HEALTH AND ENVIRONMENT COMMITTEE

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

Staff present:
Mr R Hansen—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

MONDAY, 7 FEBRUARY 2022

Cairns

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The committee met at 1.01 pm.

CHAIR: Good afternoon. I declare open this public hearing of 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, present and emerging. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share.

With me today is Rob Molhoek, member for Southport and our deputy chair; Ali King, member for Pumicestone; Joan Pease, member for Lytton; and Trevor Watts, member for Toowoomba North, who is substituting today for Mark Robinson, member for Oodgeroo. Joining us via videoconference is Stephen Andrew MP, member for Mirani.

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 remind members of the public that they may be excluded from the hearing at the discretion of the committee. These proceedings are being recorded. Media is present and are subject to the committee's media rules. You may be filmed or photographed during the proceedings. Please turn off any mobile phones or put them on to silent mode.

If witnesses have any documents they want to provide to the committee, just ask and we will table them when you are speaking. If you have any other information you wish to provide to the committee following the hearing, please write to our committee and the committee will then consider your correspondence. If any members of the public wish to provide a contribution, they should speak to our secretariat, Rob. He will take your name and after the listed witnesses we will proceed with anyone who wants to speak.

I acknowledge Michael Healy, the member for Cairns, who is here. Welcome. It is good to have a local member who is going to hear some of the issues in this space.

CAVANAGH, Ms Tania, Acting Executive Director, Allied Health, Cairns and Hinterland Hospital and Health Service

STRIVENS, Dr Edward, Clinical Director, Older Persons Health Services, Cairns and Hinterland Hospital and Health Service

CHAIR: Good afternoon and welcome. I invite you to make an opening statement. Then we will ask questions.

Dr Strivens: Thanks very much and good afternoon. I am Dr Eddie Strivens. I am a geriatrician and also clinical director for Older Persons Health Services for Cairns and Hinterland Hospital and Health Service. I would like to also respectfully acknowledge the traditional custodians of this land on which this meeting is taking place and pay my respects to elders past, present and emerging. I also acknowledge the First Nations persons in the room today. I thank the committee for the opportunity to provide the following opening statement to the inquiry about the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system.

As you know, the Cairns and Hinterland Hospital and Health Service delivers public hospital and other health services in regional, rural and remote locations that stretch across a wide geographical area of the Far North covering around 143,000 square kilometres, which is twice the size of Tasmania. We are responsible for the direct management of 30 health facilities that include hospitals, primary care, community health centres, a prison health service at Lotus Glen, an emergency health centre as well as public health, mental health, sexual health, and alcohol, tobacco and other drug services. The health service provides 95 per cent of all services we provide for our community.

The main hospital for the region is Cairns Hospital and that delivers a broad range of secondary and tertiary health services as well as specialist services for our neighbouring Torres and Cape Hospital and Health Service. The health service's footprint has an Aboriginal and Torres Strait Islander estimated resident population of nearly 30,000 people, or 14 per cent of the total population. This actually makes up around 13 per cent of Queensland's total First Nations population. It is the second largest population count of Aboriginal and Torres Strait Islanders in comparison to other hospital and health service regions. Our annual budget is now over $1 billion and we employ nearly 7,000 staff in full-time, part-time or casual capacity.

Our hospitals and emergency departments are stretched. This is due to a number of reasons such as increasing demand, and this is often for conditions that could have been prevented or better managed within a primary healthcare setting. Unfortunately, this is unlikely to change in the very near future given that the primary health network reports that, due to the current demand for primary healthcare practitioners in rural, regional and remote Queensland, there were 97 vacancies for GPs in the North Queensland primary health network region and 27 vacancies for allied health practitioners.

No doubt we will face further vacancies as we see our ageing primary care workforce as well as our older GPs retire, and often they are not replaced. Often these are the GPs that are covering aged-care facilities. Some of our GPs and allied health professionals are working well beyond retirement age as they are unwilling to leave their patients and their community without access to the primary health care they need.

To give you an idea, recently a sole medical practice in Mission Beach, south of here, closed its doors. Our health service has been working closely with the North Queensland primary health network. Despite ongoing recruitment and many attempts to secure a locum for Tully, with the national shortage of doctors, so far it has been a somewhat futile exercise. Our dedicated rural hub medical superintendent explained that, in terms of recruiting an overseas trained doctor for that region, the doctor needs the appropriate experience so they can work unsupervised in a remote area.

Surprisingly, he did actually manage to find an overseas trained doctor with the experience who was willing to work in the rural community. However, due to the COVID-19 pandemic, the doctor is unable to sit the second part of his Australian Medical Council exam, so he is unable to leave South Africa to provide the service to Mission Beach and Tully. He is currently working in general practice in a similar sized town to Tully, so the rural aspects would not come as a shock to him as they do to some other overseas trained doctors. That is just one example of the barriers to recruitment, and there are many others.

Compared to the rest of the state, there is a low volume of allied health services in Cairns and hinterland and a significant lower volume in the Far North if you take in the Torres Strait as well. It is well documented that without the access to primary care there is often a high burden of chronic disease and mental health related illnesses, and these in turn can lead to frequent ED presentations and multiple admissions to hospital as well as prolonging people's length of stay within hospital.

While the hospital and health service continues to implement initiatives for hospital avoidance, in the 2020-21 financial year, presentations to the Cairns and hinterland emergency departments increased by 8.7 per cent compared to the previous financial year. In our rural facilities—that is Mossman, Mareeba, Atherton, Innisfail, Tully and Babinda—there was a 6.1 per cent overall increase in presentations. Interestingly, in the last financial year, of the total number of presentations to the rural facilities around 65 per cent were triaged as category 4 or 5. Those categories are the ones where presentation can often safely be provided within a primary healthcare setting rather than within a hospital.

Lack of access to primary health care does place additional pressures on our public health service, as does the lack of specialist dementia care beds for our region. We look after 2,257 residential aged-care places in the region, but the nearest specialist dementia care program unit is in Mackay. This is for people exhibiting severe responsive behaviours associated with dementia. As I am sure the committee is aware, dementia is a progressive neurodegenerative disease. Those with the most severe end of behavioural symptoms are often unable to be managed effectively within mainstream aged-care services and for short periods sometimes will need that more specialist support that a specialist dementia care unit can provide. The only other option is a long-stay hospital admission, which places further strain on public health systems. Hospitals are not ideal places for people living with dementia and exhibiting responsive behaviours.

In November last year, which was our last census count, there were 21 long-stay patients, of which six were aged care, with the vast majority of those exhibiting responsive behaviours, and 14 were NDIS participants. The NDIS has added another layer of complexity to our health and disability

support system. It is already somewhat fragmented by the Commonwealth and state funding divide. Our subacute services have experienced difficulties coordinating discharges due to delays in assessment and inflexible system requirements which have delayed access to community supports and services. These delays can be significant. One NDIS patient had an 11-month long-stay hospital admission. While 21 seems like a low number, 11 months in hospital is 22 rehab admissions, so 22 people could have been receiving rehab during that period.

To assist hospital and health services to safely support the discharge of long-stay patients from hospitals, Queensland Health established an internal escalation pathway for the long-stay rapid response funding, which has benefited six of our NDIS residents and patients. Without this funding, these residents and patients would still remain in hospital awaiting accommodation.

I now move on to aged care. An increased focus on community support provision has led successive Commonwealth governments to expand community support packages access through My Aged Care to good effect. This has allowed what people want: more people to remain in their home longer receiving the services they need, although this does have its own implications for discharge planning and increased transition care requirements as well as the flow-on impacts for the acuity of older people accessing residential aged care.

The sustained high demand for comprehensive assessment and support plans by our aged-care assessment teams in Cairns is compounded by the long wait times on the national prioritisation queue for the Home Care Package. Clients frequently require reassessment because they are waiting for access to services for more than 12 months and their care needs change during that time—sometimes even longer. Despite that long wait time, due to the lack of service availability in most rural communities in the Cairns and hinterland service area, an approval for the Commonwealth Home Support Program does not actually always translate to access to that service. The overall impact of the system on clients and carers is that people do not have timely access to the services and supports they need to remain safely at home. This puts clients at risk of harm, hospitalisation and premature and early admission to residential care.

Clients and carers struggle to understand the system and how to access their packages once offered. Clients living in remote Aboriginal communities in the cape struggle to access the My Aged Care system, access an offered Home Care Package and, indeed, access enough support to remain in their community. It places demand on the public health system to provide supports that should be readily available to clients of the aged-care system, not to mention the human cost of those changes.

In our health service, specialist outpatient referrals continue to increase and, in turn, increasing elective surgery waitlists have meant that many people have either dropped their private health insurance cover or find that, due to policy exclusions, they are not always covered for the surgery that they need.

The health system is stretched and, with the added complexity of COVID-19 transmission in our community at the present time, it is important to acknowledge our hardworking staff and their commitment to providing quality health care to all Far Northerners. Despite these challenging times, our health service continues to seek innovative solutions to ease the pressure on our hospital and emergency departments and we have a number of exciting innovative initiatives. We welcome any changes or reforms that result in affordable, accessible and timely access to primary, allied and private health care, aged care and NDIS care services that will ultimately ease the pressure on the public health system and continue to provide the supports needed for our residents.

CHAIR: Doctor, those are some pretty stark numbers you have just provided us for the Cairns HHS. Can you confirm the number of vacancies? Did I hear 97 or 27?

Ms Cavanagh: It was 97 in the primary health network for GP vacancies and 27 for the allied health vacancies.

CHAIR: The impact of that is significant. The committee did receive, ironically, submissions from Mission Beach, frustrated that they cannot get a GP, and also from the Tablelands area, where residents drive an hour and a half to Cairns to access a GP. Quite clearly there is an impact on local communities if those GP places are not filled. Do you have any comments around the distribution priority area which, for the benefit of the people in the room, governs how many GPs go into particular areas? This is about solutions going forward in terms of recommendations. How do we fix this?

Dr Strivens: We know that Cairns is excluded from the GP prioritisation area at the moment, yet we still see shortages across general practices within our metro centres and this is exacerbated even more as we move outside of Cairns. We have a very good working relationship with James Cook University with the training of local graduates. We found that that is one of the things that has made the biggest difference with our hospital services as well—the ability to home-grow local

graduates. The graduates that come from the local area are far more likely to stay within the local area, and this has been a great initiative. We still find that that shortage is critically affecting what we are seeing across the community. This is not just about access to GPs by individuals in the community; it is also around the access for GPs to residential care facilities. That is where we have found that there is a cohort of fantastic GPs we work very closely with in residential aged care and community, but the use of telehealth to provide sole services to some of those facilities has really caused us some concerns and some issues.

CHAIR: For the benefit of the people in the audience, I come from Townsville. We do not have a GP providing service to the residential aged-care facilities, of which we have numerous in that area. Are there any programs that you are doing in that space to assist?

Dr Strivens: There have been a number of programs that we have brought in over the last couple of years. This has been part of the frail older persons initiative from Queensland Health, and one of these is our residential care in-reach service. We operate something called the Older Persons Integrated Health Service. That sits under my team. That provides two different facets of how we can support people living within residential care. One is the GEDI, or Geriatric Emergency Department Intervention, which is specialist nursing, allied health and medical practitioners within the emergency department seeing complex frail older people and looking at assessment, triage and streaming and trying to get people back home as much as possible. The other is our residential care in-reach service, which provides ED-level care within residential care facilities. This is providing support to individuals who maybe have a urinary tract infection, may have had a fall, may have had a laceration or a treatable chest infection and can give that ED-level care so that people get the right care in the right place at the right time and prevents unnecessary presentations and unnecessary admissions. It does not stop people getting to hospital when they need to come to hospital, but it means that they can get the care they need in the place where they want to get that care provided.

