie Island is probably the most highly vaccinated community anywhere in Queensland. That is something we can all be so very proud of, because when we do that we not only take care of ourselves and our loved ones but also take care of the most vulnerable in our community. Nothing speaks to our value for health and our care for each other more highly than that.

This hearing today and the hearings that we will go on to do all around Brisbane and throughout regional and remote Queensland are of particular relevance to our community here for a number of reasons. Although we are only an hour or so from Brisbane, people tell me that we experience a very specific kind of geographic isolation here on Bribie that many of you know very well. Some people may sometimes feel that the world ends at the bridge, but it is not just that. We sometimes experience difficulties with transport. People experience difficulties with road access. We can feel a world away from what are fairly well serviced areas in Caboolture and Morayfield. We have our own isolation issues to contend with.

Over the past nine months, around 1,200 community members have signed a petition that I have been running in relation to the terrible shortage of GPs that people tell me they experience. It was the very first issue that was raised with me, even before I was elected: the long waits for GPs

and the difficulty in getting onto the books of the local GP. People tell me that they moved to our community but continue to have to commute for GP care. Given our older community, that is a really big burden to experience. On that note, we are the oldest state electorate in Queensland. I have an ongoing arm wrestle with the member for Hervey Bay. He has slightly more people aged over 65 in his electorate, but we have a greater proportion of people aged over 65. That of course brings its own health challenges in terms of people being supported to age in place and access the very best health care as they do so.

We also have a large number of people in our area who live with disability. Every single day people express to me and to my office the challenges of navigating NDIS, of being approved for NDIS and of accessing appropriate care packages when they have to have NDIS. We are hoping to hear about some of those issues today. In addition, as part of that geographic isolation we experience, there are real problems with accessing specialist care here in our community. Medical practitioners and GP practices in particular talk about issues with recruiting doctors to our area.

These are some of the concerns around health care that are raised with me every single day. Just yesterday in our hearing in Brisbane we heard about the increased presentations in public hospitals that may be resulting from those pressures on primary and allied health care.

DOBBRICK, Ms Angie, Executive Director, Caboolture, Kilcoy and Woodford Clinical Directorate, Metro North Hospital and Health Service

Ms KING: Welcome. I invite you to make an opening statement.

Ms Dobbrick: I acknowledge the traditional owners of the land on which this meeting takes place and pay my respects to elders past, present and emerging. I acknowledge any First Nations person in the room today and acknowledge the community in which I serve as a very proud public servant. I thank the committee for the opportunity to provide the following opening statement.

My directorate forms part of the Metro North Hospital and Health Service, part of Queensland Health. Metro North delivers services to a population of over one million people, from north of the Brisbane River to north of Kilcoy. We provide the full range of public sector health services including rural, regional, tertiary and quaternary teaching hospitals. Our facilities include: Caboolture Hospital; Woodford corrections health centres, delivering health care to the largest men's prison in Queensland, circa 1,400 inmates at any given time; Kilcoy Hospital; Redcliffe Hospital; the Prince Charles Hospital; the Royal Brisbane and Women's Hospital; Surgical, Treatment and Rehabilitation Service; community and oral health, including two public residential aged-care facilities; and Metro North Mental Health services.

In Metro North last financial year, emergency department presentations increased by eight per cent, to 320,000. Admissions from EDs reached 113,740 and, despite pausing non-urgent activity during our initial pandemic response, our staff performed 42,698 emergency and elective surgeries. We performed 1,558,938 outpatient occasions of service—55½ thousand more than the previous year, and in a COVID context. Providing and supporting this healthcare delivery are 22½ thousand staff. They are big numbers.

This year will no doubt demonstrate a further increase in demand on an already significantly stretched system. These demands include conditions that could have been prevented or better managed in the community or other sectors; indeed, service gaps in complementary sectors inevitably impact our public health and hospital system, and we see it every day on the floor. The evidence is well documented of the benefit of good primary and allied health care on the management of chronic diseases in the community and the reduction in frequency and length of hospitalisations due to these diseases. Patients simply do not want to be in hospital if they do not have to be. Their families suffer for it as well, particularly in locations like this where they have to travel to their most local, being Caboolture.

The current community demand far outstrips the available primary and private allied healthcare resources in our area. This means that the acute public hospital sector and community sector are seeing and treating the outcomes of this lack of early and consistent primary and allied health care. This can manifest in frequent attendance at the emergency department, increased outpatient appointments, increased number of admissions and longer lengths of stay. From a patient's perspective, this is a very difficult and at times uncomfortable journey and—as much as I hate to discuss finances—a very expensive journey compared to one provided by the primary healthcare provider who is consistent, trusted and knows the patient, their family and the nuances of their healthcare presentations.

Public Hearing—Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

In Metro North we have identified that if we do not work in partnership with our primary healthcare network, the PHN, we will continue to face overwhelming demand on the system and, more importantly, our community will continue to encounter healthcare delivery that is not timely or delivered in the most appropriate setting. This healthcare alliance with the Brisbane Metro PHN has effectively facilitated and enabled local collaborative action. Its work is focused on improving health outcomes, progressing health system reform and integrating tertiary, primary and community care. Given the time constraints this morning, I am happy to provide the committee with some of the outcomes of that as well.

Amongst all of this, I must not forget to mention the lack of private and primary mental health clinicians and support services. It is an ever-growing issue for all aspects of our community. We have seen an exponential growth since COVID began. The seeking of acute public mental health care should be the last resort for these consumers. Rather, it is the first port of call because of the very few services or significant waiting times—sometimes up to 12 months—in the private and primary sector.

Let me turn to aged care now. In an effort to avoid hospital presentations or admissions of residents of residential aged-care facilities in Metro North, we have two key initiatives amongst others: our geriatric emergency department intervention, GEDI, and the residential aged-care district assessment and referral service, RADAR. There are 90 residential aged-care facilities with approximately 10,000 residents in the Metro North catchment, and it is growing. In the past 12 months the Metro North GEDI and RADAR services made 4½ thousand visits to the residents of the aged-care facilities to support them at their care facility, in their home, to redirect presentations from our emergency departments. Just to give some local context, 11 per cent of those visits have been here in the Bribie area and the Ningi region.

If I take a snapshot of just one of our facilities, in addition to the work that GEDI and RADAR have been doing, in the past 12 months, between December 2020 and November 2021, Metro North has had 1,795 presentations to the Caboolture emergency department for patients who are residents of aged-care facilities. This equates to approximately 149.6—I am not sure how you get the 0.6—patients per month. For patients admitted from RACFs, the average length of stay is eight days. This is much higher than for non-aged-care patients, with an average of five days. The length of stay is often impacted by complex behaviours impacting on the ability to place a patient into or be accepted by the available receiving facilities. It is also impacted on by the length of time it takes for the patient to receive an ACAT assessment.

Commonwealth funding for ACAT does not reflect the growth in demand. We accept 19 per cent of the state's ACAT referrals here in Metro North. ACAT referrals have increased 20 per cent since financial year 2015-16 and, if you take into account the 2.5 per cent increase in staff wages, the Commonwealth funding has not increased since 2015-16. It is a significant issue. It is a significant issue for the families and loved ones who wait for those. Of course, it would be also remiss of me not to mention the lack of resources or even planning for aged care for our ageing and complex comorbid corrections population. That is a whole other conversation.

Finally, I mention NDIS. Across Metro North on any given day, of our overall long-stay patients there are over 80 patients awaiting NDIS placement. Many of these patients have significant lengths of stay in environments not built to accommodate their needs. Instead of discussing the shortfalls of the system, I would like to conclude by telling a patient's story. Actually, it is almost a year to the day. In the week before Christmas last year, on a Friday afternoon at 4.30, I received a call from the local NDIS coordinator letting me know that we were going to receive to our emergency department someone who was being transferred from his local supported accommodation three hours away, because on that Friday afternoon it was agreed by NDIS that he would be moved.

He was a young man who was non-verbal, with complex needs and significant behavioural issues that required compassionate, knowledgeable support. Things that would disturb him were bright lights, loud noises and close contact, and he was coming to our emergency department because the NDIS transfer had failed. He had absconded from the ambulance in which he was being transported to the new accommodation close to our hospital. Further, the new residence had lots of windows and it was decided when he arrived that it would be a dangerous place for him to be, because he might injure himself significantly. All the while, his previous home was three hours away—the place that he was familiar with, with the staff who could support him. So, too, were his loving and extremely distressed family.

The back-up plan for this failed attempt at accommodating him was to bring him to our emergency department with the hope of an admission—to a place that was bright, loud and which required close contact, placing him and our staff at significant risk. In the end, after hours of Bribie Island

negotiation, distress for the family, significant distress for him and almost seven hours of valuable QAS transportation time, including precious paramedic time, he was returned to his original accommodation three hours away from Caboolture.

Our public health services are being stretched. With COVID in our future we will no doubt be under further pressure, but these pressures are also exacerbated by the need to treat patients whose conditions could have been prevented or better managed in the community or other sectors. It is important to address these issues both to enable better patient care and to take unnecessary pressure off the public hospital system. We need to listen to our consumers deeply. I would be happy to answer any of the committee's questions. Thank you, Chair.

CHAIR: Thank you very much, Ms Dobbrick. As is normal practice of the committee, no matter whose electorate we are in, we often go to the local member to ask the first question. Then I will move to questions from members to my left. Member for Pumicestone?

Ms KING: We all are moved and distressed by the story you have shared of that young man as well as moved and distressed by the thought of the flow-on effects for our health workers who were faced with that presentation and all of the people waiting in the ED whose health care on that day was impacted by what sounds like a very unnecessary process. I want to reflect on increasing presentations, with all of the complex reasons behind it—whether it is NDIS, systems issues or people's inability to get to a GP. You mentioned walk-ins to Metro North hospitals increasing from 144,000 in 2011-12 to 320,000 in 2020-21. Do you consider that to be sustainable?

Ms Dobbrick: No, not with the current resources that we have available to us.

Ms KING: Can you elaborate on what your views might be on some of the reasons for that very marked increase in that 10-year period?

Ms Dobbrick: That is a complex question to answer. Today I have highlighted some of the issues. Specifically here are those that focus on the NDIS, aged care and the poor access to GPs—or the availability of GPs, even to be able to recruit them. In addition to that, we have an ageing population who have complex chronic diseases who are unable to access good, supportive primary care, so they turn to public health systems at the last minute, when things are much more acute than they need to be. I am a speech pathologist by background. When I look at the allied health supportive care, even for paediatric care, and the availability and access for young families to access that in the private and primary sector, it is lacking. They turn to us as well, not just for speech pathology but for multiple other things. These children are not supported even from the very early ages, when they could establish a much more fulsome life experience and health outcomes in terms of that. Then there are the complexities of 'it's closer and easier'. People come to hospitals because it is much more a trusted scenario sometimes. We have a booming population, particularly up in this corridor, as you would well know. It just gets greater and greater.

It is curious—I heard this just the other day—but I think families are becoming distressed by the wait in the community for placement into aged care and for ACAT assessments, or even just caring for their family members in their homes because of the lack of support, and timely support, they are provided with through the care packages. They turn to acute hospitals because they simply cannot cope. It is distressing for them to have to confess that. In addition, there are tales where if you admit your family member to a hospital then they will get a quicker ACAT assessment. We often see those kinds of admissions as well.

CHAIR: We heard that yesterday. There are 20,000 people still on the wait list in Queensland.

Mr BLEIJIE: I appreciate that you work for the state government, in Queensland Health. You have talked a lot about NDIS and aged care. What I have not heard you say in your presentation this morning is anything about more resources from the state government in terms of more nurses, more doctors, more emergency department beds. As I said, you have talked a lot about what the federal government can do, but you see it on the ground. I was surprised that I did not hear anything in terms of state government hospitals, ambulance ramping or the health crisis. The Australian Medical Association Queensland released a report today saying there are systemic issues in Queensland Health. I would like you to give some guidance to the committee on those issues that are state government responsibility which no doubt you are more across than the federal government, because you work for the state government and you are on the ground in the health department. I would like to know, as a state committee, what the state government can do to fix ambulance ramping, the health crisis and systemic issues.

Public Hearing—Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

CHAIR: Before you answer that, Ms Dobbrick, I remind the member for Kawana—and I appreciate the point he is making—of the terms of reference of this inquiry. They are—

That the Health and Environment Committee inquire into and report to the Legislative Assembly ... on

1. the provision of:
 - a. primary and allied health care;
 - b. aged and NDIS care;
 - c. the private health care system;and any impacts the availability and accessibility of these services have on the Queensland public health system
2. in conducting this inquiry, the Health and Environment Committee should consider:
 - a. the current state of those services ...
 - b. bulk billing policies, including the Commonwealth Government's Medicare rebate freeze;
 - c. the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas; and
 - d. the availability of medical training places at Queensland universities, compared to other jurisdictions

With respect, member for Kawana, I would like to stick within the terms of reference.

Mr BLEIJIE: Thank you, Chair. I know that this committee has been set up to blame everyone else but the state government but, because we have a state government employee here and the terms of reference mention 'the Queensland public health system', as a state member of parliament I would like to know what the Queensland government can do to fix its own health system rather than blame everyone else. Ms Dobbrick, the nearby Morayfield health hub recently had its urgent care funding cut by the state government. What impact has that had on Caboolture and Redcliffe hospitals?

Ms Dobbrick: We actually feel that there is very little impact. We have been monitoring that, because we wanted to make sure it was not going to limit the opportunity costs for other patients who are trying to seek our care. We have not found it to be significant. We have been monitoring it. We did ensure safety and any risks that may have been a result of that reduction in service at Morayfield. We looked into supporting our GP within our services for a period, just to make sure that our patients were safe. We do have that person on site to just ensure that. To be honest, the uptake in that space has not been significant. The likelihood of that needing to continue in that way is relatively short term. We will have other priorities on which to refocus our finances.

Mr BLEIJIE: In terms of the satellite hospital that has been announced for this area, can you tell this committee how many emergency beds it will have?

Ms Dobbrick: I note that someone will speaking on behalf of the satellite hospitals this afternoon. I defer to them because we have not had significant consultation around that yet. We are engaging in that as we speak.

Mr BLEIJIE: I think the witness is the Bribie Island Satellite Hospital Focus Group, but I am not sure if that is a departmental representative. As you are one of the leaders in Queensland Health in this region, are you saying that the Department of Health has had no involvement in the satellite hospital's establishment?

Ms Dobbrick: No, I am not saying that at all. I am saying that we are engaging in consultation currently. There are actually minor accident and injury centres, so the likelihood that they will have significant numbers of beds—they are not for overnight stays. They are not like a normal emergency centre that you would find in a hospital—

Mr BLEIJIE: Like a normal hospital. Ms Dobbrick, if you have a—

CHAIR: Member for Kawana, we will pull it back. I can see where your line of questioning is going.