Hospitals are almost a perfect environment for causing delirium in older people. There is very little orientating stimuli, you get woken up at any time of the day or night and there is little natural lighting. It is not surprising that there are hospital acquired complications. We know that these sorts of programs reduce those hospital acquired complications. They have worked really well. Interestingly enough, they probably had a significant impact on how we have been managing the COVID outbreaks within residential care. We have worked very closely with the residential care providers, with GPs, with the primary health care network and with our public health team within the HHS to again provide a coordinated response rather than a fragmented one.

Mr MOLHOEK: Thank you for making the effort to be here today and thank you for your opening statement. How many beds does the Cairns health and hospital service have in total?

Dr Strivens: There are 531 beds in Cairns Hospital and I think 777 beds in total across the HHS.

Mr MOLHOEK: In terms of impact, 21 beds out of 531 in Cairns is not really an excessive impost on the system, is it?

Dr Strivens: As I explained, it is not just the number of beds; it is the length of time people spend in those beds. If you think about 11 months, with regard to the individual we were talking about, our average length of stay for a rehab episode is around 14 days. That is 22 rehab episodes that could have occurred in that time period. That is 22 individuals who would have benefited from integrated care into professional care.

Mr MOLHOEK: In terms of planning for the health service, I note that Queensland Health have implemented LANA, which is the local area needs assessment, that Queensland Health have been running separate to the PHNs. What service planning has been undertaken to meet some of those challenges for the Cairns health and hospital service? What thinking has gone in around catering for population growth and the ageing population—you touched on increased demand for dementia services and some of the others—and, more broadly, the issues of the adequacy of current bed capacity and what is required?

Ms Cavanagh: We are undertaking a LANA and we are working with the PHNs and a couple of agencies to develop that. It is still in the early stages. We are going through the process and obviously there have been some delays with COVID. Certainly, if there is other information around that I can provide that on notice, but at the moment it is a process we are still working through.

We have undertaken quite a number of service expansions or service design to help manage the non-infrastructure aspects of managing demand in the hospitals. We have ED Hospital in the Home. That is a focus on acute inpatient substitution with admissions direct from the ED department or ED short stay. We have an ED fast-track model of care, so that if there are low-acuity, low-

complexity patients that are ambulatory we can move them through the system quickly. We have a crisis support space that means mental health consumers can self-present in a crisis as an alternative to presenting to ED. We have a joint initiative with the Queensland Ambulance Service and the health service, and the QPS and the health service, around the co-responder programs for those respective services. We have system nurse navigators who work with the disadvantaged and vulnerable people in our region. They are community based nurses and their focus is on improving the outcomes for Aboriginal and Torres Strait Islander peoples and helping them navigate the journey.

Mr MOLHOEK: In terms of extra bed capacity, when I was here about 12 months ago members of your executive team suggested that you were at least 80 beds short on what you needed for current demand. I am curious to know what planning has occurred around meeting—really, at its heart, this inquiry is about the issues of bed block that are being created with aged-care services.

CHAIR: Deputy Chair, the inquiry is around access of primary care. I do not want to—but I will—

Mr MOLHOEK: I was about to say that, Mr Chair. The question around bed capacity was the one that I was curious about. I think what you have been saying is that there has been no actual planning under LANA at this point for extra bed capacity, rather than looking at alternative means of meeting demand.

CHAIR: I remind all members—and for the benefit of people in the audience—that our health committee has been asked to look at the provision of primary and allied health care, aged and NDIS care and the private healthcare system and any impacts on the availability and accessibility of those services to the Queensland public health system. I want to keep on topic in terms of that. I know that members to my left will have their views, but this is clearly in the primary healthcare space. I will allow latitude. We are at the start of the week, although we have a very busy week of regional hearings.

Mr MOLHOEK: I turn to the demands around primary and allied health care. We read in the submission from JCU and the PHN, and also we have seen in some of the material from Queensland Health, a lot of commentary around the incredible shortage of allied health professionals, doctors, specialists, GPs and rural trained GPs. I am interested to hear your thoughts on that as an issue and particularly some of the issues raised around our heavy reliance on overseas specialists. What do you think we can do to overcome that issue and get more Aussies trained to work in Cairns and other parts of rural and remote Queensland?

Dr Strivens: That is a great question. I came here for 12 months in 1996 and—

Mr MOLHOEK: We are very happy you are here.

Dr Strivens:—I am still here 25 years later. I think that probably comes to some of the issues I touched on in the opening statement around the importance of homegrown graduates. Half of our interns that started two weeks ago are from James Cook University, JCU, and we know that now increasing numbers of our specialists and GPs within the town and within the area have trained locally as well. I think home-growing our specialists across nursing, allied health and medicine is what makes the biggest difference. Within my own team at the hospital, currently five out of our seven older person consultants did their training in Cairns. That is a tremendous thing. We are finding more and more that by offering generalist training, by offering initiatives to provide people with the training they need locally, we are far more likely to get people to stay. This is not something that provides results overnight; it is something that requires a commitment over decades, really.

Mr MOLHOEK: It would be fair to say, though—we have had a health crisis and the pandemic to deal with—that this shortage of trained specialist health service providers is really our next crisis, is it not? It is looming large as an issue. I suspect there would be a lot of doctors in other countries who would love to move to Australia, but, if you look at the JCU stats, they tend to drift to Australia, come to regional parts and then, as soon as they can, they move to metropolitan areas. Would you agree it is a crisis that we need to really step up on?

Dr Strivens: I certainly think we need to step up and home-grow as many graduates across all health professions and also think about novel way of doing things. We talked before about the Frail Older Persons initiative. I would like to bring up another initiative that we have locally called OPEN ARCH, which is older persons enablement for chronic health conditions. This was initially a research based project that was jointly funded through Queensland Health and the primary healthcare network to provide specialist geriatric comprehensive assessment within general practice—so working directly with GPs in their own practices, seeing their patients there and, through a comprehensive assessment, looking at interventions, navigation and enablement. We showed through something called a stepped-wedge randomised controlled trial that people were able to maintain function rather than decline over time, which is what you would expect to see.

The reason I brought this up as much as anything is that it is looking at a prevention and interprofessional model of care. It is not just about GPs sitting over here, specialists sitting over here, nurses sitting over here and allied health sitting over there. It is coming together to create integrated care. The person who benefits then is the patient, the resident. That is what we need to be working towards.

Ms Cavanagh: There are also other enhancements we can do with our training programs. Particularly with reference to this commission, we can look at how the curriculums align with more of the growing needs for aged care, disability and community in our undergraduate training programs so that as students come through the pipeline they are more familiar with the different kinds of work and feel, therefore, more comfortable working in those rural and regional places.

Ms PEASE: May I begin by thanking all of the great health workers across all of the HHSs in Queensland. It has been a particularly trying time. We have talked about the pandemic. I want to acknowledge the great work of everyone—whether they are on the floor at the coalface or in the back room trying to make it all work. Thank you and I appreciate you, as do all Queenslanders, for your dedication. Can you give me the name of that program you are currently running? I missed the name of it.

Dr Strivens: OPEN ARCH.

Ms PEASE: It is still running?

Dr Strivens: Yes, it is. This is a great example of how you can try innovative models and get recurrent funding for them. By proving efficacy initially through the Integrated Care Innovation Fund set up by the state government in combination with funding from the primary healthcare network, we then got recurrent funding through the Frail Older Persons initiative.

Ms PEASE: In terms of how that operates with the allied health professionals—I assume you are talking about OTs, physiotherapists and all of those sorts of allied health services—are they from the private sector?

Dr Strivens: No. They are Queensland Health employees, but we work closely with private sector employees as well. We have our enablement officers, who are either nursing or allied health, plus the specialist and then a care program that is really individually designed in cooperation with the person themselves, their carers and their GPs. This can involve either public or private allied health, depending on what is the most appropriate and what is the most available.

Ms PEASE: The purpose of my question is that it is leading to cost and cost recovery. We have heard from other doctors and GPs in a particular area that the allied health services—the physios, the OTs—are not funded by Medicare and as a consequence the GPs are not able to utilise them for their older clients. If they do not have private health insurance—and you have indicated that many people are leaving their private health insurance because it is giving very poor rebates—how are you managing that side of things? Would most of the clients who are going to the private sector have private health insurance? Otherwise, the cost would exclude them. You talked about the allied services that might be available. They are not available in the regions. How do you cope with that?

Dr Strivens: Some of that is potentially available through a care plan from GPs. There are a limited number of sessions that they can access that way. Some of that does come back to the service of last resort, which is Queensland Health, and some of it is available through private health.

Ms PEASE: If they miss out on all of that, they just do not get it?

Dr Strivens: Yes. Again, I think that is where you look at innovative skill-sharing initiatives, where you are not just relying on having one of everything; you can look at other members of the team providing some of that support. There are some very good models within allied health.

Ms PEASE: You spoke about the Commonwealth funded home care packages. In a previous inquiry we heard about the huge shortfall and long delays in funding packages and keeping people in their homes. That would impact upon this program that you are talking about. If they are not eligible for that or they are waiting to get that, they have to either miss out on those services or be admitted to hospital rather than ageing in place and spending their end of days at home.

Dr Strivens: This is true. We do know that that wait, especially for the level 3 or 4 packages, can be 12 months and beyond. There is a burden on the people themselves, on their families and on the health service. Again, it is around the right care for the right person at the right time in the right place. You can fail with all four of those.

Ms PEASE: With regard to the allied health services that are not currently covered by Medicare, would extending Medicare to provide that support take some of the pressure off those patients going into a public hospital, for example?

Ms Cavanagh: While the Medicare Benefits Schedule has been excellent and has expanded to include allied health—remunerate the allied health to participate in case conferences so you can better manage patients with GPs in the community—there are still some gaps around that chronic disease provision. As you mentioned, there is a gap between what the MBS pays and what it costs an allied health professional to provide a service privately. Of course, that ends up with the patient being out of pocket and potentially then having to look to Health as a service of last resort. This is mainly because chronic diseases often involve multiple interventions. It is not just one type of allied health for five visits, or 10 visits if you are an Aboriginal or Torres Strait Islander person. That does create a gap. I would imagine that does create the capacity for patients having to look to other places for care.

Ms PEASE: With regard to the allied health services through the GPs, I thought that was just a small number of packages available.

Ms Cavanagh: My understanding is that under a GP management plan—and I am sure the PHN will be able to clarify further if I am wrong—the GP gatekeeps, mediates and initiates. They can access five allied health visits, or 10 if you are an Aboriginal or Torres Strait Islander person, over the year. That is across the spectrum of allied health professions.

Ms KING: Thank you for coming in. It is certainly a complex and very diverse community that you care for across the whole of Cairns and the hinterland region. My questions touch on that. You noted that there has been an 8.7 per cent increase in presentations to your hospital and health service. Was that over the last 12 months?

Dr Strivens: Yes.

Ms KING: That is a gigantic increase in presentations to be managing year on year. Has that been a consistent pattern?

Dr Strivens: It has been consistent over the last five years plus.

Ms KING: That is a gigantic increase each year in the amount of care and provisions of service. You went on to note that 65 per cent of those presentations in total, or just the increase, were categories 4 and 5?

Dr Strivens: They were the presentations to the rural facilities or the rural EDs.

Ms KING: If we have people presenting with category 4 and 5 type complaints, which for people who are present are generally less acute, that means they are not able, presumably, to present to a GP. Your services have again become that service of last resort for your community. I wanted to explore some of the reasons for people needing to or choosing to go through the door of a hospital rather than seeing an allied health practitioner or a GP. Is GP care affordable in this region for people insofar as you hear from your patients and clinicians?