Mr BLEIJIE: This is where the interruption starts and the opposition does not get to thoroughly investigate the issues. Yes, I know what is going to happen. We have been here before.

CHAIR: Member, you can save this kind of questioning for the House and the minister—

Mr BLEIJIE: No, no, I will call it out for what it is—

CHAIR:—and all of the things we normally see. Do not, because I will pull it up.

Mr BLEIJIE: I am interested in the point of order by the member.

CHAIR: I will counsel you on your line of questioning. Three times now you have gone outside the scope. I have allowed latitude. The witness has certainly provided that. We are not going to start this. We are here to hear from community members as well. We are right on time with Ms Dobbrick.

Mr MOLHOEK: Mr Chair, I was going to ask for the indulgence of the committee to extend the time. I am quite happy if we have to run into the lunch break, but we spent 10 minutes on opening statements that were not necessary—

CHAIR: Do you have a brief question, member?

Mr MOLHOEK: I would like to move an extension of time for 10 minutes.

CHAIR: I will allow you a brief question. Then we will move on to the other people who have given up time to be here today.

Mr MOLHOEK: Ms Dobbrick, in your opening statement you talked about the fact that demand has outstripped service capacity. What collaboration or what work has been done between the health service and the PHN for expanded services? What sort of planning work has been undertaken? We were told yesterday in a hearing that PHNs have also seen a significant increase in demand, but what we have seen over the course of the year are significant reports about shortages of staff and challenges around workforce planning. I would be curious to know how staffing is going in the health service and what work you are doing with the local PHNs to ensure that continuous service.

Ms Dobbrick: As I said earlier, we have an alliance with the Brisbane North PHN, and it is a very collegiate relationship which I think we are very lucky to have. We have several initiatives that we have identified through consultation with our communities broadly and also an alignment with Commonwealth and state key issues. If I cover a few things for you, that might answer some of your questions.

A few of the initiatives include the Aboriginal and Torres Strait Islander Hospital in the Home initiative. It is an initiative with the Institute for Urban Indigenous Health. They will be providing primary health care after admission to hospital. We are piloting that at the moment with the intention that that might open up more broadly for other service providers. It will enable our Aboriginal and Torres Strait Islander community, which in this area we have an over-representation of, to have health care provided in a more appropriate setting. That will reduce some of the impact on our service provision as well as provide outcomes for them.

In addition to that we have worked on the Starting Well initiative, which is a pathway for antenatal and postnatal women across our community. That one has been highlighted here at Caboolture and I suppose the Caboolture catchment area and has also been done in conjunction with the Queensland Children's Hospital and local GPs. We have found that it has increased compliance in both antenatal and postnatal care. It has also increased the birthweight of babies, which is a significant health outcome for our Queensland community. That will be rolled out to two areas, in the Royal Brisbane and Redcliffe catchments, to provide those services as well.

We are looking at emergency avoidance at Caboolture for some of our chronic disease patients and co-shared health care with available GPs. We are doing mental health regional commissioning where we are looking at joint funding around mental health services and how we might best utilise our dollars. They are all works in progress at the moment. There are also things like general practice smart referrals, the General Practice Liaison Officer program, HealthPathways, team care coordination and the like. I am happy to provide that information to the committee if you would like.

CHAIR: That would be appreciated.

Mr BLEIJIE: Mr Chair, if I could just seek a clarification: the agenda we have set before us from 9.30 to 10 o'clock had the Metro North Hospital and Health Service, Angie Dobbrick, who has been giving testimony—thank you—but Ms King delivered an eight-minute speech at the start, so I assume that eight minutes is not taken out of the witness's time and we are going until eight past 10 in this instance.

CHAIR: Normally, member for Kawana, I would give the opening over a few minutes. I will conduct the timing for today.

Mr BLEIJIE: I am just interested in the Queensland Health crisis. I am interested in the views of senior public servants—

CHAIR: It is not estimates; this is a public hearing—

Mr BLEIJIE: It is a parliamentary inquiry into the Queensland Health crisis—

CHAIR: I am not here to argue with you either. For the benefit of the people who are here today, we are here to hear your stories. Thank you, Ms Dobbrick, for your time.

Mr MOLHOEK: Can I ask Ms Dobbrick just one final—

CHAIR: No.

Mr MOLHOEK: It is a yes-or-no question.

CHAIR: If we could have any information that would be beneficial back by 16 December, it would be most appreciated. Thank you for your time today and for the information you provided to the committee; it is most appreciated.

PROOF

DE-GAETANO, Ms Angela, Practice Manager, Goodwin Drive Family Medical Centre

KEARNEY, Dr Stephen, Practice Owner, Ningi Doctors

CHAIR: Thank you both for being here. Our normal practice is to allow an opening statement before we move to questions.

Ms De-Gaetano: I did not really prepare an opening statement. I thought I had three to five minutes to cover my points. I have written everything down, so I will just read from that. Please feel free to stop me at any stage if there is a particular question around an area. Obviously I am open to questions at the end.

Doctor numbers on the island and locally surrounding areas are not sufficient to service the current and expanding population. A number of practices on the island are not taking on new patients because they simply cannot service the patients they currently have registered on their books. Doctor numbers have decreased due to doctors retiring, relocating and COVID travel restrictions interstate. Some doctors, particularly in our practice, moved back to New South Wales. Bribie is obviously a beautiful place to live, but for a young doctor looking to relocate and raise a family the lack of private schooling and other services is also a deterrent. Doctors tend to preference locations closer to major cities.

The current situation with COVID vaccination clinics takes away from a lot of regular consulting time and requires additional staff. Personally, we have had to lease another clinic and employ additional reception and nursing staff to facilitate that clinic. We were inundated with queries and patients wanting to book a COVID vaccination. Probably 50 per cent of those callers were not our patients; they were calling from other practices knowing that we had the vaccines.

We have also noticed, unfortunately, an escalation in abuse and aggressive behaviour towards doctors and staff which has caused a noticeable increase in emotional strain across the practice, particularly with our nursing staff who are administering vaccines at the moment, and patients not necessarily being willing to receive the vaccine and abusing the receptionist, which is unfortunate. I have had receptionists in tears and one receptionist who no longer works for us as a direct result.

After-hours services are very lacking on the island, and it is difficult to recruit doctors to work in that after-hours time frame. Nights and weekends are not seen as family friendly or offering work or lifestyle balance. We need to remunerate doctors accordingly for working those hours, but it is not financially viable without grants or government funding. All of these factors mean that patients are often required to attend at Caboolture ED, and often they do so via ambulance in an emergency situation. Communications from ambulance officers and the time it takes them to get to our practice would suggest that the Ambulance Service is struggling to handle the volume of patients requiring treatment and transport.

Ramping at hospitals, including Caboolture, causes further distress to patients, ambulance officers and staff at the hospital. Patients are suffering unduly and even dying as a result of not being able to receive critical treatment in time. This issue is obviously highlighted by the media, medical professionals and local councillors. It is a well-known long-term issue which has been talked about a lot, but I do not really see much happening in the way of it being resolved. Certainly if there is, it is just not happening quickly enough.

Patients and residents of the island are very reluctant to travel from the island for medical and other services. We see a higher volume of emergency department style cases due to this, and the Ambulance Service is very familiar with our clinic as a result.

Allied health services on the island are lacking. I feel that physiotherapy and podiatry are reasonably well provided for, but dieticians and psychologists either do not attend the island or have very long wait times. Mental health services are in high demand and are not sufficient to support the ever-increasing patient need. That requires a specifically targeted approach and investigation independent of what we are discussing here today.

The population and demographic of the island continues to grow and change rapidly, but medical infrastructure is not being supported to keep up with this demand. There are a large number of retirees and aged people who live on the island. These residents often have multiple comorbidities and they require more medical intervention than the general population. There are more housing and large unit developments under construction. New residents will need a local doctor on the island, but as it currently stands that may not be possible. We would, however, be able to increase our doctor numbers on the island if the DPA status—distribution priority area—was changed to enable this.

We are referring patients when we cannot take them to the health hub at Morayfield but, as has been mentioned here today, they recently closed that emergency service area due to lack of government funding and Medicare provisioning relevant items for the service they were providing.

This will greatly impact the future of the Caboolture Hospital ED, its capacity to service and budgeting constraints. It is much cheaper for the government to have patients treated at a purpose-built private medical centre than it is to treat via emergency departments. I believe it is somewhere between \$400 and \$500 for an ED admission, and clearly there is nothing like that being charged at medical centres. From memory, the health hub was suggesting around \$150 to treat patients via their clinic, but Medicare is providing between \$39 and \$80 for visits.

It is widely known and there is general consensus across the medical profession and the general public that hospitals need more funding. They need more beds, more staff and alternatives to emergency departments such as what was being provided by the health hub at Morayfield. There have been concerns raised by residents regarding the services that will be offered by the proposed satellite hospital. If emergency services to cater for things like chest pain, laceration and fractures are not provided, then the hospital will not meet the needs and expectations of the public. Although we are lucky to have medical services funded by Medicare in Australia, bulk-billing is not a financially sustainable business model; however, patients have come to expect free healthcare services. I personally think there needs to be more public education on the costs associated with emergency department attendances and Medicare and that people need to take responsibility for their own health and accept that at times there may be out-of-pocket costs. Otherwise, doctors will choose a more financially favourable profession and we will have a further decline in doctor numbers across the country.

CHAIR: Thank you very much for that. I might just very quickly ask you to expand on DPA. What does that mean, for people in the audience?

Ms De-Gaetano: The DPA is an area that is set by the government that allows certain doctors to work within that area.

CHAIR: Which government? It is the Commonwealth. It is the distribution priority area. What does that mean to you practically?

Ms De-Gaetano: If we had the area that we need, if it was opened up to extend to further doctors, then we would be able to have overseas trained doctors work in our area. At the moment, they need to work in much more rural locations. They are more than willing to work on Bribie Island and in the Caboolture area, and we definitely need more doctors in the area. If we were able to change that, then all the practices on the island would be able to be at capacity and potentially service all the patients and residents much better.

CHAIR: And decrease the impact on the public?

Ms De-Gaetano: Absolutely.

CHAIR: Thank you for explaining that. Dr Kearney, would you like to make an opening statement?

Dr Kearney: Here is a snapshot of the past at Ningi. For a one-minute snapshot of the future, please ask for it in question time. I grew up on a dairy farm in Central Queensland. It was dry, marginal farming land. I worked before school, after school and on weekends. I am not particularly bright but I studied so hard. I was not going to be praying for rain to put food on the table for my family. I did not go to Schoolies; I went back and helped on the farm. I got into university. My parents asked me to stay on the farm. They were desperate. I could not. I would pay my own way. The farms have gone broke and the cattle are gone, but my determination has served me well. I rowed competitively for 10 years. I joined the Army to pay my way through uni and stayed for 20 years, deploying to Rwanda and twice to Afghanistan. Predominantly after hours, I wrote a 300-page training manual for the SAS. I am very determined.

In 2011 I chose to come to this region—a place where GPs do more and refer less—and I love it, yet GPs are really hard to find. Doctors go to North Lakes, closer to the city, asking for work. At Burpengary, further out, they do not, but once they get there they usually stay. At Ningi, just down the road, the doctors find it too far to drive and they just keep turning over. In 2015 we opened the new Ningi Doctors. We opened it for extended hours, seven to nine on Monday to Friday and eight to one on weekends and public holidays—a massive decision. It is extremely hard to man but a desperately needed service. We did it by employing trainee GPs incentivised by the government to work in areas of need. We took on overseas trained doctors and rurally bonded doctors Australian trained, and we educated them.

Unfortunately, our overseas trained doctors were paid less because we are not rural enough. They also had to pass the GP exams in a minimum time frame or be sent further rural. Not surprisingly, they left. To get around this, we needed fully qualified GPs from overseas. We found one but the

application was declined. It was now 2019. We could only replace our outgoing overseas trained doctors from the shrinking pool of those already in Australia. Poaching them from other practices is unethical and very difficult.

Rurally bonded doctors are generally Australian trained doctors who have agreed to work in areas of need. Many return to the city immediately after finishing GP training. We have trained many but they are no longer with us at Ningi. The previous incentive system for overseas trained doctors and rurally bonded homegrown doctors has helped us at Ningi immensely but it is short term only, with turnover of two to three doctors every year. Training them is hard work, but we have provided uninterrupted extended hours of care for six years.

Our downfall, however, may be what sets us apart—our location and my pig-headed determination to continue the extended hours of service. Some doctors are put off and just do not come. Others complete their training and say, 'I can't do it anymore.' Now we are just surviving on the crumbs of previous government incentives that are no longer available. Applications for training positions have gone from 20 to 15 to one and none in the last intake. The bare minimum Ningi needs is to again have access to rurally bonded doctors trained in Australia. I will say it again: the bare minimum Ningi needs is to again have access to rurally bonded doctors trained in Australia. Access to overseas trained doctors will help us, but that system needs to change to guarantee real benefits.

My dad prayed for rain. I pray that you all realise you need our service because we really need your support.

CHAIR: Thank you so much. I do think that deserves a round of applause. Dr Kearney, that pig-headed determination has kept your doors open and that is a credit to you. I come from Townsville. Many people in the audience will think, 'They're a bunch of politicians. What would they know?' I have worked in health. I started in 1985 in aged care and did 25 years in the ambulance as well. That was 30 years in the area and I worked with a lot of rural GPs. We had a bunch in front of us yesterday. We know the importance of those programs where the four universities currently roll out Australian qualified GPs and the issues confronting that because there is a cap on that, as we heard yesterday. We heard it from the academics, and we have heard it now from you practising. Please keep your doors open. It is a credit to the local community. Well done. We will move to questions.

Mr BLEIJIE: Angela, you mentioned the Morayfield health hub. Can you tell the committee the impact of its closure that you have seen through the practice on the local residents here?

Ms De-Gaetano: It is not that the health hub has closed. It is just that the emergency services area that they were offering for acute care—so patients who might have had fractures, lacerations, chest pain and that sort of thing—was not financially viable for them and it was costing them something like \$200,000 or \$250,000 a month in losses that they were running at by maintaining that, so they had to close that service.

For us, we cannot refer them to that service so either we have to try to offer that service ourselves or they have to go to ED. The main thing would be that they would go to ED. We cannot stay open and expect our doctors to stay on when they have families and commitments. They always tend to run late and they are already at maximum capacity. I think the impact is more on the actual Caboolture Hospital emergency department, where they would be receiving that overflow from the Morayfield health hub closure. I was surprised earlier to hear from Angela that they did not feel that was the case.

Mr BLEIJIE: That is why I was asking, because you are on the ground and you see it with your patient referrals and so forth. If the state funded it and got it back up and running, do you think that would have a positive impact on the emergency presentations to Caboolture Hospital?

Ms De-Gaetano: Absolutely.

CHAIR: Who did fund it? Was it privately funded?

Ms De-Gaetano: It was privately funded. They rely totally on Medicare and all they can charge is the normal Medicare billing. There are not any particular item numbers to support the particular services they were offering.