Dr Strivens: You would probably have to ask the PHN for more detail.

Ms KING: I will.

Dr Strivens: There is certainly a perception from patients who come in around the availability of bulk-billing GPs and the amount of travel time that people have to do in order to get to bulk-billing GPs. There is also the importance of that consistency of GPs in having a practitioner whom you know and who knows you. That is so effective in managing chronic disease. It is not just about the affordability; it is about the individual as well.

Ms KING: There must be more to it, I would propose. It is a big thing to walk through the doors of an ED and wait for an extended period of time in some cases, as people with more acute conditions, of course, have to be triaged ahead of you. Affordability might be one part of the picture. What are the other parts of the picture?

Dr Strivens: There is sometimes the perception of an ED being a one-stop shop. It is difficult to get everything done in the one location sometimes in terms of pathology, radiology and access to multiple specialists or multiple disciplines, which you can do all in one stop sometimes within an ED. Again, that is not necessarily the best thing for you as well. It leads to potential misdiagnosis, overdiagnosis and hospital acquired complications.

Mr WATTS: I, too, would like to pass on my thanks to you for being here and to all of your staff for the hard work they do in the health service. I want to go back to the 21 beds. You gave the extreme example of 11 months. What would be the average across those 21 beds?

Dr Strivens: I would have to take that on notice to give you a precise number.

Mr WATTS: I am happy for you to do that, as long as the chair is. You said there were 97 vacancies for GPs. Do you have any vacancies for doctors within the hospital and health network at the moment?

Dr Strivens: At this time of year the vacancy numbers are relatively low because it is the beginning of the academic work year but, yes, there will always be vacancies. It can be hard to recruit hospital specialists. GPs are specialists as well but it can be difficult to recruit hospital specialists in certain specialities at certain times—much less so, I would say, in the last five to 10 years than it was 15 years ago.

Mr WATTS: Because of JCU's local impact?

Dr Strivens: Cairns has somewhat of a Goldilocks type appearance these days where it is not too big and it is not too small, but you need to get a critical mass of specialists in any one department to make recruiting attractive to people. This has play on looking at primary care as well. Gone are the days when people are wanting to be on 24 hours a day, seven days a week. If you are the sole practitioner in a GP practice or a sole specialist within a hospital, that commitment is challenging and can be difficult for anyone to sustain for a period of time. There is that concept of getting a critical mass within both primary care and secondary hospital care.

Mr WATTS: I want to go back to the 21 beds because I am curious about those. What was that like 18 months ago?

Dr Strivens: It is a good question, because one of the things we noticed from an aged-care viewpoint is that we have had a good increase in the number of aged-care beds over the last 10 years. If we were sitting here 10 years ago we would be saying how badly done by we are in terms of the number of aged-care beds. As I said, we have over 2,200 beds in the region now. The difficulty is that the people we have left staying in hospital are the most challenging in many ways. They have a significant impact on resourcing within the hospital in terms of bed availability and in terms of quality of life for people.

Being in hospital is like being in limbo. It is not the same as being within either disability housing or residential care which is your home and your life. Hospital is a place with lots of machines that go 'bing', harsh lighting and lots of noise. It is no quality of life for people, and 11 months is an interminable period of time for people to spend in hospital.

Mr WATTS: I absolutely agree. So 18 months ago it was probably about the same, or more or less?

Dr Strivens: Again, I would have to take that on notice to see what the trend was. Certainly our trend for aged care is that it is mainly challenging and responsive behaviours that are causing people to have extended stays. We know that there have been initiatives. I mentioned the initiative in terms of funding to look at a rapid response for disability which has made a difference. One of the more difficult issues is to find accommodation for people. That has certainly helped in that respect.

Mr WATTS: Based on what you are saying, over that 18-month period there has been an 18 per cent increase in ramping at the hospital, but it is not related to these 21 beds, you do not think?

Dr Strivens: It does have a relationship to those 21 beds. I do not think you can say that they are independent. If you are looking at ramping, you have a combination of two things: input and output. If you have 21 people who are not moving out, that reduces your flow. In terms of looking at increased activity as well, you have problems at the front end of the hospital and problems at the back end as well; you are looking at both intake and discharge from a hospital. Either path will cause you difficulties when it comes to the flow of patients.

Mr WATTS: But, generally speaking, you think it has been around about that number over that period?

Dr Strivens: As I said, I would have to take that question on notice. I do not have those figures at my fingertips.

Mr WATTS: I am interested. One of the things we are trying to understand is what is driving the health crisis that we are seeing. We hear a lot about bed block. However, if the bed numbers are the same as they were 18 months ago but the ramping is increasing, you have to then ask what is driving the ramping increase. That was why I was asking about the number of doctors within your own service as well. Obviously if there is a shortage of supply of doctors then that is something we need to address. I am not suggesting we do not know that there is not one, but I am wanting to see if it is impacting on yourselves as well as those external providers.

CHAIR: I think you made your point. We are just on time to take one more. This will be a technical challenge. We have the member for Mirani who has joined us via video link. Do you have a question?

Mr ANDREW: Can you hear me now?

CHAIR: I can hear you. If we need to, we will repeat your question. It will be the final question for this session.

Mr ANDREW: On the member for Toowoomba South's question about the ramping and the increase of show-ups in emergency, was most of that pre December 2017? Maybe you need to take that on notice. I am trying to understand where that came from and whether it was directly related to the lack of doctors and staff over the past 12 months or so.

Dr Strivens: As we were saying before, the increase in presentations to ED has been a consistent story for more than the last 12 months. Some of the vacancies within general practice and primary care have been an issue for more than 12 months. The question was more in terms of what might be driving the ramping?

CHAIR: Correct.

Dr Strivens: Certainly in terms of initiatives the HHS has put in place, they have done a lot of work looking at fast-tracking initiatives and working very intimately with QAS. We work, for example, with the Low Acuity Response Unit to send teams straight out to residential care at the referral from QAS; they do not even have to go anywhere near the emergency department. We have a senior consultant on a fast track to review people the moment they turn up within the ED as well. We have a hospital huddle every morning which has heavy representation from QAS there as well. My plea on all of this is always around integration. Integrated health care works. Integrated health care is effective.

Mr ANDREW: The reason I am interested is that there seems to be a trend across the state. Dr John Wakefield spoke about a 15.4 per cent increase in ED shows right across the state. I am trying to find out how that is affecting the other hospital systems, how it is affecting the ramping and the actual numbers of doctors, nurses and other staff to be able to address that and how that all ties into the NDIS matters. We need to understand exactly where this is coming from and what needs to be addressed from our end as well as the NDIS to make sure we have the best possible outcome for the patients. That is all.

CHAIR: We will take that as a comment. Thanks very much, member for Mirani. We have gone over time. I thank Dr Edward Strivens and Tania Cavanagh from the Cairns HHS. We really appreciate your insightful views and contributions here this afternoon in this inquiry.

Ms Cavanagh: Sorry, Chair, can I be indulged for a minute? I am sorry if this is inappropriate or too late, but I wish to respond to a comment earlier. We are doing infrastructure planning as well around the capacity issues. It is just that it is not being driven by the LANA at the moment—that is one of the processes that will inform it—but we have quite a few infrastructure projects underway. I just thought I would clarify that.

CHAIR: Thank you. As a reminder, any responses to questions on notice have to be back by 5 pm on Monday, 14 February. Thank you very much.

WHYTE, Ms Robin, Chief Executive Officer, Northern Queensland Primary Health Network

CHAIR: Welcome, Robin. I met you just before we started. I understand you have been with PHN for some 12 months and, interestingly, you ran a PHN in Victoria. We will be interested to see what the contrast was. I am sure you have an opening statement that you would like to start with. Thank you for your submission. Then we will move to questions.

Ms Whyte: Thank you for the opportunity. My name is Robin Whyte and I am the CEO of the Northern Queensland Primary Health Network. I would like to start by acknowledging the traditional custodians of the land on which we are meeting today and pay my respects to elders past, present and emerging. Thank you so much for this opportunity. It is great to meet you and I look forward to having a good discussion around this really important topic.

I know that the committee has already had a presentation from the Queensland PHN collective, so I do not intend to reiterate the role of PHNs, nor go over again the content of that last meeting. My focus will be around allied health and mental health in this presentation. I am taking one slice of the workforce to focus on because there has been a lot of discussion already around general practice et cetera.

Here in Cairns, the northern part of the catchment of the PHN, we have the second largest geographic area of any of the PHNs. It is just over 500,000 square kilometres. We cover an area from Dysart in the south, right up to the northern tip of Australia, and in the west to Croydon and Kowanyama. It is a huge geographic area. It has many of the diversity and complexity of geography issues that other PHNs experience, but perhaps much more so.

We have four health services in our catchment or HHSs: Torres and Cape, Cairns and Hinterland, Townsville, and Mackay. That is a large number of HHSs to liaise with, but we certainly do that; we work very closely with our HHSs. One of the things that I think is an important takeaway from our discussions, and you have heard from Dr Eddie Strivens already—Eddie has used the word 'integrated' for the service system, but we really need to start thinking about a single health service system and how that service system works, rather than thinking in silos and fragmented funding streams. We also work with 12 Aboriginal medical services. They are, of course, an important part of the service system and another group of partners that we work very closely with.

We have a population of just over 700,000. The majority of those people live in an urban or regional setting. They live in the regional centres of Cairns, Townsville and Mackay. However, we do have a substantial number of people who live in quite remote locations. Of course, many of those are our First Nations people. We have around 13 per cent of First Nations people in our catchment which is over 80,000 across our whole catchment.

As you can imagine, the geography and cultural diversity of this region present enormous challenges. It particularly occurs in the planning for health services because we need to be able to really tailor health service delivery to the local needs. The local needs are quite diverse, so we need to work with local communities very closely around planning, and we need to do that with our HHS partners, with our AMS partners and the other providers who are local to that area.

We have spoken this afternoon around the planning efforts of the HHSs, or LANAs as they are called. The PHN has its own health needs assessment. Really, for a local area, we just need one needs assessment and service assessment. We should be doing that jointly, and we are. We are working very closely with all of our HHSs. We have a joint working group and we are hoping by the end of 12 months that we will have a joint needs assessment. The importance of that, of course, is that we will have then a jointly agreed set of priorities and hopefully an agreement around which service provider will be delivering against each of those priorities. It is about making best use of what we have and working collectively.

In terms of allied health services, across our catchment we have lower availability of allied health hours than in other parts of Queensland, and that applies across many of the different allied health disciplines, for example podiatry, psychologists and dental. Those are just a few of the disciplines where we have shortages. However, one of the biggest priorities for us is around mental health and access to psychologists and other relevant allied health clinicians.

I know that there is a separate committee inquiring into the state of the mental health system in Queensland but, because of its significant impact on the public health system, we believe it is worthwhile mentioning mental health specifically to this committee. There are two key issues which are facing community mental health services provision, and they are workforce shortages and the

need to integrate across the currently siloed and fragmented funding streams. This is a consistent theme that we hear from community mental health providers. They are the two biggest issues facing the sector.

Primary care manages a large mental health disease burden. That burden of disease is increasing. It is the second most common chronic condition for general practice patients. On average, 38 per cent of general practice clients have a mental health condition. Of course, individuals with chronic mental health issues also tend to have other accompanying physical chronic health conditions. It is an important issue for us.

Northern Queensland is over-represented in the national suicide statistics. Particularly that is marked by a high percentage of male suicides and a high percentage of Aboriginal and Torres Strait Islander suicides. Cairns and Hinterland HSS has the highest suicide rate of any of the HHSs.

In common with other primary healthcare workforce, there is a maldistribution of clinicians and the psychology workforce is almost inverse to the level of need. You will tend to have a higher proportion of practitioners in areas like the centre of Cairns, but where the major areas of need are, particularly in the Far North, there are very few clinicians. Like every other piece of the primary health workforce, the mismatch is an incredibly big issue. The PHN works in close partnership with our HHSs to manage the transition of patients through the primary and tertiary systems. However, where there is a paucity of community mental health services the burden very quickly shifts to the hospital sector.

Through our commissioning, our integration and workforce development initiatives, the PHN have supported the development of the primary care service sector across the region on a variety of fronts. We provide funding to around 35 agencies in the Cairns region to provide mental health and alcohol and other drug services, particularly for our First Nations cohort, and homelessness. However, the unmet need for mental health and social and emotional wellbeing services for those vulnerable populations is now at critical levels across the NQPHN region; demand is far outstripping the availability of resources. That means that when people are unable to access support in their local community we know their only choice is to present at the ED and public hospitals.

Increased investments in mental health and suicide prevention are very welcome, but the health system needs to be integrated to prevent the gaps in the service system that currently allow so many patients to fall through the cracks between primary and tertiary care. For our region it is especially important that PHNs are given additional flexibility to co-design and implement models of care that go across the boundaries of traditional funding sources. We want to implement models of care that reflect the nature of the rural, regional and remote communities we work with. They need to be tailored to the local communities.

To make best use of limited financial and physical resources and people resources, we would recommend that there be a co-commissioning approach between state, federal and even local government funding sources that is wrapped around local communities and that is worked through between the HHSs, the PHNs and the AMSs. That means that we can make best use of a pooled funding approach and we can co-design targeted support that is directed at the most vulnerable and the highest priority needs according to the local communities. That will reduce inefficiencies and duplication of services. A connected approach is essential if we are going to tackle the maldistribution of the health workforce.

There is another thing that I would like to underline. We have spoken today about the homegrown approach for a primary care workforce. I would also like to emphasise the need to really focus on a First Nations workforce. It takes many, many years to develop a workforce and we simply do not have enough Indigenous clinicians and leaders. We need to be building that workforce so that we can provide culturally appropriate care to our First Nations colleagues.

I also want to make a note that the solutions for a primary care health workforce are very multidimensional. There is no single way that we are going to fix this issue. Instead, we need to focus on localised solutions that can take advantage of pooled funding, that can bring a multidisciplinary care team approach to primary care and that are also supported through accommodation, transport, schooling et cetera to really wrap the services around a primary care work team in a small local community. They are the major points I wanted to raise. I do think that mental health is an urgent issue in this part of Australia.

CHAIR: You are absolutely right. Thank you for bringing in that mental health aspect. The deputy chair and the member for Pumicestone are on the Mental Health Select Committee. There is more work to be done there. We are watching it very closely. In terms of the PHN, you mentioned 35 services that you fund. You have heard this afternoon that there are 97 vacancies. For the benefit of the people in the room, in that primary healthcare space, does the PHN do anything in terms of recruitment and retention of GPs?

Ms Whyte: We do a lot of work around the shortages of general practice and GPs in our region. We do some of that through advocacy and making sure that governments of all persuasions are aware of the situation. We have a lot of contact with our ministerial colleagues to make sure they are aware of our local situation as well. We support general practices in their applications for exemption. We were part of that process for the Mackay region and we were very pleased to get some successes in the Mackay region. I understand that we are hopeful of similar successes in Cairns. We do a lot of work with universities and also we go right back into secondary schools to encourage young people to step into healthcare professions. We work right across the sector to build up the workforce.

CHAIR: Does the Northern Queensland PHN have an annual budget?

Ms Whyte: Yes. Like any federally funded organisation, we have an annual budget. It is quite a complex budget. We have an operational budget and then we have specific programs. The majority of those program funds are commissioned out into the sector. Workforce is one of the ones which is encompassed within our operational funding.

CHAIR: Is any of that money returned from the PHN if it is not used?

Ms Whyte: There is a facility to roll over unused funds from one year to the next, so it is reinvested during the following year.

CHAIR: Can you provide any data to the committee about the last five years of the North Queensland PHN's budget so we can get a view on that? In terms of recruiting and retaining these GPs, I wonder if whichever minister you were talking to is aware that there are 97 vacancies right now in this part of the world, which is very concerning given the COVID situation. I and the committee would be interested to see what the budget looks like in terms of where it could be perhaps better allocated in targeting GPs in that space.

Mr MOLHOEK: On page 3 of the Northern Queensland PHN submission to the committee, the comment is made that there are no clear guidelines defining the integration between health and hospital services and PHN services. It says that, while most PHNs have excellent working relationships with corresponding health and hospital services, there is something of a siloed approach to planning for the delivery of services. Could you perhaps talk a little bit around what some of those challenges would look like and what lost opportunities occur as a result of that siloed approach?

Ms Whyte: I have spoken about our belief that there should be a single needs assessment that is a joint product of HHSs and PHNs—and AMSs as well. One of the lost opportunities there is the opportunity to join up and share data across the various parts of the service sector. If we all jointly had access to that data and could track the patient journey across the various locations of care, that would really assist that planning process. I think that is an important part of the infrastructure that really needs some investment. That is one aspect.

The other lost opportunity is to develop the integrated models of care, which have been referred to previously today. Those sorts of approaches really do require joint planning and joint design amongst the key partners. What happens instead is that we tend to duplicate services or there is a very inefficient delivery of services. It is evident right across the service system that funding is given in silos and quite defined outcomes for each funding stream. What we need more of is flexible funding streams so that we can develop flexible models to meet local needs. I think that is a real lost opportunity.

Mr MOLHOEK: We heard earlier that perhaps one of the reasons we had seen an increase in presentations to the ED was because it is more of a one-stop shop. I took from that—and I stand to be corrected—that there must be, therefore, a shortage of one-stop shops in terms of generalist practices or superclinics or whatever they call them. Could you perhaps tell us a little bit about what services are available outside of the hospital and health services as a one-stop service where there is pathology, X-ray and other services in the region?

Ms Whyte: We are funded through our after-hours funding streams to ensure that there is access after hours to locations in primary care rather than people having to go into the ED in the hospital. There are 24-hour clinics that we fund and those clinics would generally have access to pathology et cetera. They are certainly an adjunct to the service system.

What is really required is some broader hubs where there is a broader range of services that are available as a one-stop shop to patients who need to be able to access a variety of clinicians. You will find that there is a lot of advocacy around hubs for mental health—a bit like the recent federal Head to Health initiative, which is a very good initiative. That is the sort of thing we need to be investing in. We have the Head to Health service, which has just been stood up in Townsville. That has been co-designed in conjunction with the health service and the other local providers. It is an excellent

service model. The thing we would like to do is add to that service model and co-locate more community mental health services and other types of affiliated services so that there is a full model that people can access.

Similar models have been proposed for disability and NDIS, elderly, rehab—all providers are advocating for hubs or one-stop shops where you can co-locate a wide variety of services without the barriers of federal funding versus state funding—whether it is a local government service. We need to make the best use of the dollars that are being invested into local communities and clinicians actually need to be working alongside each other as well.

CHAIR: Just to confirm, I did have a conversation with you previously about looking at the budget and seeing what that rollover looked like in the last five years. Can you take that question on notice?

Ms Whyte: I will absolutely take that on notice regarding the last five years. I just note that the majority of those funds are commissioned funds and the department is quite stringent in how those commissioned funds can be used. We have a very limited amount that is allocated towards what is called general practice engagement. There is nothing specific for workforce.

CHAIR: I meant to add the context. There were a number of submissions—I think 70 submissions—and some of them talk to the short funding of programs. They will start a health funding program; it will last for 12 months or 24 months and it might be in the health prevention space; and then it will cease, so they do not have that recurrency. These are health providers that are in the primary healthcare space. That is the context. I am wondering what is happening with the dollars if these people cannot continue their programs, which are vital in some areas.

Ms Whyte: We have a three-year funding cycle. Where we can, we tend to commission for three years. We would like a longer funding cycle. I think that is already part of a discussion with the department around extending to a five-year funding cycle. It is a matter of working through how that actually happens on the ground, because that ongoing certainty is important to services.

CHAIR: Absolutely, and that came through in the submission. Thank you for that.

Mr MOLHOEK: I was going to suggest in terms of that question on notice that, because this is our first regional hearing, it may be of value to put that as a broader question to the PHNs and ask for that information across the services.

CHAIR: I will be asking all the PHNs as we go. Because I am in Townsville—and you are right that the northern PHN covers Townsville—we talk to health providers down there so I was really interested. I will be asking each of them as we go through.

Mr MOLHOEK: I am thinking that it might be good to have it consolidated so that we can see the full picture.

CHAIR: I am happy to take this one on notice as a starting point. Thank you, Deputy Chair.

Ms KING: Robin, as a member on the Mental Health Select Committee I know that we very much appreciate the focus you have brought to mental health and look forward to hearing from you further in our other inquiry on those matters. I am looking at page 5 of your submission, where you list some long-term systemic failures that have not been addressed at this point in time. Many of them feed into general practice availability. You note the declining favourability of general practice amongst medical graduates, the complex processes—we heard that from the HHS, which talked about difficulties that a particular practice had found in getting an identified GP because they could not sit their part 2 because of COVID—and also a failure of the distribution priority area system. I do have a couple of questions, with your indulgence, Chair. I want to ask about the declining favourability of general practice as a specialisation. In this region, is it your view that it is affordable to see a GP for the vast majority of your residents?

Ms Whyte: I am not sure there is a single black-and-white answer to that. I can tell you about the sorts of feedback we get from consumers in terms of access to general practice. Certainly there is commentary around the availability of bulk-billed practices and that it is more difficult than it used to be to find a bulk-billing practice. I cannot tell you whether that is a bigger problem in this part of the world than in other parts of Australia. I do not have that data.

What I can tell you is that the largest concern is not so much cost as access. Often there are not sufficient general practices if you go outside of the larger regional centres. There is a lack of access to after-hours. It is harder and harder to get GPs to go into remote and regional general practice. The views of graduates of medicine have changed. They are much less interested now in taking on the burdens of running their own private business. Most people want to work reasonable

hours. They do not want to be working after hours and they do not want to be trying to make a profit out of a business. They would simply like to be employed. That tends to be where the new graduates want to be. It really has changed; the landscape has changed.

Ms KING: Speaking to that and going more to the point of clinician feedback, are clinicians telling you that it is affordable for them to run a GP practice, particularly in light of the Medicare rebate freeze? Are these viable businesses that they seek to run?

Ms Whyte: The viability of general practice is more and more threatened, I think. It is not just an issue in this part of the world; it is more generally. I think the fee-for-service arrangements are more and more difficult.

Ms KING: You note, in addition, the failure of the distribution priority area system to properly respond to local needs. Can you fill us in more about the experience you have seen in this region and the regions that your PHN covers about how the distribution priority area system has worked or otherwise?

Ms Whyte: I start by saying that the DPA is a fairly narrow lever. It is one part of the puzzle. It is not a solution in and of itself. It is the system we have at the moment so, working within that, with COVID and with poor access to overseas trained doctors there has been enormous stress put on general practice. We have found that the DPA status has just not worked for us. It is no longer working.