CHAIR: Will the introduction of the satellite hospital in this area fill that gap?

Ms De-Gaetano: If there are going to be services provided for patients with fractures, lacerations, foreign bodies, chest pain, migraine and things like that, yes, it would. That would help within the Bribie community but it is not helping the Caboolture and Morayfield community.

Mr BLEIJIE: Would a satellite hospital with actual hospital beds help this community as well? We understand that there are no overnight beds in the satellite hospital. To me, it does not seem like it is a hospital; it just seems like it is another clinic that operates during the day. Would it assist if a satellite hospital is actually a hospital with emergency presentations and beds?

CHAIR: Let us stick within the confines, please, and not go down that path.

Mr BLEIJIE: I knew you were going to go there with that question. I am just asking because of their experience with patients and referrals and so forth. I know Ms Ali King asked a witness before for her views so I am just asking for your views in terms of the patients you see. Stephen, you may also like to answer this. If a satellite hospital was operating with overnight beds and capacity, would that also assist, in your view, the Caboolture presentations and so forth?

Ms De-Gaetano: Yes. It would assist our community.

Mr BLEIJIE: The reason I ask this is that the AMAQ have said it has to be a system-wide look at this whole thing—a bird's-eye view rather than just aged care, NDIS, what the federal government is doing. We really need to look at what the state government can do as well—

CHAIR: And primary care and federal care. Health is a big, complex system. We can go cherry-picking at this, member for Kawana, but I want to stick within the lanes of the inquiry.

Mr BLEIJIE: I think our witnesses are capable of answering the question, Chair.

Dr Kearney: I am probably going to give an answer that is not expected. I do not know that it would make much difference having beds on the island. I do not know if there is quite the population to support it. If we were to see it rolled out here, it would have to be rolled out in a lot of other places and I do not know that financially it makes sense. Sorry if that was not expected.

Ms De-Gaetano: I do not know how it would be manned. That is my main issue. Yes, there may be a hospital built but where are the doctors coming from and where are the nurses coming from? We already have a shortage amongst all other hospitals. Are there going to be people to actually be employed there?

Dr Kearney: I was just answering a question which was whether having an emergency department and overnight beds would be useful. We are really not very far from another public hospital so I am not sure about the expense of having overnight beds there—other than maybe for low-level care for the aged who are unwell but do not need hospital. I do not know if it would be financially viable to have an emergency department as such with overnight acute beds.

Ms KING: Thank you both for coming in and thank you for your advocacy on the issue of the distribution priority area situation over a long period of time. Dr Kearney, can you explain for the committee what the history has been of the distribution priority area status for our area? What has changed over time? When did that change? What were the impacts? I have a follow-up question but I will not muddy the waters by sharing that now.

Dr Kearney: Distribution priority area has replaced district workforce shortage and the borders have changed periodically over the years. Prior to 2019, we were considered a district workforce shortage area so that meant we could get overseas trained doctors at Ningi. In 2019 that was no longer the case. However, we could hold onto two positions that we already had filled. There was a grandfathering scheme so that if our overseas trained doctors left we could potentially replace them if we could do it in a certain time frame. We have replaced them a couple of times, but it has been desperate measures by me getting in an Army person part-time to hold it. We are probably out of the time frame now to roll them over, although I am going to try it again if I can.

In 2019 the rules changed when it became DPA. Certainly, unless you were quite rural you could not get people in from overseas. Where we are, which is not considered rural at all, just over the bridge, we had no ability to get people from overseas. We had to replace our overseas trained doctors with other doctors from overseas who were already in Australia, so it means we have to poach them from another practice and the pool is getting smaller. That was all to do with visas and overseas trained workers coming into Australia.

It is not DPA here either. It is quite a distance to get to a DPA area. There is also the Modified Monash Model, which is inextricably linked. Modified Monash 1 is non-rural right up to the bridge. It becomes Modified Monash 2 once you come over the bridge or if you go over the creek at Ningi north to Toorbul and those areas. Modified Monash 2 currently allows you to get rurally bonded doctors, which you have all heard about. At Ningi we cannot do that either anymore. We have been surviving because, again, grandfathered people who previously were told they could work at Ningi but theoretically cannot now were allowed to because when they joined the rurally bonded scheme, the BMP, they could work. They have been coming through even though it is past 2019, obviously.

They are getting harder on that this year. We had one who was approved to come to us and then a month later was told he had to go further rural. Fortunately Terry Young, the local member, stepped in for us and had the ruling reversed because our patients get very upset when they find a new doctor and then they change. We had someone else for whom we paid out their rural scholarship because she was very confident she could work here, she moved to the area and we need her. I know for a fact that the only two outer-metro doctors I have spoken to in a similar situation both bought out their rurally bonded doctors because they thought they were staying and they cannot do without them. I hope that was helpful.

Ms KING: I know that some time ago now there was a federal announcement of \$500,000 to get an after-hours GP service. Does anybody know what happened to that? Has an after-hours GP service been funded or commenced in the community?

Dr Kearney: We provide care to our patients until 9 pm. If anyone unwell walks in the door, we will look after them. If we are snowed under and it is obvious they need to go to the hospital, we just call an ambulance or we triage them and suggest they stay at home until tomorrow. If someone walks in the door and needs to be seen, we see them for minor injuries—not casting but foreign bodies in eyes and things like that. Not many people get broken bones and foreign bodies in eyes after eight o'clock at night. Usually we can deal with it. We are going to try to drop off our regular appointments to allow other people to come to our practice more easily. When I am on, because I am old and have been here a long time, I am booked out. We are going to try to remove some of those positions so people on the island can come. We see a lot of people from the island by the way after hours who do not regularly come to our practice. We are already providing most of the service, I think you will find.

We have been engaged by the PHN to provide this service. It is moving a bit slowly. I am not sure why it is so slow. We are ready to go and be advertised that we will see other people from other practices for urgent things. Our receptionist will decide if it is urgent or the doctor will decide with our receptionist if it is urgent. We try to make sure we are not poaching other people's patients. We have to be very careful there. We are ready to go with that system now.

Mr MOLHOEK: Stephen, I start by saying thank you for your dedication and commitment to the area. It is quite a remarkable story. In the interests of disclosing, my son is a rurally bonded doctor in Emerald, although he is off his bond now and he is the acting district medical officer there at this point.

You have raised a number of concerns around after-hours access and service delivery in the area. My question is: do you think patients in this area are at risk by not being able to get an ambulance overnight as quickly as possible? How do you actually deal with people when there is an emergency overnight?

CHAIR: Just before you answer that, we had the QAS medical director in front of us yesterday for quite a substantial time. It is in *Hansard*. Feel free to review that. I know that non-government members are looking at this from a different viewpoint. I will allow latitude in the answer.

Mr BLEIJIE: Point of order, Chair.

Dr Kearney: I am happy to answer that question.

Mr BLEIJIE: Thank you, Doctor. The reason we are interested in this is that we believe Queensland Health has a big responsibility in providing health care to Queenslanders. It is not all the federal government's fault. That is why we are particularly interested in what Queensland Health are doing about it. I realise where you want to stop us but please don't.

Dr Kearney: Again my answer might not be what you expect. I am at Ningi, which is not far from the Ambulance Service. It is just amazing. It has been fantastic. We try to triage well and they respond appropriately. I generally have not had any problems. It is obviously a bit further to get out to the island and there can be difficulties with the bridge, so experiences on the island may be very different.

Mr BLEIJIE: Angela, you have said earlier that people are dying not receiving critical treatment on time. Can you give the committee examples of what you meant by that, please?

Ms De-Gaetano: I think that is more around having an ambulance come to the patient, getting them from Bribie to Caboolture and then the ramping at Caboolture. There have been certain situations—even one of my nurses had a reaction to a COVID vaccine. She had myocarditis. When she got to the hospital she was waiting quite a considerable period of time even to be seen, and there were other patients there in obvious pain in front of her who still waited hours to be seen. Several months ago patients did die while waiting, ramping at the Caboolture Hospital.

CHAIR: As I articulated, we heard from the medical director of Queensland Ambulance Service. They look at all those cases individually and assess them. We were really interested to hear yesterday that 70 per cent of the walk-ins—I look at Townsville University Hospital as an example: 280 people a day is not sustainable—

Mr MOLHOEK: Chair, I am not really sure how walk-ins are relevant to the inquiry.

Mr BLEIJIE: We are interested in today, not yesterday—today.

Mr MOLHOEK: We are interested in today.

CHAIR: Members, we will pull it back for a moment. I just say to the members on my left that we have had questions on notice—which members on our left also asked—to which the department has provided answers and the questions that we asked were about walk-ins over the last 10 years. Before you go down that route, this is published data that we received yesterday from the department. Thanks very much. It is on the website.

Ms PEASE: May I also acknowledge the great work our general practitioners do across the state. Thank you for your dedication in looking after Queenslanders. I particularly wanted to find out about preventive treatment in terms of access to GPs by the community and how that would impact on presentations to hospitals—that is, patients being able to see their GPs to treat their chronic diseases in terms of preventive treatment. Do you have any comments on that?

Dr Kearney: I think it is probably well known all around the world that having good access to GPs is important for preventive medicine and that preventing problems is better than curing them. This area, particularly on the island and surrounds, is of interest because we have interesting populations there. People are either retiring and downsizing or coming somewhere their money buys more, so they are often people who may not even drive anymore. They may not have had huge amounts of money to start with. They are completely removed from their previous social supports. That is a big part of the people in this region.

The next group are quite a marginalised group of people. Sure, the demographics are changing, but there are a lot of people who move further out from the city because they do not have the money to survive closer to the city—a lot of people who have disabilities, a lot of people who have longstanding work injuries and then those who are just moving out because they just do not have the money.

Those two groups—the low socio-economic group and the retired group without social support—are high users of medical systems. Therefore, I think models used for looking at numbers of GPs just do not work here very well. They do not take into consideration the populations very well. The other thing they do not take into consideration is the massive growth. I am sure on the way out here you saw all the roadworks going on and all the buildings going up, predominantly for people who are going to be big users of health care.

CHAIR: Thank you very much. We will pull it up here. Thank you both very much for your contributions today. They have been most informative to the committee.

CUNNINGHAM, Ms Maree, Honorary Secretary, Bribie-Moreton Hospice Health Services Inc.

LOURIGAN, Ms Annette, Care Manager, Home Instead Brisbane North and Caboolture

CHAIR: Welcome. I invite you to make an opening statement and then we will move to questions.

Ms Cunningham: Good morning. Welcome to Bribie Island. Just make sure you leave—we haven't got any room left!

Ms PEASE: We won't take that personally.

Ms KING: I take it very personally, Maree!

Ms Cunningham: My name is Maree Cunningham. I am a retired primary teacher, a wife, a mother and a grandmother. I am sneaking up on my 71st birthday with a sense of: how the heck did that happen? I have redefined LOL: I am a little old lady!

I have been the secretary of Hospice, a small independent charity, since 2007. We moved here 20 years ago from the Gold Coast for a quieter life! I have never worked in hospitals or aged care. I do not speak hospital and I do not speak aged care fluently. I was invited to this hearing by the member for Pumicestone, Ali King, and I am prepared to tell the story of our little charity's history and what we do in this community.

I need to go right back to how it started so that you can understand what we do and why we do it. Bribie-Moreton Hospice Health Services Inc., or Hospice as we are known in this community, began as a working group in 1997. The group began with a clear vision to improve local access to services that were not readily available then—in particular, respite for carers and palliative care. Some members of that original working group are still active in our work.

Our small independent association is registered in Queensland as a public benevolent institution. We have charitable and DGR status. We have an approved constitution and we report annually to the Office of Fair Trading and to the Australian Charities and Not-for-profits Commission. In the early days, the community services that were offered by the association were mostly in-home respite and palliative care. We had registered nurses and trained volunteers to relieve the burden of local carers who needed that support.

In 2003 the association purchased a small two-bedroom house in Bellara so that that residential respite could be added to the offered services. In 2005 Suncare Community Services Ltd, a registered federally funded provider, leased Boronia Cottage from the association to add to their cottage respite services. Our relationship with Suncare remains in place today.

In 2011 we demolished the little cottage and rebuilt with the assistance of a federal government grant. New Boronia Cottage is a modern, open-plan house with four large bedrooms each with accessible ensuites. Under our agreement with Suncare, our local carers are able to access short-term respite without making the co-payment. We found that the co-payment was a problem for a lot of the local people.

Customers are able to enjoy a few days break in a modern, comfortable house. At Boronia Cottage there are no routines, no bells, no trolleys—breakfast is whenever you want it and whatever you want. Sleeping in is an option. A beer and a bet at the local is possible, as is just sitting on our beautiful waterfront watching the sunset. We do not make a financial gain from the lease of Boronia Cottage. Slim profits and grants through government and local community groups are used to maintain, improve and freshen up the house and garden to benefit the clients having a break and the staff who work there looking after them.

In 2009 the association entered into a unique agreement with Churches of Christ Care. With the generous support of the community, the association has been able to fund the single-bed hospice suite, a purpose designed suite of rooms with a kitchenette and a private outdoor patio, located in a wing of the Bribie Island campus of the Churches of Christ. The accredited nursing staff and pastoral care staff have assisted many local families whose loved one received a well-deserved and dignified end of life in peaceful surroundings with family and friends close by. I think of couple of times the family dog was there too. There is no cost for this service to the family because of our successful fundraising.

Over the years, fundraising for our work has been generously supported by members of the community who believe in what we do. Income is through our hospice op shop, our fundraising bus trips and other events, and cash donations made by individuals, local community organisations, service groups and business. Particular mention should be made of the ongoing and generous Bribie Island

contributions by the Cornett family and Busy Fingers Fundraisers, which is a legend on this island. On 31 March 2022 our small independent charity, with the support of the community, will have raised just over a million dollars for the high-care respite and palliative care services in our hospice suite.

CHAIR: What a remarkable story. There is an old saying: you don't know where you're going unless you know where you've been. Thank you for sharing the genesis of that and your work over those 20 years and to everyone who supports Boronia Cottage. A million dollars is quite incredible. We conducted a previous inquiry into aged care, palliative care and end-of-life care. We went to Dove Cottage in Caloundra; it sounds very similar. Congratulations to you and the entire community for getting behind that. That is fantastic.

Ms Cunningham: Can I tell you a story? Do you have time?

CHAIR: Yes.

Ms Cunningham: The first client at the hospice suite in 2009 was a single elderly chap who had no family to support him. Lord knows where he would have been without us. This too is a common story. This is a recent story. A chap had reached the end of treatment for his illness. There was no hope of prolonging his life further. He refused to go to the Redcliffe palliative care hospital. For him, it was home or the hospice suite. If he had been transferred to Redcliffe, in order for his wife to visit him their relatives would have had to drive down from the Sunshine Coast to Bribie, pick up his wife and take her to Redcliffe and then do the whole thing in reverse to get her home, so we have made a difference for that family.