Mr WATTS: Robin, I am interested in your comments around two areas: one is you said that 38 per cent of consults are mental health based; and the other is around how we might increase the First Nations workforce in the health system. Taking the second point first, if you were sitting here, what would you put in a submission for the state government to take a serious look at how we increase First Nations participation in health service delivery?

Ms Whyte: We have also heard to date about the homegrown approach. JCU has a very good program for homegrown. I would like to see greater use of that approach with the First Nations people. I do not know what the answer is—whether there is adding in financial incentives or quotas around First Nations people as part of the university intake. I do not know exactly what the answer is.

We convene a workforce alliance in this part of the region. That is one of the areas that has been agreed as a focus with that group. We have a working group that is looking at solutions around that at the moment. We also encourage traineeships et cetera and focus on some of the young Indigenous people in secondary school to get them into almost any aspect of health care, to be honest, because it is not just clinicians where there is a shortage; there is a shortage of administration as well. We are very strong on encouraging kids who are coming out of school to consider health care as a career and we get them trained up in certificate III so they get an easy access into the tertiary sector.

CHAIR: My apologies, member for Toowoomba North. I have been notified that we have gone over time. I apologise to the member for Mirani who might have wanted to ask a question. Sorry also to the member for Lytton. We will have to pull it up at this stage. Thank you very much, Robin, for your presence and contribution.

Ms Whyte: Thank you for the opportunity.

DOOLAN, Professor Denise, Acting Director Research Portfolio, Australian Institute of Tropical Health and Medicine, James Cook University

THOMSON, Professor Peter, Head of Dentistry and Professor of Oral and Maxillofacial Sciences, James Cook University

TRAVES, Dr Aileen, Senior Lecturer—Medicine, College of Medicine and Dentistry, James Cook University; General Practitioner, Thrive Medical Cairns

WEST, Professor Caryn, Professor of Nursing, College of Healthcare Sciences, James Cook University

CHAIR: Thank you all for being here today. We really appreciate your time. If you wish to make any opening statements please go ahead, and then we will move to some questions.

Dr Traves: We would like to begin by acknowledging the traditional custodians of this land, the Djabugay, Gimuy Walubara Yidinji and Yirrganydji people. We pay our respects to their elders past, present and emerging and extend that respect to other Aboriginal and Torres Strait Islander people who are present today.

On behalf of James Cook University I would like to thank the committee for inviting us to contribute to this important inquiry. I am Dr Aileen Traves, senior lecturer in general practice and rural medicine at James Cook University in Cairns and a local general practitioner. I obtained my medical degree and Master of Public Health and Tropical Medicine here at James Cook University and I am a proud alumnus of the inaugural class of JCU doctors. I undertook my internship in Cairns and specialist GP training in North Queensland and have spent my entire professional career of 17 years working as a doctor in regional, rural and remote Aboriginal and Torres Strait Islander communities in North Queensland. I have been involved in research regarding our medical graduate outcomes.

Joining me today is Professor Denise Doolan, the Acting Director of the Australian Institute of Tropical Health and Medicine at James Cook University. Denise is a professorial research fellow and NHMRC principal research fellow. Her expertise is immunology and vaccines. She is working on the development of vaccines, diagnostics and therapeutics for tropical infectious diseases including malaria. Professor Doolan has been appointed to the federal government's Australian Medical Research Advisory Board to provide specialist insights into Australia's medical research and innovation priorities, especially for regional Australia.

Professor Caryn West is a professor of nursing. Professor West is the Academic Head of Nursing and Midwifery at JCU, with 30 years of experience locally, nationally and internationally. Caryn's expertise involves nursing education, health workforce and nursing and midwifery capacity building. In the last 15 years Caryn has worked closely with the World Health Organization as the director of the WHO's Collaborating Centre for Nursing, Midwifery Education and Research Capacity Building. She has strong relationships in both education and research with the northern communities and health services. Caryn is also the Dean of Research at JCU Singapore.

Lastly, Professor Peter Thomson is Head of Dentistry at JCU. Peter is a specialist oral and maxillofacial surgeon and oral cancer researcher who has over 30 years of international experience in dental education and training.

We are here today to provide our lived professional experiences and expertise on behalf of James Cook University. Before I hand back to the committee for questions I would like to read an opening statement on behalf of JCU. I note that this is the opening statement for JCU and, whilst the statement might be longer than usual, it will stand as the opening statement whenever JCU does appear before your committee.

With the stated intent to create a brighter future for life in the tropics worldwide through graduates and discoveries that make a difference, James Cook University occupies a unique place in the higher education sector. In health and medicine JCU is a recognised leader in addressing the healthcare needs of rural, remote, Indigenous and tropical communities within Australia and internationally. The university offers a range of undergraduate and postgraduate courses in nursing, midwifery, medicine, dentistry, pharmacy, allied health and rehabilitation sciences, veterinary science, biomedical and molecular science, and public health and tropical medicine. JCU is also a leader in place based health research in the tropics, with a focus on diseases of high burden in the tropics, tropical health security and tropical health systems through the work of the Australian Institute of Tropical Health and Medicine.

JCU's activities span most of regional Queensland. We serve communities from the Torres Strait across to Western Queensland and as far south as the Sunshine Coast and the south-west. JCU has study centres in 16 towns across regional Queensland, in addition to our campuses in Townsville, Cairns, Brisbane and Singapore. This distributed regional presence differentiates JCU not only in relation to the spread of operations but also in the breadth and depth of our relationships with communities and industries across Queensland and northern Australia. We are delighted with the recent announcement of the new university department of rural health for Queensland that will be based in Emerald and will serve communities of the central west.

James Cook University is by far Australia's most successful university in delivering a fit-for-purpose health and medical workforce for regional, rural and remote communities. For instance, between 2016 and 2020 more than 85,000 health professional graduates responded to the national graduate outcome survey. While fewer than one in 40 of those were graduates of James Cook University, JCU graduates nonetheless accounted for more than 40 per cent of recent health graduates who are working in outer regional and remote locations in Queensland and one in five of those nationally. Mr Chair, I would like to present you with a printout of a range of infographics that present those results, along with a range of other outcome measures achieved by JCU, in a far more succinct and visually appealing manner for the committee's reference.

CHAIR: Is leave granted? Leave is granted. Thank you.

Dr Traves: These results have not been achieved by accident. The experience of JCU demonstrates that the most effective solutions for delivering a health workforce for regional, rural and remote locations is through vertical integration of education and training that is based in and designed for the needs of regional Australia, from admission to university through to professional clinical practice and beyond. This implies a greater emphasis on regional partnerships and the formal role of the university sector in supporting vertically integrated regional health professional training.

The elements of success are simple: prioritising admission of students from non-metropolitan backgrounds; emphasising rural health in the undergraduate curricular; providing extensive positive clinical placement experience in regional, rural and remote locations; providing rural health professionals are visible and making them visible across the training curriculum as academic leaders, teachers and role models and near peers; and ensuring that excellent clinical learning for students and new graduates happens in quality, well-supported teaching locations that include regional hospitals but also teaching private practices, teaching community pharmacies, teaching rural hospitals, teaching Aboriginal community controlled health services and teaching remote clinics.

Having a local presence in towns to develop and support students and the health professional workforce means having local clinical educators, professional and technical staff and Indigenous cultural educators; it means having local physical infrastructure such as accommodation, training rooms, simulation equipment and communications technology; and it means deep local partnerships, knowledge of people and community circumstances. Finally, it requires continuing evaluation and adjustments to the program design, in concert with others, to deliver the outcomes that communities need.

Research is part of the opportunity, too. We do not see research as being different and disconnected from health workforce education and training and health system strengthening. The research and innovation agenda can deliver locally relevant solutions for better access to quality care close to home. It also means that health professionals can combine clinical work with scholarship, teaching, leadership and research. Such enriched career opportunities help produce, attract and retain health professionals to regional, remote and rural environments. Upskilling rural and remote health professionals of all sorts through programs such as JCU's cohort doctoral studies program helps drive implementation research. By that we mean practical innovation solution finding in response to local issues and that is driven by local health professionals. Regionally based centres of research excellence, such as JCU's Australian Institute of Tropical Health and Medicine, provide infrastructure, expertise and local knowhow that can help make regional Queensland the ideal innovation laboratory for health services and health system innovation and research.

It is from this perspective that we are able to talk to you of the issues that are facing Queensland Health's workforce which in turn then impact on the quality of health services and health outcomes for communities in Queensland. It is across the elements that I have covered in this opening statement that we would request the Queensland government's continued help to support, strengthen and grow these endeavours. Specifically, JCU would ask the committee to recommend to government how they might better support a research agenda that serves the needs of regional, remote and rural communities of Queensland.

Given our success in supplying health professionals who go on to work in regional, rural and remote communities, we would encourage the committee to recommend supporting the expansion of health professional education outside of South-East Queensland, including JCU's bid for an increase in Commonwealth supported places for our medical program. Finally, consider recommending greater incentives and practical support for health students undertaking training in locations of workforce need, such as improved accessibility and affordability of student accommodation and reduced fees and levies for placement of students in those locations. Thank you. We would now be happy to take questions.

CHAIR: Thank you very much, Dr Traves, and all of you, for being here today. We really do appreciate it. I am going to just very quickly commend James Cook University. I have not been to the Cairns campus but I have visited Singapore, Brisbane and Townsville many, many times in terms of engagement with the School of Nursing, the School of Medicine, the rural GP training program and pharmacy—and my last visit to James Cook was around research. I cannot remember the professor's name; it was really exciting work happening in that space. Congratulations, too. I meant to bring a copy of Saturday's *Townsville Bulletin*. There was some positive news around GP training places that JCU undertakes all the time. I do not know if you can talk to that. In your submission and many other university submissions there is talk of the point that you made about the Commonwealth training places. Whilst it is great to have homegrown local people, our workforce has absolutely been reduced with COVID stopping the international medical training places as well. Can you talk to those points?

Dr Traves: Sure. I think from a JCU perspective, one of the things we have certainly been very conscious of is that recruiting and training locally has resulted in better retention. The idea behind the Commonwealth supported place increase would be that we were able to offer the entire course. As you know, at the moment only the final three years are offered in Cairns. It is a six-year undergraduate program for medicine and so students have to go to Townsville currently for the first three years of the program, which is a deterrent for some local students. Certainly every year when we get our clinical students who return to Cairns—a lot them are from this region; they are from the Tablelands and some of them are from the cape. It has been a huge disincentive for some of them to have to move to Townsville for the initial three years. Being able to provide the entire medical curriculum, from years 1 to 6, in Cairns, Townsville and Mackay would have an impact on actually improving the recruitment and potentially future retention of students across the whole patch.

CHAIR: Well said. Deputy Chair?

Mr MOLHOEK: I add my thanks to those of the chair for you being here today and the great work that you do. Reading the submission from JCU, it is an amazing story. It is a great story in terms of the impact that you are having on rural and remote health. Just to declare an interest, my son is actually an SMO in Emerald and the acting district medical officer there. He did the rural health scholarship through Griffith. As a parent of a rural health student, I have a bit of an appreciation of what is involved.

In your submission on page 12 you make some comments around participation rates in different areas of allied health. There is a comment that strong ongoing support from Queensland Health is required to ensure that as many allied health practitioners as possible can access the courses and the full scope of practice. Not to single out Queensland Health, but what would further assistance from Queensland Health and the larger university system mean in terms of training more allied health professionals and what is it that you need from Queensland Health in that respect? Is it more places?

Dr Traves: That might be best to directed to my colleague Caryn.