Ms Lourigan: I would like to say that Maree and I have a history. I had a gentleman walk into my funeral home. He was palliative and I was brave enough to have the conversation with him. Because of my relationship with Maree, we were able to get the gentleman placed into a palliative bed here on the island. Maree and other people will probably always be very grateful that it was my funeral home he walked into.

I have spent 23 years working in the funeral industry. During that time I have been a volunteer and on the state council for Palliative Care Queensland. I worked for Palliative Care Queensland and helped set up their Ambulance Wish program. I now work as an aged-care provider. I think my boss headhunted me because I have a way of connecting people. I know people like Maree and I understand how the system works from my own personal and professional view. I would like to point out that I have had four surgeries in Metro North and I am on the Nundah priority. I am still being treated by Metro North and I cannot complain about the hospital system here.

I am going to smile when I talk about this lady. The people I am going to talk about receive the federal health funded My Aged Care packages that, when they work, work very well. When they can be accessed they do work well, although a lot of the time people need an advocate to help them do that.

My first case study is a fabulous 77-year-old who has bipolar affective disorder, insomnia and several other chronic health conditions. She was approved for her healthcare package in 2017. Her main services until 2019 were domestic assistance, personal care and transport to hospitals for depot injections. That was scheduled by our mental health program. Between July 2020 and June 2021 she had five involuntary admissions into Caboolture mental health hospital totalling 21 weeks. In April this year, after collaboration and consultation with her mental health team, her enduring power of attorney and myself as her care manager, it was decided to schedule daily medication prompts for the lady instead—she had had an active reporting system at home—which I was to diligently follow up. Since that started, since July the lady has had two weeks in the mental health institute. Currently she is bugging me to get her an e-bike, although I need to find an occupational therapist and physiotherapist who will give me permission to get her an e-bike. Lord help Bribie Island if she does! She is an example of the successful use of a federally funded home care package.

I am not going to get emotional when I talk to you about these two people. They are a husband and wife. He was a fireman for Queensland for a bloody long time and she has worked in aged care in Queensland. He is 88 and she is 89. He has a level 2 package that was approved in 2013; her package was approved in 2019. He is a high falls risk with severe chronic vision loss in his right eye, severe cerebrovascular accidents plus other chronic conditions. She is an amazing woman: she has chronic asthma, arthritis and vision impairment. Neither of them can drive. They require domestic assistance, emergency alarms, gardening, home maintenance, assistance with meals and transport to all of their appointments. They do have children, but their children do not live locally and their children at this point have not given up their roles—as I did for my dad for three months—to be there for their mum and dad.

When they were informed in April that he would be having shoulder surgery, our concern was that his package, which would be suspended during his time for shoulder surgery, would not do what was needed at that time. Very simple shoulder surgery turned into 3½ months out of the home from transition care to rehab. During that time we helped the lady and in that time she abused me. We helped her balance her domestic assistance, gardening and transport. Her level 1 package allowed us to get her to her appointments only twice. If we could have had him closer, we may have got her there more. When he returned home last week he fell on Sunday. He has now been placed into residential care. I phoned up My Aged Care several times to get extra funding for this lady, and every time I phoned I was told that she has been put on a waitlist. Occupational therapists, physiotherapists, domestic assistance and gardening on the island are at capacity. This lady needs her federal package to come through. Those packages, when they do come through, help alleviate the stress on our public health system.

I visited a gentleman this morning. He is palliative. He knows about you. Because he got his home care package very quickly because the system connected him, he can be at home to die. Because he has a home care package I can organise for a private nursing service to go in and assist this man. When the VAD laws came in he spoke to me about VAD. I talked to him about palliative care. This gentleman is calmer, and we will keep him out of a public health bed because he has this package, but I know there are an awful lot of people on the island whom we could keep out of the Queensland public health system if they had better packages and quicker access to packages.

CHAIR: Thank you for articulating that story. It makes me angry when I hear it. I have heard it plenty of times, as have other members of the committee who have travelled the length and breadth of the state. People who have worked all their lives deserve the best of care at the most challenging times, so thank you for sharing that. I have no questions except to say thank you for sharing that. It is a story that we have heard thousands of times. It needs to be corrected. You are right: when it works, it works well but we still have 20,000 people on the waitlist. That was the information provided by the department just days ago. It needs attention.

Mr BLEIJIE: Thank you, Maree and Annette, for coming today. My question is to Annette. With palliative care and VAD coming online next year, obviously there will be more people at home. I do not think you explained this, but what is Home Instead?

Ms Lourigan: It is a home care provider.

Mr BLEIJIE: I thought that might be the case. If we take people out of the hospital and put them in home care—I know you talked about the Commonwealth package—are there state packages, state funding, available for this or is there an opportunity for the state government to get involved in that space if we are taking people out of public hospitals and caring for them in their homes?

Ms Lourigan: I know that Ali is going to expect me to be honest. When I worked in the funeral industry I would have people turn up and they were desperate—absolutely desperate—and they were close to end of life and they wanted to know what would happen. When people come to a funeral director to get assistance around end of life, we have actually gone really wrong. Today there was a lady who talked about ramping at hospitals and people dying. If good palliative care teams had the time in the system to do their referrals, do them properly and talk the family through, we would have fewer palliative people dying in emergency services. If we had more funding for palliative care in Queensland—not just regionally but also rurally—there would be fewer people who would need those beds to die. I do not know why you asked me to do this, Ali King! It is our palliative care system that really creates a block in our system. When I was at Palliative Care Queensland, I would have people phone me and say, 'I've just been told that my dad is dying. What can I do?' We can send people to PalAssist, we can send them to Pomona, we can send them to a whole pile of places, but if you give a person who has just been told that their parent is dying a list—they do not even know how to make a cup of tea on that day. It is actually about nurturing patients and their families, whom they want to be with.

Ms Cunningham: I just wanted to throw this into the mix. We have spoken a lot about aged people, but some of the people who have passed away in our hospice suite have been young men with brain cancer. It is not just an ageing thing.

Mr BLEIJIE: Ladies, answer this however you feel. This is a personal issue for me. Two years ago my nanna was in aged care. Then she had a fall and went to hospital. Then she went back to aged care. They could not provide the medical treatment she needed at the aged-care facility. The hospital said that she was on her way out but she was okay to go back to aged care, so they took her back to aged care. Then she had a stroke so she went to hospital. Then they put her in the hospice.

She was in Dove Cottage. But then she was not dying quickly enough, so she was taken out of hospice and put back to aged care. This went on for three weeks. In that situation, the aged-care facility could not provide the medical treatment for Nanna's conditions.

I hear a lot of people say that aged care is filling up our hospital system, but aged people need hospital services that aged-care providers are not meant to provide so they have to go to hospital. In that situation, what should happen? Let's say we live in an ideal world: we wake up tomorrow and your hospice service is fully funded; you are getting everything you want and Palliative Care Queensland is getting every dollar it wants. What would the system do in the case of my nanna who for three weeks was shipped around?

Ms Cunningham: It sounds like Nanna had complex needs.

Mr BLEIJIE: No. She was stubborn, a bit like me. She was not passing away so they put her in a hospice because they thought she had only a couple of days, but a week later they said, 'Okay, you have another week so you are going back to aged care,' but then she was back to hospital again. It was just that revolving door.

Ms Cunningham: This is not like booking a motel for a holiday. End of life is unpredictable. We have had people come into the hospice suite who lasted hours and for others it was days before they took their last breath. We have had people who have just been through the hospital system where they tried everything. They come in, they are admitted, they are put into a lovely room with a lovely outlook, they are looked after in peaceful surroundings and they rally. They last for a lot longer than people expected them to, sometimes for weeks. In two cases, two of our clients had to be admitted and put into beds from the aged-care place, and once they got into a comfortable situation they rallied. We have had quite a few people who have applied to come to the hospice but their needs were too complex and they needed to go to Redcliffe, to the palliative care hospital there. It is not a one-size-fits-all. It is not an old person's thing. It is complicated, which is not an answer.

Mr MOLHOEK: Annette, you mentioned a lady who is having trouble accessing service. If you see me afterwards I will give you my card and you can send me the details. I will follow it up with our federal colleagues. There are always gaps and holes in the system. I wanted to make that comment. Maree, I commend you on your work. In a former life I was a radio station manager and we raised money to establish the Hopewell Hospice on the Gold Coast. My wife used to volunteer there. I understand what an important role and service it is. Thank you for your 20 years of service. It is amazing.

Ms PEASE: Thank you, Annette and Maree, for coming in and for the great work that you do. It is incredibly heartwarming. I was on the committee previously and travelled with the chair, and I commend the great work that you both do. Maree, I liked your comments that end of life is a complex time. I nursed both of my parents at end of life. Many times we were called in for my father because they thought it was the end, but he would come back home. We called him the 'Comeback Kid'. Thank you for your words and your great work.

CHAIR: I think we might give the ladies a round of applause. Thank you both very much.

BLAYSE Mr Alwyn, Chief Executive Officer, Allied Aged Care

PEACOCK, Mr Bill, Disability Advocate, Spinal Life Australia

CHAIR: Welcome. Thank you both for being here. Bill and Alwyn, would you like to make opening statements before we move to questions?

Mr Peacock: Thank you for the privilege of being here to address you. I am a person with a disability, as you are probably very well aware. I am a survivor of polio, which I contracted at 4½ years of age, so I have a long history of being in a world of people with a disability. In the latter years I have worked as an advocate, particularly in the areas of aged care and disability.

One of our great problems has been the differentiation between aged care and disability. Disability does not discriminate; however, governments often do because, when we turn 65 and are disabled, the National Disability Insurance Scheme, NDIS, which was meant to be our safety net, did not cover us—whether we had a lifelong disability, we were born with disability or after the age of 65 we were given a disability. People over 65 living with a disability are funded through the My Aged Care scheme and not the NDIS. That means a person with a spinal cord injury receives \$52,000 a year maximum instead of \$165,000 a year, which is the average through the NDIS. We need to change that to ensure that all people, whether their diversity is in disability or aged care, are not being discriminated against.

Living on Bribie Island for the past 14 years, I have been able to see and work with so many people with disability in the aged-care sector. One of the greatest problems is being able to receive medical treatment and medical assistance, whether it be through your GP or any form of hospitalisation. To travel from Bribie Island to Caboolture Hospital is often the most difficult of all. When people with a disability arrive at a hospital, whether we are young or old, we are denied the right to have our carers with us because it becomes legislatively impossible for the staff in hospitals to maintain the care for our carers as well as ourselves. In the past five years I have waited up to five hours for an ambulance to arrive to take me to a hospital, only to find that even the very personal systems of care are denied me, and denied most people, because the carer cannot be with me at that time.

We have worked very hard in this area, particularly to give people with a disability in the aged-care sector the right to live a comfortable and long life. We have charitable organisations that are prepared to help us wherever they are needed. We are now being faced with some of the greatest problems we have had in many years, as we are losing carers through the aged-care system because they do not want to be vaccinated. Therefore, we, the vulnerable, are left without carers or those who do the very services that we need around the home to keep us in our homes. If I was an NDIS client I would have around \$165,000 a year to maintain my carer environment. I have been one of the fortunate ones in aged care as I have a full-time carer who receives the carer's payment and the carer's allowance, which gives me 24-hour access for all my personal needs. That is denied to most people.

In the past couple of years we have been working with our Indigenous communities to ensure they also are being made confidently aware of what is available and not available.

The unspent funds in home care packages currently have reached \$1.8 billion. We find this quite appalling as, if we were able to differentiate between aged care and the NDIS, those funds could be delineated and moved across into the aged-care sector. At age 65, people with a disability are removed from the disability pension and put onto the aged-care pension unless we are smart enough to be able to say to the government, through Centrelink, 'No, we don't want aged care; we need to remain with our disability support pension so that we can have all of the cultural aspects of our lives met comfortably and reasonably.'

In the past six months the statistics show us clearly that we are going to face even greater problems. One of the things that I always believe is that we have no problems; we just have solutions. We began in Brisbane with a group of people living with paraplegia and quadriplegia wanting to make a real and tangible difference to the lives of Australians living with disability across the board. If we are to have a satellite hospital, we must have beds. It is nearly impossible for us, as people with disability, to move to Caboolture and have carers living close by us to give us the services that we need.

As we are speaking with aged-care providers, we are also finding that we are given letters telling us that in the future we may not have the carers we need because the staff shortages are becoming great. As an example, yesterday I had to attend the Brisbane Dental Hospital. The late effects of polio, post-polio syndrome, mean that my dental care is critical to my health or what health

I may have. We believe strongly that if we are to have a satellite hospital we need to have dentistry. NDIS clients can attend a dental practice in the private sector and it will be paid for. In aged care, we are means tested and therefore have to find ways of getting that type of service. We see a satellite hospital as being an area where we can attend general practitioners, allied health care, on-call for emergencies, culturally aware support staff for our Aboriginal and Torres Strait Islander support teams, a team of volunteers to support the administration and need in aged care and disability care, domestic violence and mental health counselling practitioners and emergency dental services.

In the past six months in our disability community we have had nine suicides. Often we are asked why someone would commit suicide. I can only say to you that within disability, when you are compounded by all of the situations you live with, day in and day out, life does not always feel comfortable. We ask that our Queensland government support us in meeting with the Commonwealth government to remove the discrimination and allow us to live our lives comfortably.

CHAIR: Thank you for that. Mr Blayse, thank you for being here. Would you like to make a statement?

Mr Blayse: I want to thank the committee for the opportunity to speak, and also to everyone here and watching for having an interest in health. I am a physio by trade. I always identify as that. I am also lucky enough to be a CEO of a bigger company now that works privately. I started my private practice journey here in the regional health system in Kilcoy, and Bribie Island and Caboolture were part of that. I used to joke that I would be a physio until I was the one in the aged-care home needing massage, and I suspect that is still the case. Being here at the RSL brought back memories for me because I was literally sitting in an RSL having a bit of a gripe about aged care and whether I was the only one thinking it needs a bit more et cetera when my lovely wife very tactfully said, 'Put up or shut up. Go and talk to other people.' I had a company and I was lucky enough to do that. We found other physios and OTs.

I have been a physio for 22 years. I gave evidence at the Senate committee into aged care recently. I said that I have never been so concerned about the role of physiotherapists and allied health in the aged-care system and also the effects it is going to have all through the public hospital system if we are not there, because that is literally what we are talking about.

My professional associations, OT Australia, physio associations, SARRAH and lots of groups have been saying—and I confirm this—that the federal government's decision not to separately fund physiotherapy and allied health in nursing homes will lead to the death of physiotherapy and allied health in nursing homes. I am not saying that for shock value; I am saying it because it is real. When we do not do physio on residents in nursing homes, they die. They have a fall and they come back from hospital. If they do not get moving in that first week particularly, after that unfortunately people do end up having morbidities et cetera.

I do not want to only talk about that background particularly, because I am also going to do a submission for our organisation. I just wanted to share what we are talking about. At the moment on average in nursing homes, including in Queensland, eight minutes per day per resident is what people get of physiotherapy and allied health. I was touched by what Bill was saying about community. We also work in community. In the community, it is about five visits per year on average of allied health. In the community system, it is eight minutes per resident per day. That is not physio; that is everything.

That was considered inadequate by the royal commission into aged care. In recommendation 38 they recommended significantly more allied health, and the federal government agreed to that. However, in the May budget they did not fund it. At every point where I have raised these concerns I have been met by, 'Quality standards will look after it. Nursing homes are still accountable and need to provide physio and allied health.' I am sorry, but every nursing home I have spoken to cannot afford it, they cannot set their budgets and there is not the workforce for that. There is no point increasing compliance and penalties on nursing homes. These are some good people we work with and they want physio and allied health too. That is not under debate. What is under debate is how we are going to survive and look after our older people.

I have a mum-in-law who just came home from a knee replacement. She accessed the public hospital system through Prince Charles and had some complications et cetera. She was looked after at home before being passed back to her physio in the community. She is seen twice a week and she does not have to pay anything for that. She is on a pension. If after October next year—and that is less than 300 days away—she goes into a nursing home, she will not get that. She will not find physios and allied health. It is hard enough to get us there now. It is not exactly a sexy area to work in for physios. I was a bit different. A lot of people want to go and treat the Broncos. I seemed to like older people and people with disabilities so that is where I started.

I have seen younger people under 65 in the health system. There are 6,000 people right now under 65 in aged care. It is not just old people. We have seen a lot of post-polio syndrome. Bill, you brought back my memory of what a tricky condition that is to treat and how it could be avoided if we did better in the community. That is what I mainly wanted to talk about in our submission—that is, the effect it is going to have on the public hospital system when essentially people get discharged because there is not a physio or an allied health professional on site and the public hospitals have to do that. There is an increase of workload on nurses; it is everything. It is all interrelated. That is the key part. You cannot say, 'That is just an aged-care problem. That is just an allied health problem.' What everyone is talking about is the same thing and that is why we support Disability Doesn't Discriminate and a lot of other campaigns because we are all talking about aged-care reform and just caring about our mums and dads.

CHAIR: Thank you for the work you are doing and your passion in delivering that service. Allied health is an important aspect, and we heard it yesterday. The member for Pumicestone will remember the lady from Chinchilla. She actually got emotional—

Ms KING: She cried.

CHAIR: Yes, she broke down—when funding was pulled out of that area. There were 100 people. She was an occupational therapist. She talked about physio as part of the SARRAH group.

Mr Blayse: Was that Rachel?

CHAIR: Yes, it was Rachel.

Mr Blayse: I know Rachel. She was speaking at an AGM I was in. I have worked in that area, in Kingaroy and Murgon, so I know exactly what she was talking about. I also work in Toowoomba, so I know exactly what she was talking about when she was talking about the workforce challenges. I support that. She was trying to do this great thing of keeping an NDIS service going. I know it is easy to say, 'We're just a private organisation.' I have worked in Queensland Health. A lot of the services we do—similar to other providers who have spoken—are done at a loss and we do it because we are good people and we are trying to look after our communities.

I have been in Kilcoy and had refugees who cannot access the health system leave me pumpkins on my car to pay for my services. I would have just accepted it but my wife said—and remember that she is a good adviser—'You can't have something for nothing so get them to leave you something,' and that is what I got. A lot of us, like Rachel, are not doing it for economic reasons, even if we are in the private system.

CHAIR: You are doing it because you care.

Mr Blayse: Yes, that is right. We think of ourselves and our mums and dads and what is going to happen to them basically, and it is real.

CHAIR: Thank you.

Mr BLEIJIE: Bill, thank you for your testimony today. Can you give me some more understanding about what you said earlier? You said that with your disability if you go to a Queensland public hospital you cannot take your carer with you. I have never heard of that before. Can you explain that, please?

Mr Peacock: One of the main problems is that we have a number of issues in disability where we need our personal carers with us. If you are hospitalised, the conditions are not suitable to have your carer with you so the hospital staff have to do all of those things. Uncomfortably, when you talk about bowel and bladder structures that need to be managed by your carer on an hourly basis or a daily basis, the hospital staff are not qualified to do that. I am a fairly big person—I stand at six foot two—and to lift me in and out of a bed, even with a hoist, becomes a problem to the administration of the hospital and their insurances. If I have to spend overnight, or any person with a disability has to spend overnight, the only place you will get the service is if you are having sleep clinic observations and they put a mattress on the floor for your carer so they can be there with you during the night. Most times it is just not possible.

For any person with a disability, it is some of the dignity we go through that is very personal. It is not always comfortable when you get a nurse who is coming in to do some of that personal care and she does not know what she is doing. The urinary tract infections and the bowel problems that we have are all part of being in a wheelchair sometimes. Sometimes it is just part of the condition that you might be going through.

Mr BLEIJIE: Thank you for expanding on that because it has never been raised with me before. You mentioned the proposed satellite hospital. What is your understanding of it in terms of delivery and what do you want it to be? You mentioned beds. You were talking about if you can go there with an overnight capacity, which it does not have at the moment. Is that correct?

Mr Peacock: Yes. I think for a lot of people with a disability it is being close to where you live and close to your carers. Often with the conditions you might be going through, it is not possible to get to the Caboolture Hospital. We believe that if there were some beds available—and it would not be a great number—it would be a position that would allow your carer to be with you during the time of treatment or having the staff there who could do some of the things that are needed.

It is like Alwyn said. There are physiotherapy needs that can be part of an emergency situation. The post-polio condition allows the body to do some very strange things, like we develop osteoporosis, diabetes and so on. A bone will break very easily and very quickly. As an example, I broke my finger. I do not know how; it just breaks. I need a physiotherapist to support that and help that. Under My Aged Care, I do not have enough money in my package to be able to spend that on physiotherapy so I have to find a way of taking it out of my pension to make sure I am going to have enough money to pay for those things. People in wheelchairs would give you many different stories. Beds in hospitals become extremely important in aged care and even for patients with NDIS.

Mr BLEIJIE: Chair, is the Bribie Island Satellite Hospital Focus Group a government group or a community group?

CHAIR: I do not know.

Ms PEASE: Thanks for coming in. Alwyn, I really appreciate your comments and your dedication to your service and caring for your community. I am interested in private health insurance and the impact it has. It is such a costly exercise. I have private health insurance but get a very small benefit back for the service. I imagine that people living with a disability would not be in a position to access private health insurance because of their condition. Could you comment on that? Has there been a big withdrawal of people being able to use private health insurance for your services as a physiotherapist in the community—or any allied health service? They would then have to rely on the community or the sector to provide that service, and therefore people would not make use of those allied health services because they do not have access to private health rebates.

Mr Blayse: That is why I was saying before it is all interrelated—even here at Caboolture with a public and a private hospital that work together. I was part of that when I was at Kilcoy Hospital doing something similar. I can only answer your question in terms of our company that it would be very rare that people would have private health insurance. Most of our people are low socio-economic—pensioners et cetera. I have not personally found that a particularly effective way for people to fund physio and OT. Just to support what Bill was saying, most physios, OTs and other allied health will tell you that we subsidise greatly the cost of seeing people, particularly in the community. It is much more effective and efficient to see people in a clinic routinely. Unfortunately, a lot of people cannot travel and need access to physio et cetera.

There is one thing that I am not sure is relevant to talk about, but it is the effect of pain that happens on people in terms of hospital admissions. I was thinking about that with Bill and other people who have similar things. If people do not have physio and allied health—whether that is in a nursing home or the community—essentially we have other things happen, with lots of other conditions. Pain is not just a mental thing; it will have physical effects.

I have just seen this because I literally reviewed a resident yesterday who had been taken off a thing called a pain management list. We had been routinely looking after her for about three years with contractures. She is nonspeaking. She was taken off our list about two weeks ago. I just happened to have a little look at what was going on there. Another client was in the same boat. I cannot say for sure, but I suspect there was a little bit of economics involved in that as well. What happened is: even though there were reports she had no pain at all—of course she could not articulate it beforehand—now apparently, two weeks later, she has quite constant pain and is on heavy doses of Endone. As anyone who has worked with people taking pain medication will know, that leads to constipation, falls and deaths. Physiotherapy has been shown to decrease falls by 55 per cent. I just thought I would use that as an example of why it has an effect all through the health system.

CHAIR: That is an interesting point. Just to follow up on a point the member for Lytton made, according to the data we received from the department and director-general the other day, 60 per cent of Queenslanders now do not have private health insurance. For the 40 per cent who remain, the gap is so wide that they end up going through the public system for procedures so there is more pressure on the public system. It is just incredible.

Mr Blayse: My mother-in-law could not afford private health cover. She was on a waiting list for four years to get her knee done. I live in Cooroy and she lives in Maroochydore, but she had to go to the Prince Charles in Brisbane because she was on that waiting list already. Yes, you will hear lots of examples of that. I suppose the aim of private health was to take the strain off the public hospital system. I just have not found that in reality, from my perspective.

Mr Peacock: Most people who have gone onto the NDIS have given up private health cover because there are finances there to do that. Each service is paid for under the program, whereas with My Aged Care often it is impossible to continue payment with private health cover.

Ms KING: Thank you both for coming in. It is lovely to hear from you, Alwyn. Bill, I acknowledge and thank you so much for all of your advocacy for people with disability in our community. I know how much work you invest in airing these issues every single day and your work with other groups right across the spectrum of our community, and I thank you for that. I wanted to ask you: did you ever have an opportunity to be on an NDIS package at any stage?

Mr Peacock: No.

Ms KING: You did not 'age out'?

Mr Peacock: Our area was the last area to be allocated NDIS, and many of us had reached 65 by the time they came through. Some people were waiting four or five years to go onto the NDIS and moved interstate so they could access it.

Ms KING: Forgive me for inquiring too closely into your personal circumstances, but if you were on an NDIS package of \$165,000 a year, how do you imagine your health would benefit from that if those were your circumstances now? What services might be you able to access that you cannot currently?

Mr Peacock: Physiotherapy home visits would be one. It is nearly impossible for me to travel in my wheelchair to have physiotherapy. It is also the fact that I cannot be treated in the wheelchair, so I could be treated on my own if that was necessary. There is also occupational therapy, which is becoming very expensive under My Aged Care. My last visit with an occupational therapist to give me approval for purchase was nearly \$700. The purchase of the item was \$26,000 and I sit in it. I could probably buy a small motor vehicle.

Ms KING: Easily. My goodness, \$700 is absolutely eye-watering. Amongst your disability community, have you heard many accounts of people having to access expensive specialists to get reports for the purpose of reassessment for the NDIS?

Mr Peacock: That happens every day. I advocate for some 40 people personally, and each of those people, I would imagine, would be paying for those services on a weekly basis. The cost has just exploded since the NDIS, which has placed aged-care clients into an even more difficult position. A mobile chair has to be prescription designed. I noticed John Morris behind me here. His chair is probably even more expensive than mine because of the services. Four years ago my chair was \$12,500. This chair, purchased in March this year, was \$26,900. That sort of expense in your package is just unrealistic. I have been meaning to see good physiotherapy on a regular basis. It is a way I can keep my mental attitude going. That is denied me. Often pain management is the area where a physio can support you as you are going through each of those steps. It would stop suicides within the younger members of our disability community.

Mr MOLHOEK: I would just add my thanks to both of you for coming today. Alwyn, you and Dr Stephen Kearney and Angela De-Gaetano have talked about the challenges of accessing doctors and specialists. We have heard some commentary around funding, migration status and all sorts of other things. The reality is that there are significant shortages of trained doctors and allied health professionals across the board, so how do we address those shortages at a local level and a national level? I am sure health services are struggling to find people just as much as private practice. It is a more complex issue than just the states blaming the feds. How are we going to get more doctors and specialists into the system?

Mr Blayse: That is such a good question. Yes, I am personally involved in this quite a bit. About 75 per cent of our team is actually trained overseas and have five to seven-odd years experience before coming over. They are often very experienced physios and OTs who have run departments et cetera. We literally have to do that because Australian trained physios often will not work in regional areas, particularly aged care. I do not think it is a blame game between states and governments. I think we are all in it together. We all have mums and dads; that is what I keep saying. We have some very caring people.

In terms of workforce issues, before the pandemic I read stats that we were 6,000 physios short of what we need. That was before the pandemic. During the pandemic we had about 21 physios who were about to come over—actually, that is not true. I tell a lie: it was 11. All of them, of course, had to then seek exemptions. I was very grateful to particular members who supported that and said there was a critical shortage. They used Queensland Health data to show that in those regional areas. Senator Nita Green from Cairns reminded me just how difficult it is to find people in regional areas.

The short answer about what would work is that you really have to start with barriers to access for allied health. For example, there are a lot of OTs and physios who would love to come and work here in Australia. We are a very lucky country. Yesterday I talked to a lady and her husband from Lebanon. There are significant barriers to her financially. Then there is Ahpra compliance. For people who do not work in the industry, the Australian Health Practitioner Regulation Agency regulates our entry. For a physiotherapist it can take two years, at least, to get through and significant financial cost to have to fly to Melbourne to sit their final clinical exam. It is absolutely ridiculous that during a pandemic we cannot do that in some other way. I am also a supervisor of physios. I love that part of my role. We have some really good physios who should be coming through more quickly than that.

What I see as the biggest issue is the delay in the AHPRA process for physiotherapists to come through, because there are a lot of them who want to work here and would be grateful to work in regional areas, including Goondiwindi and Cairns—areas where maybe others would not want to work. This is just a quick story. I was telling a lady about Goondiwindi. I said, 'It's very drought-affected. I've driven out there. There's dead kangaroos everywhere'—

CHAIR: Not at the moment.

Mr Blayse: Maybe not at the moment, no. Interestingly, we just had a flood evacuation for them. The same team members were telling me, 'You don't understand, Sir Alwyn'—because they call me that, which is funny. I just go, 'I'm just Alwyn. I'm a physio, just talk to me like that.' They said, 'You don't understand: my children are dying of smog in Mumbai,' or something like this. This is a lucky country: we can get physios and allied health even if we do not have enough coming through the universities.

I also talk to CQU. They have a dementia program going at the moment. They face that issue too. It is not trendy and sexy to work in aged care or community. It is much easier for physios and allied health to work in other areas. There are just not enough of us. It is pretty simple if you get more people through—for now, I think from overseas—to meet some of that demand. I think I heard the doctor previously talking about the difficulty GPs have in that area as well. I hope that answers that.