Prof. West: Thank you for the question. I cannot speak specifically to allied health. I can speak specifically to nursing and midwifery. In both instances it is never as simple as just offering enough places or educating more students in that space. The health costs associated with allied health students and nursing midwifery students are absolutely vast. The degree itself does not cost a lot, but it is uniforms, transport to and from their professional experience placements and accommodation when they arrive—even if there is accommodation. Certainly since the pandemic accommodation access has decreased immeasurably for many students.

Mr MOLHOEK: There was a comment in your submission around the cost impost. You come to Townsville or Cairns to study, you then get a placement in Cunnamulla, Emerald or Stanthorpe or wherever it is, and then there are additional costs.

Prof. West: There is an additional cost on top of that. From the university we pay the health service for that experience, but the students have to pay for their own transport to and from whilst they are there and for their accommodation costs.

Mr MOLHOEK: Is your program similar to the Griffith University program where they actually have created these dorms and training centres at different hospitals across the state?

Prof. West: For some health students, yes, accommodation is provided, particularly for medical students. For nursing/midwifery and allied health students, no. We have had nursing students go together and stay in a caravan park or rent an apartment if they can get one. You cannot rent an apartment at the moment. I currently have a nursing student on professional experience placement living in a tent in a caravan park because there is nowhere else for them to live. There is the cost of getting to and from most of the very remote communities in the cape. Often the accommodation is what we can beg, borrow and steal. We have a great relationship with Queensland Health. If we can access Queensland Health accommodation we can for a small stipend, but often the cost is down to the students. In saying that, with sending a student anywhere, whether or not in a regional setting, they have to have a clinical educator that is going to guide them through that process. That comes at a cost, too. Our program within nursing/midwifery is very different to other universities. We provide the clinical partner, or we have a partnership with the health service that means that we have training program that is one-on-one and they have a clinical coach that they stay with for the time they may be allocated in that facility.

Mr MOLHOEK: Given we have heard a lot about the shortages of allied health workers right across the broader spectrum of Queensland, and probably Australia for that matter, I guess it makes this inquiry fairly timely, but it would seem it is time for the educational institutions and the health services and the PHN and everyone to come together with a much higher level strategy on how we are going to—

Prof. West: Absolutely. Our colleague from the PHN earlier spoke about a shift in burden. When we look at these problems we look at what we can access in a regional place, but Queensland and the communities we serve are vast and there are great distances between. As of last year, there were 7½ thousand registered physiotherapists in Queensland. To send a student on a clinical placement and have them supervised so that they are supported and safe—and that is huge in health; we have to make sure that our students provide safe care to the community member that is receiving that care—you have to have a senior or an expert in that field that is there and prepared to take that on, on top of their normal workload, and often that is not the case. We cannot always find that expertise. Across the board in health we have an ageing workforce, we have a workforce that is decreasing and we have a fatigued and burnt-out workforce.

Mr MOLHOEK: About six months ago one of your colleagues in Townsville said to me that the other issue is that a lot of the goodwill in regional, rural and remote health has left the system as well.

Prof. West: Yes.

Mr MOLHOEK: A different generation saw it differently, but they have kind of run out of steam in some respects because the system has been so stretched.

Prof. West: Across the board in health the system is stretched. It is paper thin. People are worn out. We are expecting a critical shortage of nurses—midwives in particular—by 2025 across the globe for many, many reasons. Currently in Queensland there are about 69,000 registered nurses and midwives.

CHAIR: Another 9,000 on the way.

Prof. West: We can keep making allied health professionals and student nurses, but as our colleagues from the Cairns Hospital also said, once they come out of my doors over a period of three to six years there has to be someone at that end who can also nurture them and grow them. We have a three-year in particular nursing/midwifery course. Many countries have a four-year one. The expectation is that I can provide work-ready nurses in three years and, given the scope of health and the landscape of health care, it is a challenge.

CHAIR: Is JCU aware of the availability of medical training places in other jurisdictions? I am interested to look at the comparable data. How is Queensland going compared to South Australia, New South Wales, Victoria and Western Australia? I do not know whether that is available or whether JCU is looking at that.

Dr Traves: It certainly is. I think that would be, from the medicine perspective, a good question to defer to Professor Richard Murray, who is appearing on Wednesday in Townsville.

CHAIR: We will hold that over, thank you.

Ms PEASE: Thank you very much for coming in. I am not sure that you can actually answer this question. You have talked about the great work that you do in training participants to stay remote, to go regional. I know that you train them to be a specialist and a GP or whatever, but in terms of being able to continue to run their practices when they go out into the community or work in the

community, particularly in terms of the costs that are associated with it for them and the freeze on Medicare, is that something that you get involved in at all? It is a very costly exercise and I can only imagine that it is much more costly to do it remotely. To be getting paid $39 for each visit—I cannot imagine that that would go anywhere near covering the cost for a GP.

Dr Traves: Certainly that is something in my teaching. I coordinate the fifth-year general practice rotation for our students in their second clinical year in Cairns. They do a lot of placements in practices and we encourage them to spend time going and talking to practice managers, finding out what is actually involved in running the practice, because I do not think that is well taught. We certainly do not spend a lot of time teaching business skills and other necessary skills to be able to run a private practice that does come at significant risk and significant cost. Certainly that has been a disincentive for people to go into general practice, because they see that happening: they see many small local practices being bought by corporate clinics that are perhaps better prepared to be able to take on board those risks.

The reality is that the Medicare freeze since 2013 has not kept up with the costs of running a practice. It just does not compare. Unfortunately, as much as we value Medicare and are grateful for that system, it does not actually cover the costs of running a practice anymore. Hence there are increased access issues. There are problems accessing bulk-billing GPs because, unfortunately, the only way to actually make that sustainable is to offer very short consults, which do not actually provide good quality care.

Ms KING: Thank you all so much. Can I specifically thank you for that incredibly well put together submission that we all read with enormous interest. The scope of it was extraordinary, so thank you so much. I do want to go to a particular point that you made on page 18 of your submission. Specifically there was a comment—

> The Australian General Practice Training program (AGPT) is no longer fit-for-purpose and would benefit from a comprehensive review as part of this broader examination.

Could you please provide us with a bit of commentary? Specifically, how is the AGPT no longer fit for purpose and what changes, in your view, are required to bring it up to date and make it effective?

Dr Traves: I am sure that Professor Murray would also like to comment on this on Wednesday, but, certainly having seen several iterations of AGPT—I know that when I first began my training the AGPT was relatively recently introduced. We have certainly seen various changes along the training program over that time, including a change from a previous regional training provider to a regional training organisation to it being actually delivered by James Cook University in our local area. With each change an enormous amount of knowledge is lost and an enormous amount of goodwill in the community is lost. It takes a while to rebuild that, and JCU has had the advantage of having those connections, because of the undergraduate training, to be able to pick that up and actually not go backwards in the transition period. The ongoing problems with that program, having it geographically distributed and delivered and constantly changing, have led to things going backwards. The change to college-led education will add another level of issues and we can see that that is actually not moving things forward.

Ms KING: I have been absolutely unable to locate the comment I read in your submission, but somewhere you noted about the transfer of Commonwealth supported places to Orange. Is that part of what you are describing there, or not specifically?

Dr Traves: I do not know whether that is specifically what that was referring to. That would be a question best directed to Professor Murray.

Ms KING: I may have dragged it from somewhere else but I will talk to Professor Murray about that.

CHAIR: It is in the JCU submission, but we will ask Professor Murray.

Ms KING: We will ask Professor Murray. I did want to ask for further information about the demand versus supply issue. Very clearly, you do an incredible job of providing health workers who are highly motivated overall to work in a rural setting. Do you have enough Commonwealth supported places to capture all of the people who are interested in remote, rural and regional practice or are there some going unmet?

Dr Traves: Yes, there are definitely some going unmet.

Ms KING: Say I was a medical student who was burning to work in a regional setting and I did not manage to secure a place with you. What would be the barriers to me ultimately ending up in a regional practice setting?

Dr Traves: Obviously it is dependent on where the training does occur, but there are various barriers.

Ms KING: Say I ended up in a metro setting because that is where I could find.

Dr Traves: Yes. The reality is that if you train in a metropolitan area you are more likely to establish networks there. We know that people are more likely to meet life partners there, settle down there, have family there and enrol their children in local schools and less likely to leave the metropolitan area. If training only occurs in a metropolitan area with outreach style regional, rural and remote experiences rather than being based in those areas, it does not lead to retention of those practitioners because they establish their links in the metropolitan centres.

Mr WATTS: Obviously we are representatives of state government and your places are primarily federally funded. From a state government perspective, when we design and build medical facilities should we be designing and building more accommodation so that students and others can go there more easily?

Dr Traves: I think that is hugely important and certainly beneficial for the students. Certainly it has been a very clear difference between our medical students and other allied health and nursing students who have not had the same ability and provisions for them in our rural and remote training areas. We see very clearly for medical students that if we can provide accommodation in the local areas that definitely decreases the barriers to going to those places. It is important to remember that those students are also paying rent in their home location at the same time and they are students, so they are financially stretched anyway. They are leaving their jobs: they often have part-time work where they are living. They are leaving those opportunities, leaving their financial income and continuing to pay rent in the home place while they are on their rural placement. Because in the medical program it is a significant amount of placement hours, the provision of accommodation in those areas certainly helps.

Mr WATTS: Someone trains in a metro area, they have their life set up in a metro area and they then go out to a regional area. It is not only the travel time, distance, friendship, part-time job, accommodation but all of these barriers added together, and they go, 'I think I will just go to one down the road.' Is that a fair surmise?

Dr Traves: Yes, that is very fair. It also makes a difference what their backgrounds are. If they come from a regional and rural area, they are much more likely to appreciate what it is like living in those areas and be willing to continue living there and to actually seek out further employment in similar areas.

Mr WATTS: That brings me to my second question. How do we increase the First Nations workforce participation in health services of all descriptions? In terms of recruiting people from First Nations, particularly those who live remotely, and getting them to university, is there any specialist adaptation program or support program to help people transition into studying in health services at JCU?

Dr Traves: Yes, there are. We certainly have support programs in place in terms of our Aboriginal and Torres Strait Islander support services within the university, but I think as our colleague Robin from the PHN was saying, we certainly have spent a lot of time at James Cook University going on rural high school visits, going and talking to students in rural areas and taking our students out to the communities as part of things like the Rural Health Club, which actually goes out into communities and talks to students who do not actually believe that that is a possibility for them and to make it real and to give them a contact point of people with whom they can discuss what is involved, whether it is possible and whether that is something they could look at. Unfortunately, we know that one of the barriers for them is cost, because they are generally having to leave home. Other universities have significant amounts of funding and scholarships that they are able to offer to students. That is not insignificant in terms of financial support, and JCU does not have as many scholarships available at the same amount to the students.

Mr WATTS: One of the things the state government could do to increase workforce participation would be to look to scholarships and look to support accommodation—all of these things that add to participation in studying and hopefully retention in those areas. Am I reading that right?

Dr Traves: Yes, that would be correct.

CHAIR: I am mindful of the time. I am not sure if the member for Mirani has a question.

Mr ANDREW: Doctors and professors, thank you very much for coming in and giving evidence and bearing witness to this event. I have recently had a lot of students come to me and send me emails about not being able to complete their course because of the mandates. Do you have any issues with mandates affecting your nursing staff and the staff going through your courses at the moment?

CHAIR: Member for Mirani, I am going to rule that question out of order. It is not relevant to the inquiry. Do you have another question?

Mr ANDREW: It reduces the overall staff, Chair.

CHAIR: I have made a ruling, member for Mirani. Professor Doolan and Professor Thomson, you have heard some commentary today around student placements. Did you have any observations before we wrap up this session?