Funding for us in aged care would be a good place to start, because at the moment there are shortages anyway. The OPA was talking about 6,000 physios losing their jobs next year, so where do you think they are going to go? They are going to get out of aged care and then it is going to be even harder to access physios and allied health than it is already, which is insane. Excuse my passion for this, but I get quite emotional about that part because, as I said, I do not want to be the person on 30 September to look these guys in the eye—and probably even sooner than that—and say, 'I'm sorry, I can't see you four times a week anymore at no cost. You're going to have to try and pay and find a physio who's happy to come and visit you in the home.' It will just be ridiculous. It will be even harder than getting a physio to see you at home. Some of us who really care and want to will stay in, but there are going to be a lot of people who get out. I hear from them all the time.

Mr BLEIJIE: Obviously there is a process in place to make sure that overseas trained doctors and allied professionals—physiotherapists—are up to standard.

Mr Blayse: I agree.

Mr BLEIJIE: Surely you are not suggesting that we quicken the process, because then you run a risk with service delivery to patients across Queensland. If you are saying you need to quicken the Ahpra process, how would you do that to ensure we are not just letting—if I could use the expression—every Tom, Dick and Harry from overseas in and that standards are up to scratch? It will be worse for patients if we do not make sure the people we are allowing into aged care centres are properly trained.

Mr Blayse: I completely agree with you. I look at the end result as quickening it, but you are not changing the process. You are talking about the waiting list to get a clinical exam. The final step for a physiotherapist in that two-year process is to sit the clinical exam. They are not allowed to be registered as a fully registered physio. They can practise, but they cannot be a fully registered physio without a supervisor until they sit their final three clinical exams and pass those. Yes, absolutely that is needed as a requirement.

I would never want to change that Ahpra process. What I am saying, though, is that last year that process was entirely stopped because of COVID. Now we have waiting lists for that because people have to fly to Melbourne. They will not say when they are sitting. For OTs, for example, it is six months. They do very similar work to us, but the process for an overseas OT is only six months. What I am basically saying is that it would be a lovely one to look at. Of course Ahpra and public health bodies much more qualified than me are very good at protecting the public. I believe in that too. I do know there is a bit of red tape around people doing their last exams. That is where that comes from.

CHAIR: I have one clarification before we have a short break. Did you say 6,000 physios?

Mr Blayse: Yes, that was from the Australian Physiotherapy Council. I can send that through in our submission if that is helpful. I have a lot of that data; I just did not want to bore everybody. You get the general picture. We are very short—

CHAIR: That is in Australia?

Mr Blayse: Yes, that is in Australia.

CHAIR: Can you break down the Queensland cohort?

Mr Blayse: Yes, I have a bit of data on it. It just came out. They did another workforce survey which was not well answered by physios, particularly in aged care, because a lot of them have given up on this. Yes, there is some data for Queensland and I am very happy to send that through.

CHAIR: I mentioned that in this area there are 10,000 residents in multiple residential aged-care facilities—I cannot remember the exact number, but I know—

Ms KING: Ninety.

CHAIR: Ninety? Yes, there were 456, I think, in Queensland from our last inquiry. I want a clarification on that federal funding. You mentioned a date: 30 September next year. What is that funding and when does it stop? When does that gate come down? These are things that the committee needs to consider in its work going forward with recommendations.

Mr Blayse: Without boring everyone about the funding type, I was there in the whole system before 2008, when it was not this system, which is called the Aged Care Funding Instrument or the ACFI. I was working in Kilcoy. About every six weeks I would get called in to maybe review the most severe falls at that point, so it was very uncommon. I certainly never saw an OT in aged care at that point. In 2008 it all changed. They had funding specifically for physiotherapy and occupational therapy. It was very limited in scope. We were allowed to do massage and not exercise. That is an important distinction. People think physios are paid to do exercise but we are not. It is very specific. The Department of Health says that you are required to do massage at this point. Good physios and OTs will find a way to still do other things as well while not breaching those requirements, because we do take our professionalism seriously about following directions et cetera.

That is the basis. It is a broken system—excuse my language. That is what the royal commission found and they recommended it be replaced with a thing called the AN-ACC, which starts, according to the Senate and everybody, on 1 October 2022. That is when the funding changes for physiotherapists and occupational therapists. That part is an incentive for nursing homes to pay us because they get to claim extra funding for pain management. Although I sound a little critical of massage, it is still very effective. We can help people such as Bill quite significantly with pain. That is why we were sharing the story of what happens when they do not have that.

The short answer is that the funding changes. It goes from something that is beneficial to a nursing home to do to just being a cost. We have heard from industry advisers, including Miris, that they are advising nursing homes right now—that is what I am saying: this is not October next year; this is right now—to start workforce planning. It is like it is in inverted commas: ‘start talking about lifestyle programs’.

The term ‘allied health’ is quite confusing to a lot of people. You are including diversional therapists, lifestyle coordinators. What we are calling for is separate mandated funding with minimum minutes for physiotherapists and other allied health who are university educated and, yes, Ahpra registered, not because we are better than physio assistants or anybody else; it is because we have specialised skills and knowledge. We need to work in with those guys as well. That is what we are talking about from October. I do not think mine or other professional associations are being heard by the federal government about the effect that will have, particularly on Queensland and the public hospital system.

CHAIR: That is exactly what we were talking about. We conducted a previous inquiry into aged care. They are struggling enough in terms of nurse-patient ratios and the costs currently.

Mr Blayse: Thank you for mentioning the nurses. I am so supportive of them. We work hand in glove with nurses. I really worry. There is actually a gap between the AN-ACC that I was talking about—the minimum 200 minutes a day that nursing is going to happen, which starts in October 2022, so they have a whole year or maybe more without physios and allied health. I have heard nurses say, 'We're too busy already. We are paid for work. How are we going to prescribe walkers and manage pain?' They are going to manage pain by increasing analgesics and pain relief. That will lead to, as I said, preventable deaths and more admissions into our public system. Already there has been evidence of this: when they are short-staffed of nurses, providers often use hospitals as almost quasi-nursing facilities for routine things, not the really complex ones—like catheter changes, for example. The emergency departments should not be doing those sort of things; they should just have nursing onsite to do it.

CHAIR: I agree: care in place. Can you provide the committee with that evidence?

Mr Blayse: Absolutely.

CHAIR: Could you send any evidence to the secretariat by 16 December? We have fulfilled the wish of the deputy chair and the member for Kawana that we go over time. Our break is now 10 minutes. I will ask people to wait or have a stretch for 10 minutes and then we will come back for the next session.

Proceedings suspended from 11.48 am to 12.03 pm.

WATSON, Ms Flo, First Nations Bribie Island Community Elders Group

WATSON, Ms Michelle, Pumicestone Indigenous Education and Employment Council Inc. and First Nations Bribie Island Community Elders Group

CHAIR: I welcome you both here today. Can we start with an opening statement before we move to questions, thank you.

Ms M Watson: Good afternoon. My name is Michelle Watson and I am a Ghunghanghi, Kuku Yalanji and Wulgurukaba woman from North Queensland and Cape York.

CHAIR: I know Wulgurukaba. That is Townsville.

Ms M Watson: Today I am representing the Pumicestone Indigenous Education and Employment Council. I am the chair of the council. The Pumicestone Indigenous Education and Employment Council, PIEEC, has an Indigenous employment strategy for Bribie Island relating to the satellite hospital. Indigenous elders are being disadvantaged, unable to access culturally safe and competent doctors trained in Indigenous aged care and disability. Cultural awareness and health are a critical component of all the health care across the region. Indigenous health care must consider the diversity, equality and inclusion of all ages of Aboriginal and Torres Strait Islanders' physical and mental health. The cultural aspects are ignored in the strategies developed by My Aged Care and the NDIS. The satellite hospital and all medical and environmental issues must be addressed on a cultural level to ensure the specific needs of people are met by culturally competent medical practitioners and those in allied health.

Charitable organisations, through what they see as kindness, bring children from around Queensland onto the island for respite without any consideration to their medical or cultural needs, causing practice allies to have cultural needs or making decisions ignoring the cultural aspects of children. There needs to be a multidisciplinary approach so that unexpected medical issues that may occur are managed with multidisciplinary consultation about aged care, NDIS and any other matters. Nothing about us without us.

I want to talk quickly about my own circumstances. On 27 December 2018 my son and I were driving on Bribie Island Road towards Caboolture when a speeding car hit us head-on. Since December 2018 I have tried—for nearly three years now—to access Indigenous medical services on the island. I have not been successful. To gain access to medical health care that is culturally appropriate, I have to travel to Caboolture, to Morayfield or into Brisbane city. That puts an absolute strain on my family. My parents have to drive me to those appointments and obviously drive me back. There is a cost in petrol for us. My parents are only on seniors pensions. I am on a single parent pension. After the accident I had to give up my full-time job as a community solutions domestic violence manager and counsellor up the coast. Since the accident, because of the brain injury I suffered, I have had a traumatic brain injury diagnosed and post-traumatic stress disorder, which often makes me forget things. From the accident I also had a stroke that made me lose frontal lobe memory. All the services that I need I have to travel for.

When I heard that the satellite hospital was going to be built on Bribie Island, I was really excited. However, will I be able to access any mental health services? What Indigenous health services will be provided on the island for our elderly and ageing aunties such as Aunty Flo and other members of Indigenous families on the island? From Ningi down to Bribie, there are over 1,000 families. We do not live in standard family units with mum, dad and the kids. We live in groups of families, so there is aunty, uncle, grandma, grandad. Houses are often overcrowded for our First Nations people. What also needs to be looked at is proper housing for Indigenous elders on the island.

CHAIR: Thank you very much for sharing. When was the accident?

Ms M Watson: It was 2018.

CHAIR: That must have been an awful experience. Thank you very much for sharing your personal experience. Flo, would you like to make an opening statement?

Ms F Watson: I am Aunty Flo Watson, a community elder. We have a First Nations Bribie Island community elders group. We go throughout the region, throughout Pumicestone and to all the different schools around Caboolture and we do a lot of cultural awareness. I have delivered cultural awareness for rural and remote doctors. I am Wulgurukaba. I am an applicant up there in Townsville. We should have determination in February, so I am hoping to work with the Townsville community.

I am a great supporter of PIEEC. We have our yarning circles every week where elders get together and we bring people in from schools and from the communities. I also do a lot of work with the reconciliation action plans. I am still doing that now with the Moreton Bay council. As a wonderful friend said to me before, we have done the hard yards and we have worked with government on Tracks to Treaty and in different areas. We hope that we can leave a legacy with what we have done.

Ms KING: You both leave that legacy every day. Briefly, before the chair goes to questions, I want to acknowledge the incredible work that the two of you do—as an elder in our community, Flo, and as an emerging leader in our community, Michelle. I see the work that you do every day. You talk about yourself not working, Michelle, but I see your work and it is extraordinary. Thank you both so much.

Ms M Watson: Thank you.

CHAIR: Thank you very much, Aunty Flo and Michelle. I love that saying: nothing about us without us. It is quite powerful. I want to talk about, if I can use the phrase, your mob accessing GPs, be it culturally appropriate to Indigenous people or not. Have you some practical examples of the inability to access GPs and, therefore, there being more pressure in having to travel to public hospital emergency departments?

Ms M Watson: From personal experience, I have been to four doctors on the island I have found to be not culturally appropriate in the way they were delivering their service. The most recent was three weeks ago. I managed to get an appointment. I said to the doctor, 'I am an Aboriginal woman. There are certain things that I want to discuss with you that are of a culturally sensitive nature.' He said to me, 'Look, I go out in the sun and I have brown skin so we are just the same.' That was from a doctor on Bribie Island. I politely thanked him and I left the practice. I will not say where it is.

With regard to the psychologists that I need for my depression, it has been three years and this afternoon I have my first appointment with a psychologist on the island. Three years is a long time to wait for those services. If I did want to access a psychologist off the island, there were only ones available in Burpengary or Brisbane who I felt were culturally appropriate. When I want to access a medical service or any medical professional, I do a lot of background checks on them to see what their experiences are with Aboriginal people.

Something that another doctor said to me on the island just popped into my head. I rang up and spoke to the receptionist. He rang me back and he said, 'Look, I don't know what level of Aboriginal you are.' I did not realise that there was a ranging system in place for how Aboriginal I am. Those comments are enough for me to say, 'You know what, I am not going to use that service.' We need more culturally appropriate services on the island.

IUIH do not provide services on the island. They will come to the island—I know they provide Aunty Flo with meals, but that is all they do. If I wanted to access the service, I would have to go to Caboolture or Morayfield. At nearly \$2 a litre for petrol, that is a lot of money for me to be travelling to and from there and it is a lot of money for my parents, who have to take me to those appointments.

CHAIR: Aunty Flo, do you have any of those experiences you want to share?

Ms F Watson: I have had many experiences over the years. When I first arrived at Bribie Island about three years ago I went to see a doctor. I found him quite good. Apparently they did some cultural awareness through Queensland Health. He was quite good and showed me how culturally safe it was. They have Aboriginal flags and things like that. Since then I have been with IUIH. It is just hard to get appointments. To make a doctor's appointment you have to wait and wait. I have gone to another Indigenous centre in Caboolture which is quite good. It is just the travel for people to come here. For me to get psychology appointments or physio, I would have to go to Ningi Doctors and things like that. We need those culturally appropriate services.

CHAIR: Thank you for sharing that.

Mr MOLHOEK: I want to acknowledge the traditional elders past and present. It is my great privilege to be the co-chair of the Parliamentary Friends of First Nations People—a role that Leeanne Enoch asked me to take on.

Ms M Watson: She is a good friend of ours.

Mr MOLHOEK: She is a very good friend. I have had the privilege of visiting a number of First Nations providers across the state. You have talked a little bit about culturally appropriate care. For the sake of the committee and for those of us who are perhaps not as well educated around those issues as we should be, can you explain or provide some examples of what that would look like and how that would be different?

Ms M Watson: I am not a doctor or a nurse or a healthcare provider, but one of the things that I look for—and I know from talking to my group, the mums and dads who are in this region of Pumicestone—is that a culturally appropriate service needs to firstly understand that women want to see women doctors or women health professionals. We do not like talking about our women's business with male doctors. If we do see a male doctor, we need him to provide us with the time to explain that. We understand that doctors are very pushed for time with their appointments, but we need to have those discussions and to allow us to bring support people to our appointments.

For our elderly First Nations population, they need to have access to doctors who can come into their homes—you know how you have on-call doctors who go to their homes. I have not accessed any previously and, in speaking to elders, they have not accessed them previously. They need to have cultural training. They do not understand the generational trauma that has occurred. A lot of our elders come from the stolen generation. They have a lot of mental health issues that they would like to talk about and discuss with, say, a psychologist, but the psychologist does not have an understanding of what that generational trauma is with regard to the stolen generation, so that training needs to take place.

PIEEC, for instance, because we are an education and employment council, runs teacher symposiums. We get teachers in and educators from childcare centres in the region. They come and they have cultural days with us. That has been positive for them. We have had a lot of positive feedback for us. Because Pumicestone does not have other Indigenous organisations that specifically look at health, we have had to pick up that issue because elders and local First Nations people are coming to us. Because they do not have another service that they can go to here on the island in particular to talk about those issues, they have us be an advocate for them when they are dealing with things like their health issues.

Mr MOLHOEK: I have been doing some work on the Gold Coast with Griffith University around the intake and encouragement of Indigenous young people to take on professions like medicine, child safety and things like that. Aunty Flo, do you have any thoughts on how we could attract more Indigenous workers and First Nations people into our universities, colleges and TAFEs to take on some of those professions so that we can actually have a more culturally appropriate or sensitive response to First Nations issues in Australia?

Ms F Watson: I have been a part of many mentoring programs within universities. Next week I will go and do a talk with QUT for the Oodgeroo Unit, where they bring students in. My granddaughter—I am very proud of her—is now a fully qualified secondary school teacher. My brother's daughter is the first Chief Aboriginal and Torres Strait Islander Health Officer, Haylene Grogan. She is my niece. I am very proud of her.

CHAIR: Yes, we know Haylene.

Ms F Watson: I have been a part of many recruitment and career development strategies within universities and schools. Mentoring programs, I believe, are great programs. We work with elders. We go out and talk to them about what we have done. We had a session the other day with Sandy Angus talking about how we can get out there and get our kids into employment and into universities. Our education participation rates are still quite low. I am very proud. You go to universities and you see our children there being educated. All my granddaughters have degrees, and my daughters. I am very proud of them.

Mr MOLHOEK: Sounds like you are doing a great job with your mob and your family.

Ms F Watson: Yes. It is fantastic.

Mr MOLHOEK: Griffith University on the Gold Coast has just over 3,000 students who are of First Nation heritage. They have a full-time professor who works with them to encourage them. I think that is important. Finally, Michelle, you mentioned that a lot of local GPs are perhaps not always culturally appropriate. How do you find your experiences in dealing with Queensland Health and other allied health services? Would that be a broad view?

Ms M Watson: The waiting is the biggest thing. You would hear that a lot. For me, I can ring up the Indigenous unit at Caboolture Hospital and tell them a situation and they will get back to me and say, 'We cannot get you an appointment for six weeks.' After the car accident, there were injuries to my spine and back, so I often will need to go to a physio. I had four physio appointments here on Bribie that were paid for by the insurance company. That was all. I now have to pay for any of those appointments myself or access the hospital, but I cannot often get an appointment for two weeks.

Ms KING: Thank you both so much. We have heard today about the importance of allied health professionals being available to community members to keep their health at its optimum level. I wanted to ask you about your mob here on Bribie. In your view and from what they tell you, are people able to access physios, dieticians, podiatrists and those important allied health professionals when they need them?

Ms M Watson: Yes, we can, but, like I have said, they will not often go back for a second appointment if they feel that particular allied health professional does not make them feel culturally safe. For us at PIEEC, we are often asked to drive them to Caboolture or Morayfield to attend those appointments because after one or two appointments here on the island they just will not go back to them.

Ms KING: I wanted to ask as well about the barriers of cost in accessing health care. Do local First Nations people talk about that as an issue? Is that something you experience in your community, that cost is a barrier to getting the care that people need?

Ms M Watson: There is Closing the Gap. We get reduced prescriptions and things like that. Again, when we are talking about a particular health issue, we are often referred to IUIH. IUIH is a great organisation. They do a wonderful job, but there are a lot of us Indigenous people who will not access IUIH for certain things because we know everybody there. You walk in there and it is all mob that we know, so there is no confidentiality or privacy to when we attend appointments. To be able to have a designated Indigenous space—and maybe that is something we need to talk to you about with the satellite hospital being constructed, that there is a First Nations area there, even if it is just for Indigenous health workers to be there to refer our local community on to different services.

Another thing that PIEEC is doing now, and we are working with Bill—the wonderful Bill—is having a referral type of portable office where we can drive around in a van to different spots and our First Nations community, plus the rest of Bribie Island and the Pumicestone region, can come to us and we can provide them with information about all the different services that are here. There are so many different services that may come on to the island or are already established here on the island that our First Nations people do not know about and do not know how to access. Being able to have this van that we can drive around to different spots and set up—it gives access.

There is still that mentality that if you build an office everyone will come to it. Us blackfellas do not do that. We are not going to go there. We are going to have a yarn between ourselves. That is what is really good with the elders. The local community know that Thursday afternoons, in particular, they are on Bribie Island at the skate park and if they need to have a yarn the elders are there to have a yarn with them and assist them with things like that.

CHAIR: If there are no further questions, I would like to thank you both very much. Thank you for having us in your part of the world today. It is really good for members of parliament to be here in the local member's area. Thank you for your advocacy. It sounds like a really good idea in getting out there. Sometimes the health system is hard to navigate. Both of you are doing great work. Thank you so much for your time. We are now going to have an open forum. We will first invite Janet Watson to the table, and Joan is going to accompany her.

WATSON, Mrs Janet, Private capacity

Ms PEASE: I am here with Janet. She is going to share her story. It is a very difficult story. Her husband passed away just three months ago. She wants to talk about her experiences. She is obviously very upset, so I hope you do not mind if I assist her.

Mrs Watson: My husband, Graeme, was in a nursing home in Caboolture for the last three years. For the last nine months it was hell. He had no GP for nine months, and the only thing we were offered at the nursing home was either to get an after-hours doctor or to go to the hospital. The after-hours doctor would only come and see him once a week.

Graeme had multiple problems. The first time he was diagnosed 30-odd years ago with asbestos related disease. That was a big thing. Then he found out five years ago that he had a very rare muscle disease that affected every muscle in his body and every cell in his body called mitochondrial myopathy. He had that all his life. I took Graeme to doctors throughout Queensland for nearly 40 years and they could not tell me what was wrong with him. It was only because a doctor at the Prince Charles did a biopsy of his leg muscle that we found out. Three years ago he had a fall at home. He had a fractured hip. I had to put him into a nursing home.

The first year he was at the nursing home it was fine, and then because of the almighty dollar—that is all I could put it down to now—a GP saw Graeme regularly, but he got to the stage where he had complications and complications. He could see several patients to Graeme's one, and this is when we found out Medicare was not paying the money for him to see him so regularly, so therefore he could not see him. That is why the doctor resigned. Then I had to ring all of the doctors around Burpengary, Morayfield, Lawnton, Bribie—everywhere—to see whether I could get a doctor to Graeme. They said no, they will not go to the nursing homes. The doctors at the Prince Charles ended up giving him botox injections quite regularly so he could walk.

He was supposed to have physio every day of the week; he did not get that. He only got massages three times a week, and that was all Graeme got. At one stage he actually started to commit suicide. He was in a lot of pain. He had permanent catheters and he was continuously having urinary infections. There were two choices. I had to either go to an after-hours clinic, which would only see Graeme for one thing. Instead of multiple things, they would only see him for the one thing. It was getting very impossible to get him scripts. At one stage the chemist had about 25 scripts out owing to them, and that was a lot of scripts that they had to find people to write them up. At one stage the pharmacy told me that if the backdated scripts did not come through they would refuse to send his scripts through. That is my story. Thank you.

CHAIR: Thank you for sharing your very deeply personal story. Sadly, the committee has heard similar stories in a previous inquiry around Queensland. Please know that we made 77 recommendations as a result of that inquiry to try and get better care into aged-care facilities. This inquiry backs onto that. We have heard your story today and we thank you very much. I have no questions.

Ms KING: Thank you so much, Janet, for coming in. We really appreciate you sharing your story with us.

MORET, Mrs Elisabeth, Private capacity

MORET, Mr Theo, Private capacity

Mr Moret: We are relatively new to Bribie Island. We moved here a year ago so we may not have a long history with Bribie, but we were researching for a GP. We are typically the kind of people who find that difficult because there is no availability. We were enthused with the prospect of a mini hospital that just happens to be across the road from where we built so it could not be any more convenient, thank you very much.

What we would like to impress on the committee is the type of services that might be provided there. We did go to the show in town at the showground. We were not all that enthused by the limited amount of services they might provide. It seems fluid. One of the reasons I wanted to attend was to say: whatever the limited amount of services, can you crank it up to suit the situation that is desperately needed with respect to medical care? I do not know whether it is all set in concrete yet, but I believe that we do need that.

I appreciate the fact that people have to take responsibility for their medical requirements. I just wanted to share a small story. About 45 years ago I was diagnosed with migraines. A family doctor diagnosed those. We talked about treatment and the like moving forward. We resolved all that and we had a method of treating them. Approximately 10 years ago I had codeine based painkillers for that. You now have to go and see a doctor to have a script. Whilst I appreciate that GP services are scarce on the ground, decisions by a committee like this, which may possibly say that we may not be able to trust some people with their own decision-making, create an extra workload on our GPs. That does not help a great deal when you actually need a GP service. I see our GP service for scripts and referrals to specialist services; I do not see it for emergency services. Generally they work office hours, so if you have an emergency you end up going to hospital. I would like to think that if the mini hospital that is proposed eventuates we have an emergency service close by that does not involve necessarily an ambulance ride to Caboolture. They always say that minutes matter, and it is a long drive.

Mrs Moret: This is unusual husband and wife behaviour because we both have different things to say. I want to address also the lack of GPs, particularly during COVID. Looking for a new one was really hard. When you went through their websites, they were all not taking new patients. I had a recent look and some of that seems to have disappeared, but we have not yet made that transition. Currently we go 75 kilometres each way to our old GP when we need to get some sort of medical attention. Luckily we have not had colds or the flu, because you do not want to travel that far. Over the 35 years I have been going to this one clinic I have noticed that they have gone through a number of GPs, and as time has progressed there seems to be less and less choice within the clinic itself as they move on. There are fewer choices and it is hard to find a GP that you can relate to and discuss your issues with. I think it was Michelle who just said that you need to be able to relate to people, regardless of who you are. That is an issue.

When we first decided on Bribie we had a look around and thought there were lots of clinics here and it should not be a problem. Wrong. With the new satellite hospital—which is not really a hospital—I hope there will be the ability to bring in services or at least consultation rooms so some specialists can come in one day a week or one day a fortnight, particularly as we are facing aged care ourselves as we get older. It is not that you do not want to travel; it becomes too difficult to travel. We are okay at the moment, but I can see that it will become an issue for us in the future. I am hoping that things like that can be brought in there, including some of those specialists that you might need to see on an ongoing basis. I am a coeliac and my mother died of bowel cancer, so I need to see a gastroenterologist to have scans every couple of years. I am hoping that those sorts of things might be done there rather than having to travel a long way away for that. Some diagnostic services are basic on the island, which is great, but you need more detailed specialist things sometimes and I am hoping they will not be too far away. I realise it cannot all be on the island, but I would like to see it all come up closer so that Caboolture or Morayfield have some sort of centre where these more specialist things can be done.

With regard to private health care, it is becoming ridiculously expensive and I can see why 60 per cent are no longer in private health. It is no longer value for money. In 1984, when Medicare first started, I remember going to the doctor, and between Medicare and my private health insurance for the first number of years there were no out-of-pocket expenses. They covered everything 100 per cent; it did not matter what you did. Now would I bother being in private health? There is so much they want to include that you do not use, so it is really no longer value for money to be in private

health. I can totally understand why everybody is not staying in there. The amount they go up each year is well above the inflation rate, unless inflation rates are not being properly recorded and reported. That is another thing.

In terms of aged care, in the past 12 months both his parents have gone into aged care, so we have managed through ACAT and all of those issues for both of them. It has been a nightmare. You wait months—sometimes six to eight months—to get an ACAT assessment. By the time they get the first assessment and they come in at a particular level you have to wait nearly 12 months for that. By the time that assessment comes in, they are ready for the next level, so you have to go through that process again.

The way they work is that you get this much funding. Then you go to a provider and they convert that funding to hours. Somewhere between ACAT and the provider—ACAT would say, 'You'll get this many hours for that,' and the provider goes, 'No, no.' So you get about 50 per cent of what ACAT think you will get. They are the sorts of issues that I would like to see addressed. Whether it is on a state level or federal level, I am hoping that this committee can do some good for those sorts of issues.

CHAIR: Thank you both very much.

Ms KING: Theo, I think it may have been you who wrote to me and suggested there should be a billboard at the bridge telling new residents that there are no GPs available on the island before people move here. Was that you?

Mr Moret: No, it was not, but I like the idea! It has been really tough going. We were attracted to the island like everybody who is attracted to moving here, but we realised that we would need medical services as we get old. I will tell you a short story. Sorry to take up your time. As we were buying the property, there was a gentleman on a mobility scooter on Welsby Parade who beat us up the road to the high school while we were driving. We thought, 'This is fantastic. Aged people can get around the island. There is no problem. It is well catered for.' That was until we started looking for doctors. We are committed, but finding doctors is hard. I do appreciate—I did corner Dr Kearney here while I had him. I would not let him out of the corner, so I now have an arrangement.

Mrs Moret: Maybe.

Mr Moret: Maybe. It depends on him hiring the next doctor, Ali, so thank you for that.

CHAIR: We have fixed something.

Mr MOLHOEK: You can leave pumpkins on his car!

Ms KING: That is my pleasure. Amongst the friends that you have made since you moved here, for those who have managed to get on the books of a GP in a longstanding way, what did they tell you about the wait times to get a GP appointment in this community?

Mr Moret: I want to say that our neighbours are fantastic. They have been really warm and receptive of us. They are older than we are. Our first call was, 'Who do you see?' They said, 'Don't bother ringing. He's not taking any new patients.' We tried that avenue. We get the usual horror stories. We have a friend, an acquaintance, who lives here. They told us it took 40 minutes for an ambulance to come to take him to the hospital. They had a heart attack and could have died—that sort of story. That does not make you very comfortable.

We were really concerned that the Ambulance Service was wanting. On one of our morning walks a chap was working outside the ambulance station over here, so we decided to front him and say, 'We've heard that there are only ambulances at Ningi.' He said, 'No. That's not true. Let me show you our ambulances. We have a team of people.' We were ultimately relieved that there were so many ambulances there. We were not aware of it, and I guess other people are not aware of it either. That might be a message to get out there as well.

Ms KING: In fact, Bribie is one of the only communities in Queensland where we have a one-in one-out system—when an ambulance leaves the island, another one is dispatched ready, even if there is not a job here. We have that unique priority arrangement with QAS which is very helpful to the community. I was more asking about GP appointments. What do your friends tell you about the wait for a GP appointment?

Mr Moret: These people have been here for 20 years, so I figured they were well established. They tell me it is still a long wait. It did not make me comfortable. It was easier for me to drive to my practice at Morningside that I have been going to for 30-odd years than it was to make an appointment here. I can make an appointment within a week and see my regular doctor. At the moment I am choosing to drive all the way to Morningside to get my script which is ridiculous really. I think Dr Kearney might fix that for me.

Ms KING: I am sure he will.