Prof. Doolan: I am here from a research perspective and I wanted to reiterate that research is really important in things that may not be so obvious. One of the things which actually is obvious is that the health needs are different in Tropical North Queensland as opposed to elsewhere, and that is why addressing whatever issues we particularly need to be addressed up here is really important. What we can do is really work with the local communities and identify areas of need and diseases of need. For instance, melioidosis is an area that is regarded as a fairly high priority up here whereas it is not down south. The research and innovation agenda, as has been communicated, is not really a separate area. I know it is not featuring very much here, but it is really an important underpinning of the whole inquiry.

Not only do we address particular research needs; we are also helping to build the capacity of the local GPs. We are trying to help the recruitment, because bringing up the rural GPs and providing them the ability to upskill actually helps recruitment. It is also providing enriched career opportunities as well as helping find health solutions which can help the communities access our health system. I know that some of the members of the committee have heard a lot from the Australian Institute of Tropical Health and Medicine and other avenues and I think are aware of some of the work that we do, but I also want to extend the invitation for anyone to come and visit us anytime.

CHAIR: Thank you very much, Professor Doolan. Professor Thomson?

Prof. Thomson: I really do have to extend a formal invitation to you to come and visit us at JCU Dental in Cairns. JCU dentistry has been phenomenally successful in its 11 years. About 65 per cent of the students we recruit are rural and regional applicants. If you look at the statistics, 75 per cent of all rural and regional Queensland dentists are JCU graduates. We have JCU Dental clinical facilities at Cairns and Townsville. Those facilities have contracts with Queensland Health to deliver public health care.

One of our aims is to improve the range and the quality of available care for patients. Over 70,000 patients have been treated by JCU Dental since its initiation. These are people who would not be able to afford dental care anywhere else. As a plea to the state government, the funding for those patient treatments has not changed in 11 years. That means that it is not going to be sustainable in the long term as we have had to increase our expenditure, obviously, to improve the safety in COVID times for our staff, our students and our patients.

In terms of placements, our fifth-year students have a unique opportunity to travel to over 20 rural and regional hospital and healthcare rural health services. We are very proud of the effects of that not only on producing a work-ready graduate but also in locating and identifying those centres as places to come back to. Again, like nursing and midwifery, we find that our students have to pay a lot for accommodation and travel. These are areas where I think help would be welcome.

CHAIR: I just wanted confirmation on the funding. You said it had not changed in 11 years. Is that federal funding?

Prof. Thomson: It is Queensland Health. We provide over 66,000 weighted occasions of service for dental care. Queensland Health's budget for that is $3.55 million. It has not changed in 11 years. Increasingly it is becoming unsustainable, taking it forward.

CHAIR: Thank you very much for highlighting that. I thank you all for your contributions. It has been excellent having you here. Again, James Cook does commendable work in all of its campuses. I am immensely proud of the work and output of training local GPs. I have a friend in the Ambulance Service who went through medicine and is practising in Townsville. Well done. Thank you very much.

Proceedings suspended from 3.03 pm to 3.19 pm.

BURNS, Dr Louise, Private capacity (via teleconference)

CHAIR: Dr Burns, thank you very much for dialling in and being available. Would you like to start with an opening statement before we move to questions?

Dr Burns: Good afternoon. Firstly, I would like to thank the committee for allowing me the opportunity to speak today. What I have to say is purely from my own experiences and personal opinion, not from the perspective of an expert in the field of health related economics and politics. My name is Dr Louise Burns. I am currently a medical intern at Mildura Base Public Hospital in Victoria. I was born and raised on the Tablelands, mainly in Dimbulah and Mareeba, and at the end of high school I was accepted into the Bachelor of Medicine/Bachelor of Surgery program at JCU under a medical rural bonded scholarship. It had always been my intention and passion to return to Mareeba as a doctor.

I was unable to complete my internship in the immediate year following my graduation and as such lost the pool A applicant status for the internship recruitment. The intern recruitment is allocated to different pools, and pool A is for Australian citizen immediate graduates of a Queensland university and guaranteed an intern position in Queensland. Pools B to D comprise all other applicants, who are not guaranteed a position and are subject to merit based selection. I applied for exemption from the merit based selection and to be placed in pool A as my absence from medicine was due to extenuating circumstances. I was unsuccessful in obtaining this exemption and was given little feedback as to why.

As a result of being a pool B applicant, I was not offered an internship position in Queensland. It is my understanding to be due to two reasons. One, the merit based selection heavily relies on support from previous medical supervisors. As I had not had any supervisors for a number of years, this put me at a disadvantage. My referees were unable to complete the report because of this. Two, the number of applicants for the 2022 internship recruitment was overwhelming. Once pool A had been allocated, the number of positions left for pools B to D was minimal. I do not have exact numbers, but I estimate there were several hundred applicants for approximately 10 positions. I would like to point out that I have not been able to obtain exact figures. I was unsuccessful in the Q Health recruitment and have moved to Victoria to begin my career.

The doctor shortage in rural and remote Queensland is widely publicised. There is a shortage of senior doctors and it has been suggested that more medical student places are needed. I absolutely disagree with this. The bottleneck is not with the body of students but with the number of intern places available. I reiterate: there were several hundred doctors who did not get an intern position this year in Queensland. There is no shortage of junior doctors, just doctor positions. My case is an example. I am an Australian citizen who graduated from a Queensland university that has a focus on rural and remote health who wants to work in rural and remote areas but was denied the opportunity of an internship in Queensland as I was not an immediate graduate of the previous year.

It seems that the Queensland government is trying to patch up the situation by flying in international doctors to fill senior positions. I believe this is a bandaid solution. To maintain a sustainable doctor population there needs to be consistent transition from medical student to senior doctor. The way forward is to increase junior doctor training positions so there is a flow-on effect to increasing senior clinician numbers in years to come.

I would also assume that the retention rate of Australian trained doctors would be higher than that of our international colleagues. There is not a shortage of medical students and potential interns, but there is a shortage of positions available. The health budget needs to focus on training Australian doctors from their intern year. However, I do not believe this is a matter of simply increasing intern numbers. There needs to be an increase in senior clinicians to guide intern training. It is a catch-22. I believe that while the Queensland government is temporarily boosting senior doctor numbers it should be taking advantage and slowly increasing intern positions with the view of long-term sustainability in the profession. Thank you.

CHAIR: Thank you very much, Dr Burns. We would welcome you back to rural, remote and regional Queensland in a heartbeat. There are 97 vacancies, we just got told, in this area which covers Mareeba and the Tablelands, in the Cairns HHS. I wanted you to unpack that pool A number of intern places. That is guided by whom? Who makes those decisions?

Dr Burns: The number of intern places?

CHAIR: Yes.

Dr Burns: I am not sure exactly. It is a Queensland Health recruitment. I am not sure whether Queensland Health is the body that decides or the health department. I am not sure.

CHAIR: Those placements are federally funded. We have had the PHN in here today. There is very much a recurring theme in the submissions that medical places are capped at universities by the Commonwealth so that would be the governing body that oversees the amount of medical placements. Your story is a real shame because I would much rather see you back up here, considering you are from the area.

Mr MOLHOEK: I do not want to seem to be contradicting you, Chair, but I thought, Dr Burns, what you were saying is that there is not a shortage of graduates or student doctors; there is a shortage of intern opportunities within the health system. Did I misunderstand?

Dr Burns: That is what I believe, yes.

Mr MOLHOEK: Are you on a rural generalist scholarship program?

Dr Burns: As I was away for a number of years, my medical bonded scholarship was decided to be—how do I put it? We came to an agreement that I did not have to repay the years in rural practice. Actually, when it comes to the rural generalist program, I am sure you are aware that the student can apply for the program from their intern year. I actually went to apply for it but was knocked back because I was not an immediate graduate. There is another shortfall, I guess you could call it. It seems that if you are an immediate graduate you have all the opportunities in the world, but if you did not start work immediately after graduation then your opportunities as an intern become extremely limited.

Mr MOLHOEK: We might raise some further questions about that down the track.

CHAIR: Dr Burns, thank you very much. We have your contribution recorded in *Hansard*. We do appreciate you phoning in. All the very best with the situation. I hope you get back here at some stage.

Dr Burns: That is the plan. I do plan to come back to Mareeba.

CHAIR: Thanks very much. I am just going to open it up to anyone else who might want to make a contribution.

de BRUEYS, Ms Carrie, Service Manager, Tableland Community Link Association Inc.

Ms de Brueys: We made a submission around the issues with our clients getting doctors appointments or any new clients coming to the region unable to get a local doctor. It has a knock-on effect around continuity of doctors appointments or seeing the same doctor each time which we feel impacts their health long term. There are no specialists on the Tablelands, or very few that outreach. In saying that, we support people all the way from Ravenshoe to Kuranda and everywhere between from Atherton. If they have specialist appointments they need to attend in Cairns, they do not consider travel—whether they have to be supported or whether they have a disability—to attend those appointments or the waitlists for therapies, OTs in particular, which are vital for NDIS funding to continue. The ones we have are doing a brilliant job, but there are not enough of them. There are huge waitlists for OT and speech in particular. Then if they do have a medical issue alongside their disability they are on huge waitlists for surgeries and things like that, which obviously now have been extended because of the current issues.

Just to give an example of appointment issues, if we are travelling from the Tablelands and they have an appointment at 9.30 in the morning, that can be a huge thing if it takes an hour to get the person ready in their home and to then transport them down to an appointment. Sometimes they care; sometimes they do not, so I point out that that is a huge issue. There are also no bulk-billing services on the Tablelands at all. There used to be a dial-a-doctor type bulk-billing service, which did not last very long. That has disappeared now.

CHAIR: Thank you, Carrie. We did receive some submissions from the Tablelands area identifying the lack of GPs and access and people having to drive here for care. Do you have any observations about that? Obviously you have been following the committee's work. In terms of providing those GPs, what would your message be to the government responsible? Under the provision of GP training places, we have heard from the universities and the PHNs that that is a federal government initiative. When we are hearing from people in Mission Beach and the Tablelands who cannot access a GP, what is your message to them, because you are looking after people in the NDIS space who need care?

Ms de Brueys: Yes, it is vital. I do not know what the answers are, but I guess this is a great start—putting it all on the table and looking at solutions across the board. Something I did not put in my submission but I would like to say around the NDIS health debate is that what is funded where is often a big issue. Health will say it is funded by NDIS and NDIS will say, 'That's not funded by us,' and the fact is that there are people in the middle there. They have a disability and they often have complex health issues alongside that and that needs to marry together for the best outcomes.

Mr WATTS: You said there was difficulty getting in to see specialists for appointments. What sorts of time periods are people waiting and what complexities is that adding to the services you have to provide if they cannot get to see a specialist?

Ms de Brueys: It can vary, but often they are waiting over a year. I guess it is how they are categorised within the system, which would say it is either more important or not, but for many of the clients we support it is a long time and in our opinion that can then cause further issues to differing health.

Mr WATTS: I am just trying to understand if that is also impacting. There is a lack of GP services, and we accept that, like everybody. I think that has been firmly established. They cannot get to see a specialist. Obviously as complications are occurring they also cannot get to see a GP, so the whole thing is just cascading.

Ms de Brueys: Yes, so often they will end up at the hospital and back to square one and along you go.

Mr WATTS: So more specialists being available within a more appropriate time would be helpful?

Ms de Brueys: Yes, absolutely, and if they are servicing regional areas more often.

Mr WATTS: What would that look like in terms of a specialist going into the region and offering their service?

Ms de Brueys: That does happen on the Tablelands but not a lot, and then if you want to see them on the Tablelands that list is even longer than actually getting them to Cairns.

Mr WATTS: Are these coming out of the public health system—the specialist who is coming up?

Ms de Brueys: Some are private. I think most of them are private who go up to the Tablelands; yes, they are private.

Mr WATTS: So there is no Queensland government specialist being provided to go and do those kinds of remote clinics?

Ms de Brueys: No, not that I am aware of. No, I do not think so, no.

CHAIR: In terms of the allied health—occupational health, physio—that is what we heard were required. You might recall that in the first hearing and on Bribie we had a group of allied health professionals who had stood up a service in Western Queensland.

Ms KING: Yes, in south-western Queensland. It was around St George, wasn't it?

CHAIR: Yes, out that way, and they were doing some really good work with NDIS participants, and that lady became emotional. The funding had been cut and the whole service was removed from that area, not unlike an Atherton or Mareeba shire, so the importance of keeping those processes in place is absolutely vital. That is just a comment from me. It just reminded me of that in terms of what I was picking up.

Ms PEASE: Thank you so much for coming—it is really lovely to see you—and thank you for your commitment to your organisation. I missed where you said you were from. Are you from Mareeba or Atherton?

Ms de Brueys: From Atherton.

Ms PEASE: Do you have any GPs at Atherton at all?

Ms de Brueys: Yes. There are quite a few doctors surgeries.

Ms PEASE: Right, and are you able to access them?

Ms de Brueys: Not if you are a new person, no, and even to get a general appointment is very difficult.

Ms PEASE: So you need to know three weeks in advance if you are going to be sick?

Ms de Brueys: Absolutely; yes, you do. You can generally get a follow-on appointment fairly easily and within a good time frame, but you need to know well in advance that you are sick in order to get an appointment, yes.

Ms PEASE: Do any of the practices bulk-bill?

Ms de Brueys: None that I am aware of, no.

Ms PEASE: What is the demographic of your community? Can they afford to visit the GP?

Ms de Brueys: No. I sit on a lot of committees at local level council and we are a very aged community, in Atherton in particular, or the Tablelands regional area, so, yes, it is very hard. To be on NDIS you have to be under 65, but if you are in the scheme you then get a pension card, and we have a couple of clients. One sees a doctor in Yungaburra because the doctor in Atherton was never there and it was very hard to get them in, so we moved him over there, and he now still has to pay for that appointment because he is seeing a doctor outside his geographical area and it is not covered, so he pays $80 a visit and he has some ongoing health issues so he visits regularly. I do not think that is fair. If he saw a doctor in Atherton it would be free because he has a pension card, but he has to pay because he sees someone 13 kilometres away because that is all we could get at the time.

Ms PEASE: Thank you, Carrie.

Mr MOLHOEK: I add my thanks, as everyone else has, to Carrie and for such a beautiful part of the country. I served some time up there with the Atherton council a few years ago in a different role. Tell me about outpatient services and other services that are available up there. Is there a hospital and Queensland Health service there?

Ms de Brueys: Yes, there is a hospital. We are actually getting a new hospital as we speak. I believe there are no extra beds in that new hospital, but it is a new hospital with upgraded facilities as such. If we have to send a client for a catheter change or whatever, it is a long wait sitting in the waiting room, and that could be an issue. To do some services you have to be a registered provider under the NDIS and a lot of services are pulling their registration because of the issues around that which means they are back to the health system to deliver services. We have a particular client who is NDIA managed, meaning all their services have to be done by a registered provider, but they cannot get Blue Care to come and do their catheter change so they have to go to the hospital.

CHAIR: That is crazy.

Ms de Brueys: Yes, and that is where the disjoint I was talking about between health and NDIS services is. There is still some work to do but, in saying that, it is a great scheme and we love it.

CHAIR: The burden goes back on to the public health system.

Ms de Brueys: Yes, it does.

CHAIR: We really need to fix that primary space.

Ms de Brueys: And mental health space as well. I heard them speak previously. We do support people with mental health issues and it is an enormous issue between where they get services and the ongoing services available to them. They often end up in the mental health system down here in Cairns because we do not have a facility up there. We try and keep connected with that, which is very difficult, and they are basically set up to fail. They are sent home without what they need in place. We do our best, but they often end up back in the system because there are not all of those services around that support them to be at home, basically.

Mr MOLHOEK: Pre the NDIS, because this is all fairly new, how did that all work? How did people get the services they needed?

Ms de Brueys: They did not.

Mr MOLHOEK: So has it actually improved?

Ms de Brueys: It has. They used to get the five appointments through Queensland Health for whatever services they might need, but the lists were huge to get into the actual hospital to see any allied health. The fact that they are funded now through NDIS means there are more options, but there is still a big lack of services. They might have the funding but they cannot get a service because we do not have the service.

Mr MOLHOEK: I suppose you could say that maybe there has been a lag in the system catching up with the new demand because of all the NDIS funding?

Ms de Brueys: Yes, absolutely. We have long waiting lists for new people, especially OTs. Like I said, their reports are crucial.

Mr MOLHOEK: Would you prefer the current system or do you want to go back to the old system?

Ms de Brueys: No, I absolutely prefer the current system.

Mr MOLHOEK: We just have some work to do between Queensland Health and the federal government and everyone getting the mix right?

Ms de Brueys: For sure, yes.

Mr MOLHOEK: Thank you.

Ms KING: Thank you, Carrie. I think we all recognise and appreciate your commitment to your clients that brings you in here to sit all day through the submissions and to have your say about the people you care for and what they need. I want to talk about a couple of things you mentioned. You specifically mentioned that there is a lack of NDIS services, so people might have a package but are not able to spend their package on the services they need and deserve to give them the best life that NDIS is designed to provide.

Ms de Brueys: Yes.

Ms KING: Can you just give us a sense of what is the greatest need? What are the services that people cannot get on the Tablelands?

Ms de Brueys: Probably the allied health. Then if you are talking about registered providers it is just simple things like cleaners and lawn mowing, because—

Ms KING: So everything from assistance with everyday living through to specialised allied health?

Ms de Brueys: Yes.

Ms KING: Can you run us off a little bit of a list of some of the allied health practitioners who either are in too high demand or just are not available for your clients?

Ms de Brueys: OTs in particular—like, big lists—and speech therapists. Physio and exercise physiology is pretty good in that a lot more have opened up in that space in the Atherton region, so the lists are not huge to wait for them. OTs would be the biggest because their reports are so important, especially going into reviews, which can be yearly—some are pushed out to two-yearly or three-yearly—but without those reports and evidence not much happens. An OT looks across the board at a person and how they live and how they function.

Ms KING: Are your clients paying out of pocket for those reports for their reassessments through NDIS?

Ms de Brueys: They are generally funded—unless they are new to the scheme, and then they are paying big money for those.

Ms KING: We took submissions in some of our other hearings, particularly in my community of Bribie Island, about people paying up to $850 for those, multiple times in some cases.

Ms de Brueys: I was going to say that that is cheap.

Ms KING: Gosh! What kinds of prices have you heard of for those assessments?

Ms de Brueys: For a complex assessment, between $500 and $1,000 generally.

Ms KING: I also wanted to ask you to elaborate, if you would please: what are the major specialists that your clients wish they could access closer to home or more readily?

Ms de Brueys: I am not sure I could even elaborate exactly because everybody is different, but any specialist really. If it saves them a trip to Cairns—that sounds simple but it is definitely not; it is huge—even for a simple procedure to be done at Cairns Base over Atherton Hospital. We have clients who have to come down for chemotherapy, for instance, in Cairns ongoing and we often ask them to admit the client because coming up and down when you have had chemo for 10 days straight is not pleasant. That would add to people in beds in hospital who potentially could be at home every night if that could be done in Atherton.

Ms KING: Are there enough NDIS providers in the Atherton community to meet the need?

Ms de Brueys: No. We knock back people all the time in that we do not have the capacity to take them all on. Sometimes we will do part of their plan, so we will help with plan management or coordination of that plan, but we cannot deliver the services they require, or when we are doing coordination we cannot get the allied health professionals to get in there to assess them and do what they need to do.

Ms KING: What happens to those people you cannot take on as a client?

Ms de Brueys: We will refer them to other services to see if they have capacity. We have capacity, but it really depends on what comes in your door as to whether we can actually take them on or not. Like I said, we will take part of them on and we will refer them elsewhere, but often they get just referred back. We get asked by Mission Australia, who is the LAC for our region, every other day to take on people, but we do not always have the capacity, especially if they are complex and they have a lot of issues.

Ms KING: These are people who have gone through all of the hoops required to get approved for NDIS and then they cannot find somebody to help them?

Ms de Brueys: To take them on, yes.

CHAIR: How many clients do you have?

Ms de Brueys: We currently have, I think, 161 clients.

CHAIR: Commendable work, I have to say.

Ms de Brueys: And we have 48 staff. That is a range of plan managed clients, support coordination and we do direct supports both in home and in the community. Our main focus as an organisation when we started was community access, so getting people out into the community. That is still our main focus, but we are even now looking at providing housing in Atherton because there is a ridiculous need for housing and waitlists and stuff not relevant to this but still.

Mr MOLHOEK: Will that make you one of the biggest employers up there?

Ms de Brueys: We are one of two of the main providers in Atherton, but there are a lot of pop-up ones that have come about since NDIS came into the region.

CHAIR: What is your company name?

Ms de Brueys: Tableland Community Link.

CHAIR: That is right. I read the submission. Thank you so much for it, too. It was a really good submission. Thank you so much for coming down here. Member for Mirani, did you have any questions?

Mr ANDREW: Not at this stage, no, I do not. Thank you for your work, Carrie. I bet you are up against it out in the back sticks there.

Ms de Brueys: Yes. We do our best.

Ms PEASE: I just want to elaborate on the shortage of allied health providers. Is that across the board for the general public up in Atherton? I know that it is not just access for NDIS clients, but is there just a general shortage?

Ms de Brueys: I imagine so. Obviously we only focus on who we support and what we can get, but I presume it would be, yes.

Ms PEASE: Do you have any comments about why?

Ms de Brueys: Just that people actually have funding now to get those services.

Ms PEASE: But there is a shortage. Do you have any idea why they might not want to be in Atherton? Is it too remote? Do they not get paid enough?

Ms de Brueys: No, I do not think so. I think it is what you were saying before: the NDIS came in and the demand did not match what was being offered.

Mr MOLHOEK: There is plenty of funding, just not enough people to do the work?

Ms de Brueys: It seems to be, yes.

Ms PEASE: I guess what I am alluding to is the fact that you cannot claim those allied health services on Medicare. For a holistic approach to health, if you went to your GP—and the primary focus is to look after the patient, to help them in their journey through life and wrap around all of the services that are there—that is not available in Atherton, where you are, for your clients in the NDIS but the general population. What is causing that? Is it because people are not going to set up shop there because they cannot afford to go there because it is not covered by Medicare? I know that they get a practice plan where they can go five times, or 10 times if you are Indigenous, but it is not going to be an ongoing business model for those people to go in there. That was all I was trying to get to.

Mr MOLHOEK: Is there a question there, Chair?

CHAIR: I think it was a comment. Carrie, thank you so much for your contribution and for speaking today. We really do appreciate it. Thank you to you and your team for the work you are doing in your community in what I consider a beautiful part of the world. I love the Tablelands.

Ms PEASE: My family is from the Atherton Tablelands. Pease is a very well-known name.

CHAIR: It reminds me very much of New Zealand—just replace the cattle with sheep. I thank everyone for their contributions today. We have the good doctor who stayed on to listen. It has been really good to be here in Cairns to hear about the local challenges. That concludes the hearing. I declare this public hearing closed.

The committee adjourned at 3.50 pm.