CHAIR: I can only draw comparisons to North Queensland. We have Maggie Island off Townsville. We do not have a bridge.

Ms KING: It might be less trouble.

CHAIR: I do not know what the population here is. I do know I only have a handful of doctors on the island, so I get the struggles that do occur. Thank you both very much for articulating your own personal stories and challenges. Thank you for your contributions. We appreciate them.

PROOF

MORRIS, Mr John, Private capacity

WALKERDEN, Ms Tania, Private capacity

WATSON, Mr Ron, Private capacity

CHAIR: I now welcome Ron Watson, Tania Walkerden and John Morris. John has been waiting pretty patiently over there so, if Tania and Ron do not mind, we might get John to start with his opening statement and tell us his story.

Mr Morris: I am John Morris. I am a virtual quadriplegic due to an immune mutation, I am told. It could have been anything—best guess! That probably leads me to one of the first concerns. I may be able to reinforce some of the comments that have been made earlier.

I have had cause to go to Caboolture Hospital in an emergency situation. I was not allowed a carer. That led to all sorts of problems. In fact, I hope I never, ever have to go to that hospital again. If I live long enough, I will go anywhere but there due to the sorts of things I was subjected to. I was not allowed a carer in there. My carer is my wife. She is with me 24 hours a day and she can manage my care at the moment. I got stuck in the toilet for 10 minutes or so because I could not use the doors—in a wheelchair it is just about impossible to push them open or hold them open long enough so you can scoot out. They all have strong springs and everything on them. That was one of the issues. Nobody nursing in there understood my situation or knew how to treat me. It was thoroughly unpleasant and painful because I did suffer injury.

My good friend Bill Peacock commented on the cost of OTs. I have paid over \$700 for an OT. At one stage I simply wanted a new cushion for this chair that I am in at the moment. I have been in it for eight years. I said it gets a bit sore around the edges at times. I have no problems with pressure points or things like that. It just gets hard to mould. It usually moulds around me so it is best to sit in every day because of the constant use. I am in the chair 23 hours a day. I sleep in it. I need to have something that is suitable for that. I asked for a replacement cushion. I was told that I could not have a replacement cushion until it was approved by an OT, using my funds from My Aged Care. I missed out on NDIS as well.

My Aged Care said that anything I purchased had to be approved by an OT first, so they sent an OT around who said I might look at other cushions. I did not know what was on the market. I thought something new might be around. Basically I was quite happy with the one I had. They provided one. She slapped it on the chair while I stood up. I can stand for about a minute under certain circumstances. She put the cushion on and so on. The next time I came to get off I was just about at the point of pushing off to a standing position because I had to have my knees locked and the cushion took off. She had not battened it down. This is an OT. It was not attached. They then proceeded to drop off another four cushions, which were all different sizes and none of them were any good because I could not attach any of them. I could not use them. Anyway, after two or maybe three visits I had to ring up and say, 'Don't do any more to help.' That cost me \$770.

I tried to organise my home so I could cut down on any issues by having everything set at the right height—lights, fans and that sort of thing, having a basin that was hanging would be better and so I could access the toilet and flush it. I have always been able to do that. Starting with a brand new home, none of those things were put in. I had itemised them. I had put them all in the plan—dotted them in. I had the builder initial them. They did not do any of them. I went to QCAT. The member who was sitting there for the day said, 'You haven't got any of this in the contract.' I said, 'It is all there on the plan.' What the builder had done was took the plan away to professional certifiers, drawn up a new plan, cut all of that out of it and given that to the judge. That is all he wanted to see. He did not bother with the one I gave him that we had signed. He just turned around and said to the builder, while I am in the dock, 'Well, would the house be suitable for a normal person?' That makes the hair stand up. I could not get over that and I still haven't.

These are the attitudes that affect health. If the builder had done the right thing then, everything would have been cheaper. Since then I have been trying to get OTs to try to correct a lot of the things around the house that I could not reach. I still cannot reach the tap and the basin in the bathroom. The carers have to use a side hose because I cannot get to the one behind because they put it on the wrong wall because it was more convenient. I really need an emergency exit because as soon as I hit the grass outside my place, especially at the back, it is all sand. I cannot move. I am stuck. That was another \$770 to say, 'You would benefit from one.' That is all I got—a page and a half for \$775. I could go on. It just goes on and on—thousands of dollars.

The one that really gets me is where the law apparently says that if I need to buy anything I have to get an OT to approve it. For things that break or crack that you have been using for years—like the seat on my commode needs changing; it has broken twice in I think 10 years—I still need an OT to come around and approve it. It is just crazy. They just fritter away my funds. I am only on \$52,000. I could tell you without even counting it that less than half of that actually goes to anything that I require. All of that is taken up by the provider and fringe dwellers—OTs, physios and so on. They are just doing the job that they are given to do, but it should not be needed. It is just crazy. I cannot believe it.

I saved up for years and years on my system to get a replacement chair. Eighteen months ago I asked for a new cushion and I have not got it yet, but I have had the \$770 bill from the OT. The cushions are only \$1,500, for goodness sake. They will probably want it approved again now! These are the sorts of things that happen.

I see they have been making plans to have a standard building plan for doorways in houses to cater for disability. They set it at I think it was 850 millimetres. I cannot get through anything less than 850 for sure. You have to remember in a house you are going in on an angle. You have to be inside the room before you can turn. A lot of these things are not taken into account. If you had a wider hallway, sure, you can do things on the angle and other things. They have to think the whole process through. Just setting an arbitrary limit on doorways is not going to help. Anyway, I digress. I just wanted to make those couple of comments.

CHAIR: Thank you very much, John. You really articulated some of the issues with getting some of those specialist services. Thank you for sharing that. Tania, would you like to make your contribution?

Ms Walkerden: I am here today as a disability service provider. I have lived on Bribie for 17 years, so I am very familiar with Bribie and the health services that are here. Today I want to talk about a young fellow whom I provide support to in a supported independent living home. He is an NDIS participant. He is a 30-year-old male who has severe autism spectrum disorder. He has anxiety disorder. He has mental health issues. He is about six foot two and 170 kilos. He is non-verbal, very routine oriented and has lots of sensory issues. We provide support to him 24 hours a day seven days a week. He has family support as well. His mother and sister both live here in the Bribie region and are very involved in his support.

Last year he had an oesophageal stricture. He was sick for about five weeks while we tried to get medical assistance for him. He cannot be taken to a GP. He will self-harm—so he will hit himself in the head, bang his head on the floor, lash out at the staff, lash out at his family. We go on his behalf or we try to get home visits. With home visits, quite often they want to do telehealth with him. They will ask if they can talk to him. We will say, 'You can talk to him but he is not going to answer you and he is not going to understand what you are saying.'

We have taken him to the Caboolture Hospital. The Caboolture Hospital do not know what to do with him. We have had security involved. We have had to have him sedated. They have sedated him enough to be in his environment to do checks on him and then had to sedate him again to have more procedures done but not sedated enough for him to have CT scans though. He starts to act out when those sorts of things happen because he is out of his environment, he is out of his routine and his anxiety is sky high.

He got told to have Nexium and go home. Of course that was not going to do anything when he had a stricture. He was then referred to Prince Charles and he had the procedure done at Prince Charles. They asked us to do a follow-up visit with him in six months. He was referred to Caboolture Hospital for a follow-up appointment. At the follow-up appointment they were not listening to what his needs are. They are complex issues that we have around his sensory issues—the fact that we cannot go and sit in a waiting room for his appointment time, that people cannot get in his space. It sets him up for failure.

They booked two appointments and we said, 'You're just not listening and it is not going to work.' His doctor then referred him to Royal Brisbane instead. I had a meeting with Royal Brisbane via Zoom on 21 October with the gastroenterology clinic. They said that he needed to have a follow-up endoscopy procedure and that it was an urgent level 1 that had to be done within 30 days. They booked an appointment time. Again, they were not listening. Again, they do not understand that we cannot put him in a car and drive him for an hour and walk him through a hospital. We cannot have him nil by mouth. He will not get up in the morning and not have something. We cannot stop him from doing that. He will just help himself out of the fridge.

We then asked to speak with a disability liaison officer at the hospital. We got told there is none. They put us through to a social worker. The social worker said, 'I don't know what to do. I have to refer you back to the gastro clinic and see what they can do.' We have made the suggestion that what really needs to happen is have patient transport pick him up from his home environment and sedate him and take him in to have the procedure done. We were told that because they are not going to be admitting him they cannot do that. At the moment I am still going round and round in circles and his family are still going round and round in circles trying to get this urgent appointment sorted to take him in and have this done when they just have no understanding of the complex issues of this young man who has a disability that he has lived with all his life. That is one example.

Another example is the COVID vaccine. We were told about the My Voice Brisbane North Primary Health Network, that they were doing home visits to give the vaccine to people like this young man. I put the referral in. They contacted me. They said, 'Can he go to his GP?' I said, 'No and these are the reasons why.' They then said, 'Can the GP do a home visit?' 'No. The GP will not do a home visit.' That is what this clinic is for—to come out and give vaccines at home.

They told me they needed to talk to his parents to organise it, so it was organised for a day that she could be there and provide the support to him because of his complex needs. It was on a Monday. They rang on a Friday and said, 'Can we do it Saturday instead?' We are not set up to be reactive like that and be able to have the supports that he needs for them to change the appointment times so quickly. They then called the parent on the Monday and said, 'We need to narrow down a time because you are chopping and changing.' She said, 'We are not chopping and changing. We had something that worked for us and you asked to change it and it didn't suit.' We are still waiting to hear back from them about booking in a time.

Another thing that we deal with is that he cannot go to GP appointments. His GP used to be here on Bribie and they retired. We got another one at Beachmere who would understand his complex issues. Her clinic closed and she ended up moving to Morayfield. I have chased her into Morayfield so that we can keep that consistency with somebody who knows his support needs. I have arrived at the clinic and they have said, 'I don't think you can see the doctor on his behalf because he is not here with you.' I said, 'I am here because this doctor knows him and knows his complex issues and he cannot attend appointments.'

We have a great group of people who are involved in his support. He has a psychiatrist who he sees quarterly via Zoom, so I can show the doctor what is going on with him. We have a couple of key doctors who are great in his support. If they were to leave, we would have to start from scratch again with somebody who has such severe complex needs. When he has a medical issue, the medical system just does not understand and will not take on board what it is that we are recommending for everybody's safety.

CHAIR: Thank you so much, Tania. It sounds like this young man has really complex needs.

Ms Walkerden: Very.

CHAIR: Quite clearly all the supports you are giving him are commendable. Parking the specialists aside, can I confirm that it was the primary health network offering that home service for the COVID vaccine? Was it the Brisbane North PHN?

Ms Walkerden: Brisbane North Primary Health Network.

CHAIR: We had the PHN in front of us yesterday. Clearly, with these really complex cases, I deeply value personal relationships between GPs and patients. If you had the ability to have GP home visits, would that resolve a great deal of the issues you are facing with this young man?

Ms Walkerden: It would. Again, they would have to have some understanding of the complexity of somebody who is not able to answer questions, who has support staff who work on his behalf, who are the people who are his voice. We can ask him whether or not he is sore. He will point to his head and say, 'Sore,' but whether or not that is a true indication of how he is feeling we do not know. It is really difficult. We can see other things that are happening that make us believe he is sore.

For us, even for things like the dentist, we cannot do that sort of thing. If we end up getting him to a hospital and he is sedated, we ask them to do a thorough check of him while he is there simply because we have no way of getting into his space. My staff sit arms-length away from him to work with him on a daily basis because he is just so complex. Even for things like water running into the kitchen sink he will be putting his fingers in his ears because it is a sensory overload for him. Something as simple as that can cause an escalation and self-harm.

My team are great and have an understanding of what his needs are. We all do advocate on his behalf. In terms of having a GP home visit, that would be great because it takes away him having to go somewhere, but they would still have to have some sort of understanding of not being able to Bribie Island

get into his space and take his blood pressure or do a check of his ears or take his temperature. We are limited with what we can do in his environment. Showering is an issue for us—the sensory noise from the shower, people in his space in the bathroom and the echoey sound.

Ms PEASE: That would be one of the benefits of having a regular GP who knows the person—patient centred care.

Ms Walkerden: Yes, absolutely. That is why we have followed this GP from Beachmere to Morayfield so we have that consistency and continuity of care for him. It is just so very important. That is aside from all of the medications that he takes and all of the other things that go on with his medical side of life. It is just really complex.

CHAIR: I am mindful that we have 15 minutes left.

Ms KING: No, Chair. We were meant to finish at 1 pm.

CHAIR: Mr Ron Watson. Thank you very much.

Mr Watson: Good afternoon. Thank you for the opportunity. I am not here to criticise the hospital. All I am going to say is that the hospital is being built in the wrong location. If you want me to go on, I can tell you why it is in the wrong location.

Mr BLEIJIE: Which hospital are you referring to?

Mr Watson: The one here on Bribie Island.

Mr BLEIJIE: The satellite hospital?

Mr Watson: Yes, the satellite hospital.

Mr BLEIJIE: It is not really a hospital.

Mr Watson: Okay. The satellite facility is not being built in the right location. I am just going from the newspaper for figures. The average cost of these satellite clinics is \$40 million. The one here on Bribie Island is coming in at \$14 million.

Ms KING: No, that is not correct, Ron.

Mr Watson: I am just going from the newspaper articles. Also, the clinic is being built inside a depression. The depression is about two metres deep, give or take. The road system around it is built above the flood plain. Going on costings for what the government does on roads around here, the cost of the infrastructure for First Avenue for dual lanes will come to about \$20 million. If the engineers decide that the hospital has to come up to road level, then there is going to be a conga line of B-doubles coming in with solid fill to fill this depression so that building can commence on the clinic. For the private hospital that is being built near Woolworths, it took them about a year of B-doubles coming in to build the foundations up so that the building could then commence. That is all I am saying. The clinic should not be built in that location. The current location to me is unsuitable. The clinic should go further down First Avenue down towards Woorim on solid ground.

CHAIR: Ron, we appreciate that you have given your position on that. It is outside the scope of the inquiry. I would take you back to the GP waitlist and access. Do you have any practical examples to give the committee where you have not been able to access a GP and have had to go to a public hospital?

Mr Watson: No. My medical needs are completely different to everybody else here because I am covered by DVA, so I have no complaints about the medical system whatsoever or about what happens here on Bribie Island—all the procedures and everything else. All the support services here on Bribie Island and all the voluntary services here are simply brilliant.

CHAIR: Excellent. That is a lovely thing to say. That is a very good note on which to end this session. I am reminded that we have gone well over time. I thank all of you for being here today. I particularly thank those who have been observing in the audience for their patience. It is always nice for members of parliament to get out and actually hear from people about the challenges around this particular inquiry. We do appreciate you all being here today. Thank you for your time, for your participation and for your contributions. I now declare this public hearing closed.

The committee adjourned at 1.18 pm.